CHILD LIFE SPECIALISTS' EXPERIENCES WORKING WITH PHYSICALLY ABUSED CHILDREN

THESIS

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CHAPTER 1

INTRODUCTION

The hospital experience can be frightening and stressful for anyone, particularly children. In the past few decades, child life programs have become universal in almost all children's hospitals in order to offset the psychological effects of hospitalization for children (Child Life Council, 1998-2003). Within these programs, child life specialists work with children and families in order to increase their understanding of the hospital and the stressful life experiences that accompany it (Child Life Council, 1998-2003). They also recognize and support the strengths of the family involved, provide an emotionally supportive environment, and help promote normal growth and development (Child Life Council, 1998-2003). As a result, child life programs have been very effective in reducing stress and anxiety in hospitalized children (Lizasoain & Polaino, 1995; Zahr, 1998); therefore, making hospitalization a more positive experience. However, due to the effects physical abuse has on children, child life specialists must sometimes adapt their usual practices to better work with this population.

In 2003, Child Protective Services (CPS) investigated three and a half million reports of abuse and neglect and found substantial evidence of abuse in 872,000 of these cases (U.S. Department of Health and Human Services, 2005). Physical abuse constituted 152,200 of these cases (U.S. Department of Health and Human Services, 2005), According to the Federal Child Abuse Prevention and Treatment Act (CAPTA), physical

abuse is characterized by "the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking, or otherwise harming a child" (Hornor, 2005, p. 5). As a result of this abuse, many children need medical attention.

It is not uncommon for children in the hospital to be admitted as a result of physical abuse even though not all abusive parents will bring their children to the hospital. In fact, 10% of all emergency room visits for children are the result of physical abuse (Chang, Knight, Ziegfeld, Haider, Warfield, & Paidas, 2004). Furthermore, the American Academy of Pediatrics (1998) found that 57% of the 608 pediatricians surveyed had treated at least one injury resulting from child abuse. It is often the doctors and nurses who are first to recognize the signs of abuse (Kaufman, 1999). However, misleading histories and parents who appear caring and interactive with their children make it hard for health professionals to identify or even suspect child abuse (Dickens, 2001; Leventhal, 1999). Thus, the continued interaction with the child and family put child life specialists at an advantage in identifying cases of abuse. Specifically, because child life specialists focus on the family as well as the child, they have the opportunity to observe parent-child interactions and identify patterns that might suggest child abuse (Benbenishty & Chen, 2003). Additionally, child life specialists are an integral part of helping abused children cope with the hospital experience.

Theoretical Framework

Although child life has been around since the early 1920s, it has never really been a focus of empirical research. There is, however, a vast amount of empirical research regarding both children in the hospital and children who have been physically abused, but the research assessing these two phenomena together is non-existent. This study will

examine child life specialists' education, training, confidence, and knowledge working with physically abused children, as well the experiences they encounter working with this population. Furthermore, child life specialists will identify characteristics they have observed in physically abused children and discuss how these characteristics affect the ways in which the child life specialist works with these children in the hospital. Because there is a lack of previous research in this area, qualitative methods are used to better understand the experiences of child life specialists. More specifically, grounded theory, as outlined by Strauss and Corbin (1990), will provide an appropriate theoretical basis for this study.

Originally developed by Glaser and Strauss (1967), grounded theory provides a set of procedures for inductively discovering theory from data directly as opposed to using previous research or theoretical frameworks. Rather than establishing a theory and using research in an attempt to support the theory, the grounded theory approach analyzes themes as they emerge from the qualitative data in order to create theory. Thus, the methodology, data collection, analysis, and theory are all interconnected. In this approach, once a research problem has been identified, researchers immediately begin collecting data (most often by conducting in-depth interviews and focus groups). Then, they begin coding the data (most often transcripts from the interviews), line by line, to identify emerging themes that can be categorized. Data are continuously analyzed and incorporated into the emerging theory until the categories become saturated, meaning no new ideas emerge.

In order to ensure grounded theory has practical applications for the specific phenomenon being studied, four central criteria must be identified: 1) the theory must *fit*

the area in which it will be used, 2) the theory must be *understandable* by laypersons in the field, 3) the theory must be *general* enough to apply to a variety of daily settings within the field, and 4) the theory must provide some *control* over the situations it describes (Glaser & Strauss, 1967). Because this study seeks to understand the experiences of child life specialists working with abused children in the hospital, as well as identify practical implications for future use, the grounded theory approach provides an appropriate framework for the analysis of the qualitative data in this study. In addition, a quantitative analysis will be used to describe child life specialists' experiences, especially those relating to education, training, and knowledge of physical child abuse, as well as confidence working with physically abuse children. Furthermore, this study will combine the qualitative and quantitative data to provide a multi-method analysis of some of the concepts included in this study.

Problem Statement

Despite their extensive education of medical practices, most professional staff in the hospital feel they have limited education regarding appropriate practices for situations involving child abuse (Flaherty, Jones, & Sege, 2004). Although not empirically supported, it is assumed many child life specialists would feel unprepared to handle such cases as well. This assumption is based on the fact that certification for child life requires courses and training in the areas of child life, family dynamics, child development, family development, counseling, psychology, education, sociology, expressive therapies, and therapeutic recreation (Child Life Council, 1998-2003). However, there are no requirements for education or training in recognizing or working with children who have

been physically abused. Therefore, it is important to determine the current levels of education and training child life specialists receive regarding child abuse.

In addition, in order to determine how child life specialists can work most effectively with this population, we must examine, from the child life specialists' point of view, what characteristics physically abused children exhibit in the hospital setting and how these characteristics may influence the ways child life specialists work with them. Finally, there are many experiences that healthcare professionals will encounter that will remain ingrained in their minds forever; working with victims of physical abuse is one of them. Some of these critical experiences will affect the ways in which professionals handle these situations in the future. In this study, a critical experience will be defined as one that "has had a significant effect on you and/or your approach to working with physically abused children." By analyzing these critical experiences, one can further educate child life specialists who will be facing these same challenges in the future.

Research Questions

Research Question 1: How much education and training have child life specialists had in recognizing physical abuse and working with physically abused children?

Research Question 2: What knowledge do child life specialists have regarding working with child abuse?

Research Question 3: How confident are child life specialists in working with children who have been physically abused, and what factors are related to this confidence?

Research Question 4: What characteristics have child life specialists noticed among physically abused children, and how do these characteristics influence how the child life specialists work with these children?

Research Question 5: What critical experiences have child life specialists encountered working with physically abused children, and how have these experiences influenced the way child life specialists work with these children?

CHAPTER 2

REVIEW OF LITERATURE

The purpose of this chapter is to examine the education and training of child life specialists and review the literature regarding physically abused children and the experiences of health care professionals who serve them. The review begins with an investigation of what is currently known about the education and training of certified child life specialists. However, because no research exists regarding child life specialists' experiences working with abused children, other healthcare professionals' experiences recognizing and reporting child abuse are discussed. Next, the qualities that characterize physically abused children are examined, as well as the ways in which these qualities may influence how child life specialists work with these individuals.

Education and Training

As a profession, child life was developed in order to help children turn their hospital experience into a positive one. In order to do this, child life specialists provide a number of services to both the children and their family. These activities include non-medical preparation for procedures the child may encounter, support during these procedures, therapeutic medical play, activities to promote normal growth and development, and support for grief and bereavement (Child Life Council, 1998-2003). Certification for child life requires a minimum of a bachelor's degree and an extensive child life internship (Child Life Council, 1998-2003). Child life specialists typically have

a degree in Child Life, Child Development, Family and Human Development, Early Childhood Education, Special Education, Recreation Therapy, or Psychology (Miami Children's Hospital, 2004). However, any degree is acceptable as long as the individual has a minimum of ten three-hour courses in any of the following: child life, family dynamics, child development, family development, counseling, psychology, education, sociology, expressive therapies, or therapeutic recreation (Child Life Council, 1998-2003).

In addition to a bachelor's degree, child life specialists must complete a minimum of a 480 hour internship under the supervision of a certified child life specialist (Child Life Council, 1998-2003). The general goals of this internship include: 1) providing meaningful therapeutic relations and activities, 2) assisting children and families in adjusting to the healthcare setting and experience, 3) sharing observations and experiences with on-site supervisor, 4) participating in the interdisciplinary team approach to care, and 5) preparing and carrying out healthcare education for patients and/or family members (Children's Hospital of Philadelphia, 1996-2004). These goals were taken directly from Children's Hospital of Philadelphia because it was rated as the number one pediatric hospital by U. S. News and World Report (2005); however, these goals are common among most child life internship programs. Following the internship, potential child life specialists must pass the Child Life Certification Exam before they can become certified child life specialists.

Interestingly, there is no mention of formal training in recognizing and reporting child abuse in either the educational requirements or internship goals. In addition, there are no educational requirements on how to work with children who have been physically

abused. It is likely that students will only receive training in this area if a child abuse case presents itself during the course of the internship. As a result, many child life specialists may feel unprepared to handle such cases.

Recognizing and Reporting Child Abuse

Most of the current research regarding child abuse and medical care focuses on the healthcare professional's responsibility to recognize and report abuse (Flaherty, Jones, & Sege, 2004; Gunn, Hickson, & Cooper, 2005; Russell, Lazenbatt, Freeman, & Marcenes, 2004). Flaherty and colleagues (2004) found that both past experiences and a sense of responsibility to make a correct assessment greatly affected physicians' decisions to report suspected child abuse. Specifically, physicians who previously made a report to Child Protective Services (CPS) and later found out the report was unfounded or the injury was not the result of abuse, subsequently held a much lower confidence in their ability to detect abuse (Flaherty et al., 2004). In addition, every physician described at least one emotionally charged experience that strongly influenced his or her subsequent response to suspected child abuse (Flaherty et al., 2004). Some of these experiences caused physicians to change their office routine, while others began to question the consequences and value of reporting to CPS. Similarly, Gunn and colleagues (2005) found that physicians who previously testified in child maltreatment cases or had been threatened with a lawsuit were less likely to report future cases of suspected abuse. Although there is no knowledge of how these situations have affected child life specialists, it is likely they have experiences similar to these physicians.

In another study, Russell and colleagues (2004) investigated healthcare professionals' perceptions of their ability to recognize child abuse in order to determine

further educational and training needs for these individuals. The researchers identified several barriers that prevented professionals from taking action against suspected cases of abuse: 1) fear of misdiagnosis and its consequences, 2) uncertainty of guidelines for reporting child physical abuse, 3) professional challenges (such as red tape, time constraints, workload stresses), and 4) perceived need for further education and training. This is extremely important given the fact that the National Society for the Prevention of Cruelty to Children (NSPCC, 2002) found that if all healthcare and social professionals were better informed, more confident in their ability to recognize child abuse, and put best practice procedures in place, many infant deaths and serious injuries to children would have been prevented.

The healthcare professionals sampled for each of these studies included physicians, nurses, and social workers. The literature regarding child life specialists is sparse. To date, no studies have been done investigating child life specialists' knowledge and training of child abuse, their confidence in their ability to recognize abuse, or their experiences in reporting to CPS. This study looks to fill this gap by examining the education and training child life specialists received regarding recognizing and treating victims of child abuse.

Characteristics of Physically Abused Children

In order to identify implications for treating physically abused children, it is important to first examine the qualities that characterize this population. Previous researchers have studied both the characteristics of abused children and the psychosocial effects of the abuse. Although, much of this research is significantly outdated (e.g., Chan & Leff, 1988; In & McDermott, 1976; Kempe & Kempe, 1978; Martin & Beezeley,

1976), current research and textbooks still reference these seminal studies (Crosson-Tower, 2002; Scott, Burlingame, & Starling, 2003).

Martin and Beezeley (1976) were the most prominent researchers to study the characteristics of physically abused children. In their study, which included more than fifty abused children, ages 2 to 13, the most notable characteristic identified was the child's inability to enjoy life. In fact, abused children described life as very unrewarding. This has significant implications for child life because research has shown that attitude and positive affect will speed up the recovery process (Gidron, McGrath, & Goodday, 1995; Smith & Zautra, 2004). As a result, this characteristic could negatively impact abused children who have been seriously injured and require a longer time in the hospital for recovery.

Another characteristic Martin and Beezeley (1976) reported among abused children was "pseudo-maturity," meaning they seemed very old for their age. However, physically abused children are often developmentally delayed due to a lack of comprehension and ability for abstract thought (Tarter, Hegedus, Winsten, & Alterman, 1984). This incongruence presents a problem for the child life specialist who may have a difficult time determining developmentally appropriate activities for these children. Furthermore, the effects of hospitalization, psychosocial needs, and level of understanding of the hospital experience are all greatly dependent upon developmental age (Gaynard et al., 1998). As a result, appropriate interventions can be complicated by children's mismatched developmental and maturity level.

Kempe and Kempe (1978) also studied characteristics of abused children. In fact, they were the first to describe the "frozen watchfulness," or hypervigilance, seen in these

children. This term is used to describe the way in which abused children are very aware of their surroundings and will react quickly to any changes in those surroundings. Because the hospital is a new environment, it is likely this hypervigilance will be even more observable in the hospital.

Hypervigilance also makes it very difficult for these children to play, explore, and move spontaneously from one toy to another (Chan & Leff, 1988). This will affect the ways the child life specialists is able to work with the child because play is such a large part of the interaction between a patient and the child life specialist. Additionally, this hypervigilance oftentimes presents the child with too many nervous stimuli, causing physically abused children to have difficulty paying attention to and following through with instructions (Chan & Leff, 1988). As a result, child life specialists would need to address these issues in their interventions by working to lessen the environmental stimuli surrounding the child and perhaps providing the child with simple one-step instructions.

Researchers have also found that physically abused children often report feeling a complete loss of control (Bly, 1988; Crosson-Tower, 2002; Simmons & Weinman, 1991). As a result, it is likely that children will try to exhibit control over their environment (Crosson-Tower, 2002). For example, a child may attempt to assert his or her control over the situation by refusing to take medicines or not participating in activities arranged by the child life specialist. Therefore, child life specialists must take these issues of control into account when planning therapeutic interventions. One way child life specialists could accomplish this is by giving the children simple choices regarding their environment (e.g., Would you like your family in the room for this procedure? Would you like to take this medication with water or apple juice? Would you like the curtain

open or shut?). In doing so, they are providing the opportunity to enhance the child's sense of control, which is generally something that has been lacking in the home environment.

Previous research has also consistently shown that physically abused children tend to be withdrawn (e.g., Hoffman-Plotkin & Twentyman, 1984; Kaufman & Cicchetti, 1989; Martin & Beezeley, 1976; Salzinger, Feldman, Hammer, & Rosario, 1991, 1993), possibly as a defense mechanism against further punishment (Crosson-Tower, 2002; Horton & Cruise, 2001). In other words, the less the child draws attention to himself/herself in the home, the less likely he/she will be abused. Furthermore, Chan and Leff (1988) found that extremely withdrawn or inhibited children who have been abused may need to learn how to play. In fact, their research found that some of these children may not be able to use the toys purposefully, and some may not even be able to recognize toys (Chan & Leff, 1988). This will greatly affect how child life specialists work with abused children because they generally spend a significant amount of time with the children in play.

On the other hand, some researchers have found that children who have been physically abused may show more aggression (Erikson & Egeland, 1987; Kaplan, Pelcovitz, & Labruna, 1999; Kendall-Tackett, Williams, & Finkelhor, 1993). This aggression will not only be demonstrated with peers, but may be observable in the child's relationships with adults as well (Horton & Cruise, 2001). Aggressive behavior towards an adult is often used to test the relationship; the child is trying to determine if aggression towards the adult will result in counter-aggression (Chan & Leff, 1988). Mann and McDermott (1983) found that caring adults, such as child life specialists, working with

these children must use positive guidance strategies by enforcing consistent, firm, yet non-punitive limits when addressing behavior problems and attempting to increase compliance.

Besides aggression, physical abuse impacts children's ability to form social relationships with individuals who are trying to help them. For example, children who have been physically abused have more socially disturbed behavior, start more fights, show less cooperation, and demonstrate less leadership (Ammerman, Cassisi, Hersen, & Van Hasselt, 1996; Haskett & Kistner, 1991; Lane & Davis, 1987; Salzinger et al., 1993). Although the general nature of the relationship between the child and the healthcare professional is within the context of the doctor/patient relationship, the lack of social skills could greatly affect the relationships the child develops with the doctors, nurses, and child life specialists who are trying to help.

Research has also shown that children who have been physically abused may be subject to great social distortion. In other words, the child may have strong misconceptions of other people's feelings, behaviors, or intentions (Salzinger, Feldman, Hammer, & Rosario, 1993). This misconception may interfere with establishing a strong, trusting relationship between the child and those who are trying to help him or her. These shortcomings could not only affect abused children's ability to create a trusting relationship with the professionals, but also hinder their ability to differentiate between the pain caused during medical treatment and the pain inflicted on them at home. Most maltreated children fear adults, in general, and the future violence they may encounter by being around them (Jones, 1986; Mann & McDermott, 1983). Chan and Leff (1988) found that by using simple, gentle, supportive statements frequently throughout

procedures, health care professionals could help the child understand that the pain is the result of the treatment by a caring adult, rather than an attack by an abusive adult.

Furthermore, children who have been abused are very susceptible to the fear of being "bad" and tend to interpret the abuse as their own fault. Subsequently, they are very likely to view the hospitalization as result of their own behaviors (Horton & Cruise, 2001). If parents leave their abused child at the hospital alone (a common practice), this abandonment only reinforces his/her belief that he/she is "bad" and deserves to be in the hospital (Jones, 1986; Kempe & Kempe, 1978; Mann & McDermott, 1983). Therefore, it is important for the child life specialist to help the child understand his or her hospital experience.

In addition to the qualities and implications already reviewed, poor language development and verbal inhibition are generally seen in victims of child abuse. This has been attributed to the interruption in development of self-esteem, lack of opportunities to converse with others, and lack of trust that coexist in abusive relationships (Crosson-Tower, 2002). This poor language development is also seen in abused children's inability to label feelings and use language to understand these feelings. Because the ability to label and understand feelings can help relieve some of the tension brought on by these feelings (Chan & Leff, 1988), this inability to relate language to feelings can be detrimental for children as they attempt to heal in the hospital.

This poor language development also has implications for play. Mann and McDermott (1983) noted that abused children communicate much more through actions than through verbalization. Because of this, play is extremely important for the child life specialist in communicating with the child. However, pretend play of abused children has

been described as a "disjointed, chaotic puzzle" (Irwin, 1983), therefore, making it difficult for child life specialists to use play as a tool for communication.

Summary

In this review of literature, healthcare professionals' experiences working with physically abused children and the specific characteristics of physically abused children were examined to explore how these concepts might relate to child life specialists working with physically abused children in the hospital. It was found that most healthcare professionals lack confidence in recognizing child abuse (Flaherty et al., 2004) and perceived a need for further education and training (Russell et al., 2004).

Child life specialists, in particular, could benefit from further education and training because of their unique relationship with hospitalized children. In fact, many of the characteristics of physically abused children have direct implications for child life. For example, the hypervigilance seen in these children makes it difficult for them to play and explore (Chan & Leff, 1988), while their lack of control in life has caused the children to try to exhibit control over others areas of their environment (Crosson-Tower, 2002). Both of these characteristics may interfere with the child life specialist's goals for the child. In addition, research has shown physically abused children tend to be withdrawn, aggressive, and subject to great social distortion (Salzinger et al., 1991, 1993; Kendall-Tackett et al., 1993; Kaplan et al., 1999) which will all present problems for the child life specialists attempting to help them.

It is important to note the dearth of recent research in the fields of child life and child abuse. Furthermore, to date, there are no studies exploring child abuse within the realm of child life. Therefore, this study will provide a qualitative examination of critical

experiences child life specialists may have when working with physically abused children. Not only will this provide current information regarding child life specialists' perceptions of physically abused children's experiences in the hospitals, but it will also help prepare other child life specialists to appropriately handle working with this extremely fragile population. In addition, this study will assess the current levels of education and training child life specialists receive, as well as the knowledge and confidence they possess, regarding working with this population.

CHAPTER 3

METHODS

The purpose of this study was to assess the levels of education and training child life specialists received regarding child abuse and the experiences they have had working with children in the hospital who have been victims of physical abuse. Both quantitative and qualitative data were collected to provide a multi-method analysis of these concepts. Data for this study were collected from child life specialists via an on-line survey. An on-line survey was chosen for its feasibility in collecting data on a nationwide scale and cost effectiveness.

Participant Selection

Participants in this study consisted of Certified Child Life Specialists (CCLS) who were employed by hospitals listed in the Directory of Child Life Programs (2003) at the time of the survey. This directory provided contact information for more than four hundred child life programs in the United States and Canada. Initial contact was made using the email addresses published in this directory. In programs with more than one child life specialist, whoever received the email, usually the director of child life, was asked to forward it to other child life specialists in their hospital. If an email was returned as invalid or undeliverable, phone calls were made to the child life department asking for contact information for child life specialists willing to participate.

A total of 90 child life specialists submitted a survey; however, not every survey was complete. The sample consisted of predominately white (n=80; African American, n=3, Asian American, n=2 and Hispanic/Latino, n=4) females (88 out of 90 respondents), which is consistent with the general demographics of those in the field. Participants had a mean age of 34.1. All participants had at least a bachelor's degree (as this is a requirement for the position) and 39 held a master's degree. Participants represented child life specialists in 27 states, with the most participants responding from Texas (n=18). Additionally, there were a number of respondents from Canada (n=6).

Procedures

Initially, an email (Appendix A) was sent to each child life program in the Child Life Directory introducing the study and informing the participants that they would be receiving the survey (Appendix B) the following week. The following week, a link to the survey was sent. An additional email reminder (Appendix C) was sent one week later to those who had not completed the survey. For participants in the latter waves, the introductory email (Appendix A) and link to the survey (Appendix B) were combined in one email to expedite the response time. The introductory email was modified slightly for each wave to include a more accurate description of where their contact information was retrieved and an appropriate requested date of completion.

Informed consent was obtained by including a consent form on the first page of the survey. This page of the survey was created so the participant could not continue on to the survey without responding "I Accept" to the informed consent. Informed consent was the only question that the participant was required to answer. All other questions could have been skipped if the subject chose to do so. Once the survey was completed, all

identifiable tracers, such as names and email addresses, were deleted from the dataset so no names could be associated with the responses.

Instruments

Basic demographic information, such as sex, race, age, highest level of education and residential state, was collected. In addition, the survey asked questions about child life specialists' education, training, and general knowledge in the area of child abuse. General knowledge of child abuse was measured using items from a test created by Lucas County Children's Services (2005). Sample items included: "Abuse may be directed toward only one child in the family;" "Bruises on the elbows, knees, shins, or forehead are likely to be accidental in preschoolers;" and "If you report abuse or neglect, and your suspicions are unfounded, you are liable for civil or criminal suit." These items were answered in a true/false format. The correct answer was scored as one; an incorrect answer received a score of zero. A sum of the responses was used in the analysis, with higher scores representing more knowledge.

Additionally, a version of the National Child Protection Education Project Questionnaire (2001), developed by the Center for Pediatric Emergency Medicine, was modified for use with child life specialists. This instrument contained statements regarding child life specialists' confidence in working with child abuse (e.g., "I feel confident in my ability to assess suspected physical child abuse."). Responses ranged from strongly disagree (1) to strongly agree (4). A sum of the responses was used in the analysis with higher scores indicative of more confidence.

This instrument also assessed child life specialists' responses to hypothetical situations (e.g., "A 6-month-old female is brought into the ER. Her father says that she

fell from her crib with the rail up. Upon examination she has purple, brown, and yellow bruises on her inner thighs and buttocks"). Subjects were asked to choose one of four assessments of the situation: (a) suspicious of abuse, (b) suspicious of neglect, (c) not abuse/neglect, or (d) more information needed. Correct responses were scored as a 1; incorrect answers received a 0. Furthermore, this instrument included general knowledge questions regarding recognizing and reporting child abuse, difficulties encountered when reporting abuse, and areas where additional education were desired. Questions regarding recognizing and reporting child abuse were scored according to the number of correct responses.

The survey concluded with open-ended questions assessing special implications for child life specialists working with physically abused children. Additionally, child life specialists were asked to identify a critical experience they may have had when working with abused children. A critical experience was defined as having "had a significant effect on you and/or your approach to working with physically abused children." Open-ended questions in the survey included: (1) What characteristics have you noticed among physically abused children? Describe in detail and, if possible, provide specific examples you have encountered. (2) How do you think these characteristics affect their hospital experience? How have you seen this in your own experience? (3) How do these characteristics impact the way you work with abused children in the hospital? If possible, provide details, examples, or personal anecdotes. (4) What have you found to be the most effective therapeutic tool for working with physically abused children? How have you seen this work with the children? (5) Describe any critical or significant experience that has had a significant effect on you and/or your approach to working with physically

abused children. (6) Overall, do you feel that your education and training adequately prepared you for working with children who have been physically abused? Please explain.

Data Analysis

Quantitative Analysis

Descriptive statistics were run to provide a basic understanding of the current education, training, knowledge, and confidence of the child life specialists in this study. Child abuse knowledge was reported as an average score, and frequently missed questions were identified. In addition, problems encountered when reporting abuse and areas where additional education were desired were determined. Furthermore, correlations were run to identify the relationship between confidence and age, years of experience as a child life specialist, number of child abuse courses taken, number of hours of continuing education or on-the-job training, and knowledge of child abuse. A t-test was run to determine if there was a difference in confidence or knowledge in child life specialists who received training during their internship compared to those who did not. An analysis of variance was run to determine group differences in knowledge and confidence of child life specialists based on the number of child abuse cases they saw in the last year.

Qualitative Analysis

Due to the nature of the responses, two different methods of analysis were used to analyze the qualitative data. Some responses were coded using a basic content analysis in order to place the responses into one of a number of categories, while other responses

were coded using a grounded theory framework (Strauss & Corbin, 1990). All qualitative responses were coded by two independent coders.

Content analysis. Responses to several questions were coded into categories in order to provide a better understanding of the group as a whole, and in order to run descriptive statistics on some of the data. In coding child life specialists' college degree, their primary degree was recorded and coded into one of the five majors listed by the Child Life Council as appropriate majors for child life specialists or "Other." The number of child abuse courses the child life specialists completed was coded into three categories: zero, one, two or more. Responses to "Did this internship include any training on child abuse?" were coded as "yes" or "no." In analyzing additional training for child abuse, coders identified four categories of additional training mentioned by child life specialists: in-services in the hospital, professional conferences outside the hospital, experience or training from previous jobs, or other. Child life specialists' reports of their hospital's protocols, guidelines, and standard operating procedures were also categorized into five categories: those who report to child protection team, those who report to social work, those who report to a nurse or doctor, those who report to child services outside the hospital, and those who mentioned mandatory reporting. Additionally, all responses were coded as "yes" or "no" in regard to the hospital having guidelines and protocols.

Grounded theory framework. The open-ended questions at the end of the survey used a more detailed analysis following a grounded theory framework. Each coder initially read the responses in their entirety before each began coding the responses. Individually, each coder then used open coding to deconstruct the responses. Each response was broken down into its most basic elements while each coder attempted to

identify all concepts being verbalized in each response. Then, each coder identified the categories in which each concept fit and identified commonalities among the responses. For example, in response to the question, "How do these characteristics impact the way you work with abused children in the hospital?" one child life specialist responded, "Just take extra time to spend with them and be with them, take baby steps in creating rapport." The first part of this response was coded by both independent coders as "focusing attention on the child" while the second part of the response was identified by both coders as "a tool for building a trusting relationship with the child."

After these steps were completed independently, the two coders compared their findings regarding the concepts in general and the corresponding categories. Additional themes noted by each coder were also discussed. Any discrepancies were discussed at length until a unanimous decision could be reached. Furthermore, once categories and concepts were identified, the primary coder reviewed the responses to identify responses that might have been missed, as well as contradictions to the current findings. Concurrently, memos were written to present free associations of material, to overcome blocks in the data, and to document the beginning of conceptualization of the theory. Data collection and coding continued until categories were saturated and no new themes emerged (Strauss & Corbin, 1990).

Triangulation. Due to the subject matter of some of the open-ended questions, two of these questions were analyzed both quantitatively and qualitatively. The first open-ended question referred to the characteristics child life specialists noticed among physically abused children. Participants generally responded in list form, expounding very little on their reasoning behind reporting these characteristics. The characteristics

could easily be categorized into larger themes as dictated by grounded theory, but frequency of the usage of the characteristics reported was also calculated. For example, one child life specialist mentioned physically abused children "tend not to look you in the eye" which could be categorized on its own, but was also coded as a characteristic describing the child's body language in general.

Additionally, the final open-ended question asked participants, "Overall, do you feel that your education and training adequately prepared you for working with children who have been physically abused? Please explain." While grounded theory was utilized to deconstruct these responses in order to identify how these participants answered this question, coders also separated the responses dichotomously to determine what percentage of these child life specialists overall reported "yes" and what percentage reported "no."

CHAPTER 4

FINDINGS

The purpose of this chapter is to examine the findings of this study. Specifically, five main research questions were addressed: (a) How much education and training have child life specialists had in recognizing physical abuse and working with physically abused children? (b) What knowledge do child life specialists have regarding working with child abuse? (c) How confident are child life specialists in working with children who have been physically abused, and what factors are related to this confidence? (d) What characteristics have child life specialists noticed among physically abused children, and how do these characteristics influence how the child life specialists work with these children? (e) What critical experiences have child life specialists encountered working with physically abused children, and how have these experiences influenced the way child life specialists work with these children?

Both quantitative and qualitative methods were utilized to analyze the data. Descriptive statistics were run to provide a basic understanding of the current education, training, knowledge, and confidence of the child life specialists in this study. Furthermore, correlations were run to identify the relationship between confidence and age, years of experience as a child life specialist, number of child abuse courses taken, number of hours of continuing education or on-the-job training, and knowledge of child

abuse. A t-test was run to determine if there was a difference in the confidence or knowledge in child life specialists who received training during their internship compared to those who did not. An analysis of variance was run to determine group differences in the knowledge and confidence of child life specialists based on the number of child abuse cases they saw in the last year. Qualitatively, some responses were coded using a basic content analysis to place the responses into one of a number of categories while other responses were coded using a grounded theory framework (Strauss & Corbin, 1990). It should be noted that agreement was reached between the two independent coders.

Education and Training

Education

As can seen in Table 1, 85% of the child life specialists in this study reported having an undergraduate degree in one of the majors reported to be most common for child life specialists. These included Child Life (n=7), Child Development (n=14), Family and Human Development (n=17), Early Childhood Education (n=7), Recreation Therapy (n=5), or Psychology (n=13). Additionally, five child life specialists who did not specifically major in child life had it listed as a professional concentration.

Although the majority of participants had a degree in one of the Child Life Council's preferred fields, 70% (n=51) reported they never took a college course specifically related to child abuse. On the other hand, 12% (n=9) of the respondents reported taking one course in college covering child abuse, while another 11% (n=8) reported having two or more classes. The courses these respondents referred to included Child Abuse and Neglect, Emotional Needs of Abused Children, Culture and Abuse, Mandatory Child Abuse Reporting, and Hospitalized Children and Youth.

Table 1

Undergraduate Majors for Child Life Specialists

Major	*n*
Child Development and Family Studies	14
Child Life	7
Early Education	7
Human Development and Family Studies	17
Psychology	13
Recreational Therapy	5
Other	11
Art	2
Behavior Sciences	1
Counseling	1
Health	1
Physical Education	1
Science	1
Social Work	1
Sociology	1
Speech Pathology	1
Women's Studies	1

However, several respondents mentioned it was too long ago to remember the number of courses taken or the names of the courses. Although the number of courses specifically related to child abuse was incredibly low, most respondents (73%; n=46) reported taking courses that included information regarding child abuse. Only seven of the respondents reported never having a class specifically on child abuse or one that included information on the subject.

In addition, this survey identified the areas in which child life specialists felt they needed more education. Fifteen areas of additional education were listed in the survey. More than half of the child life specialists in this study reported they needed more education in each of the following areas: interviewing techniques with children and parents/caregivers, documenting methods (medical/legal), and cultural diversity and child abuse and neglect (see Table 2). Two of these areas, interviewing techniques and cultural diversity, reflect child life specialists need for practically applicable education in working directly with the children and their families as opposed to more general knowledge of child abuse. Less than 9% (n=5) of the child life specialists reported, "I do not need any additional education."

Training

Approximately 48% (n=33) of child life specialists in this study received no training during their child life internship on how to work with children who had been physically abused. The remaining 52% (n=30) received varying amounts of training via many different mediums. Some child life specialists who received training during their internships were involved in in-services with child protection or social work teams, while others got experience rotating to outpatient clinics that dealt more specifically with abuse.

Table 2

Areas of Additional Education Desired by Child Life Specialists

Areas of Education	*n*	%
Definitions of child abuse/neglect	17	29.3
Signs and Symptoms	27	46.6
Interviewing techniques with children and parents/caregivers	41	69.5
Protocols/guidelines/standard operating procedures of the hospital	13	22.4
Town/City and State Regulatory requirements	21	35.6
Documenting methods (medical/legal)	32	55.2
Possible characteristics of abusive parent/caretaker and/or abused/neglected child	23	39.7
Interacting with children and families	23	39.7
Interacting with law enforcement and social service agencies	25	42.4
Environmental assessment	21	36.2
Cultural diversity and child abuse/neglect	36	61.0
Economic status and child abuse/neglect	25	43.1
Developmental capabilities of children at different ages	12	20.7
Resources available to deal with your feelings arising from handling this issue	26	44.8
I do not need any additional education.	5	8.6

Two of the child life specialists spent two half days shadowing child life specialists who worked in the abuse clinic and with the children suspected of being abused. Some child life specialists reported getting training with physically abused children by going on rounds with those who investigated child abuse. Finally, training for child abuse at some internships included less experiential methods such as required readings, videos, and discussions. Furthermore, four of the child life specialists who did not receive any official training during their internship reported receiving on-the-job training as situations arose during their internship. One child life specialist responded, "I definitely had situations in which there was child abuse. As far as training goes, I got hands-on experience with how to help children under child abuse and how to handle those situations."

Child life specialists were also asked about additional training they received outside of their formal education and internship experience. While 26% of child life specialists (n=17) reported receiving no additional training in regard to working with physically abused children, the remaining 74% (n=49) reported various experiences. The most commonly reported methods of training were seminars and in-services presented within the hospital. Child life specialists reported these in-services were facilitated by social workers, the education department, or other child life specialists. Topics for these in-services included detecting and preventing child abuse, mandatory reporting, programs for abused children such as the Guardian ad Litem program, and post-traumatic stress as a result of abuse.

Although some of the child life specialists reported attending these in-services, there is no way of knowing the quality of these in-services. One child life specialist

reported, "We have an in-service given by the education department at the hospital I work in, but it is very vague and discusses spousal abuse and abuse of the elderly more than child abuse." An additional source of training commonly reported among the child life specialists included professional conferences outside of the hospital setting. Child life specialists reported receiving training for working with this population at conferences specifically for child life, as well as conferences focusing on child abuse, play therapy, and family and child maltreatment.

Some child life specialists received their training working with physically abused children at previous jobs outside of child life. One specialist explained, "I worked extensively in group homes and therapeutic summer camps with children that had been abused and received extensive training at each site." Another child life specialist stated she had been "trained by the Division of Family Services in recognizing and responding to children of abuse due to connection with a camp for abused children." Only one child life specialist reported receiving training during her orientation at her current position in child life. However, this particular child life specialist was working in the emergency room and CARE clinic (a clinic within the hospital for abused children). This training included videos, observation, readings, and in-services covering many aspects of child abuse. A few of the other child life specialists surveyed were part of their hospital's child protection team and received training associated with that position.

Has the Education and Training Been Adequate?

In an attempt to determine how well their education and training prepared these child life specialists, they were asked to respond to the following question: "Overall, do you feel that your education and training adequately prepared you for working with

children who have been physically abused?" Only 40% (n=17) of child life specialists responded that they felt as though they had received adequate education and training for working with this population, either through their education at the university-level or education or training provided by the hospital. A number of child life specialists (n=6) who provided a more thorough explanation felt it was important to state they felt they had received enough education or training to work with these children within the realm of child life. One child life specialist reported:

> In this hospital, the social worker and medical staff have the bulk of the responsibility to investigate and report the abuse. Child Life provides support as we would any child. Thus we respond to the individual child's needs. Yes, the training and education is adequate. If a child life specialist suspects abuse based on the way a child plays or interacts, we discuss that with the social worker, who assesses the family and child also and takes appropriate action.

Another child life specialist agreed with this in her statement, "Yes, but being PRN [pro re nata, which refers to employees who work as needed], I have not had to directly work as a team member in an abuse case. I have interacted with children of child abuse, but that's about it. I have not had to report it."

Others mentioned the training they received was adequate for their specific department, but they felt as though they would need more to better help children who had been physically abused. One child life specialist's statement portrayed this idea quite clearly:

> I had some education and internship experience that has definitely helped, but I could always benefit from more education. However, I work on a surgical floor,

> so not all of my patients are abuse and neglect patients; therefore this is not my "specialty." So, I feel that the training that I have had is adequate for the work that I am currently doing.

Furthermore, several child life specialists (n=8) felt that although they did not necessarily have adequate preparation when they began working in child life, they currently felt, through on-the-job training, they were better prepared for working with these children. When asked if she felt adequately prepared to work with abused children, one child life specialist explained:

> When I first took the job working in the emergency center, I would have said, "No." However, I was lucky to have an incredible medical staff to work with as well as other more experienced child life specialists to learn from. This on-the-job training, combined with the high number of abuse patients we treat here, has more than adequately prepared me for working with these patients.

Another child life specialist concurred with this remark by stating: "I don't think coming out of school I was prepared to work in the environment I'm in now. I am well prepared after being trained by our team. I do feel however that you aren't always trained well to be in any area, you learn a lot as you go." One child life specialist also reported that while she did not necessarily receive adequate training in her undergraduate program, graduate classes and child abuse conferences had more adequately prepared her to work with these children in the emergency room. A few (n=4) also mentioned that although they had received some education and training, they could "always use more training."

In contrast to those who felt they had adequate education and training working with child abuse, almost half (49%) the child life specialists' reported they did not receive adequate education or training. One child life specialist explained:

> I wish I had more education on abuse. Not only how to recognize it, but also the appropriate steps to take to ensure the situation is being taken care of. I believe child life specialists need more training and maybe even a class in college on abuse/neglect such as signs, symptoms, interactions with the child and family, interaction with the medical staff in this case, documentation, and therapeutic activities.

A common idea shared by the child life specialists was that nothing could really prepare an individual for working with victims of physical abuse. One child life specialist explained, "My education and training gave me the knowledge and tools to work with these children/families, but nothing could prepare [me] for the emotional aspect of working with the children/families. Experience has helped, but has not made anything easier." Another child life specialist shared this same sentiment: "There is no education that can completely prepare you for the actual event of working with these children; our hospital needs to provide ongoing information regarding all aspects of abuse/neglect." Overall, it seems as though child life specialists felt unprepared to work with abused children within the realm of child life.

Child Life Specialists' Knowledge of Child Abuse

Child Abuse Knowledge

According to their responses on the Child Abuse Knowledge survey (Lucas County Children's Services, 2005), most of the child life specialists in this study have a

general knowledge of child abuse. In fact, they answered an average of 15 out of 18 questions correctly, with scores ranging from 11 to 18. Furthermore, all but three of these true/false questions were answered correctly by at least 80% of the respondents. The most commonly missed questions included: "Child abuse and neglect occur at about the same frequency" (46% (n=31) incorrectly answered true), "Neglect is most apt to involve children from infancy to six years of age" (34% (n=23) incorrectly answered false), and "Early reporting is encouraged so that children may be removed from the home of the abusive parent" (88% (n=59) incorrectly answered true). In addition, as can be seen in Table 3, there was a significant difference in child abuse knowledge between those who had never been involved in a case of suspected child abuse or neglect compared to those who had been involved in five or more cases (F=4.086, p<.05).

Table 3

Comparison of Child Abuse Knowledge by Number of Cases Worked

	N	*M*	$F_{(2,57)}$
Number cases involved in the last year			4.086*
1. Zero	15	14.53[4]	
2. One to two	14	15.29	
3. Three to four	7	14.86	
4. Five or more	22	15.95[1]	

*p<.05

Knowledge regarding suspicion of abuse. One section of the National Child Protection Education Project scale utilized in this study presented scenarios in which child life specialists were required to determine whether one should be suspicious of abuse, suspicious of neglect, if it was not a case of abuse or neglect, or if more

information was needed. Out of six scenarios, the child life specialists answered between one and six of the scenarios correctly, with an average of 3.42 correct responses. Each case in which more than fifty percent of the respondents answered incorrectly, the most popular answer choice was "More information needed."

This assessment also included three other items related to recognizing signs and symptoms of abuse. Child life specialists were significantly more accurate in assessing symptoms related to bruising than those related to burns ($p<.001$). Specifically, 63% ($n=37$) of child life specialists correctly recognized suspicious bruising characteristics which included a hand-shaped bruise on the cheek and multiple ages of bruises over upper arm and chest, whereas only 12% ($n=7$) were able to identify signs of abuse caused by burning including a pattern of hot object (brand) on skin, a burn of irregular depth, and bilateral, symmetric burns (stocking/glove distribution).

Additionally, 73% ($n=43$) of the child life specialists could correctly identify indicators of abuse when gathering statements from the parents (mechanism of injury/child's developmental capacity don't match, child and caretaker give different stories, significant delay in seeking EMS assistance, and parent(s)/caretaker change story). However, only 19% ($n=11$) correctly identified appropriate actions for obtaining a history from a child suspected as a victim of abuse or neglect (comfort the child, listen to what is being told to you, use age appropriate vocabulary, and maintain your composure). Child life specialists incorrectly identified "Tell the child he/she will be safe" in most cases. Although it seems to be an appropriate response, it is important not to make promises one cannot keep.

Reporting and documenting child abuse. Regarding child life specialists' knowledge of documenting suspected child abuse or neglect, only 7% (n=4) could correctly identify the two requirements of documenting suspected abuse (describe the interaction between parent and child and record statements from parents using quotation marks). All other individuals also thought it was necessary to document to whom they report their suspicions or findings, which is not necessary. Additionally, out of the 60 who responded to this question, most child life specialists (91.7%) reported needing suspicion (which is the only requirement) in order to report suspected child abuse and neglect; some also thought substantial proof (15%), proof to establish the claim beyond a reasonable doubt in court (8.3%), and physical evidence (11.9%) were also necessary.

Almost all child life specialists (96%; n=54) reported their hospital did have protocols, guidelines, or standard operating procedures in the recognition and management of suspected child abuse; 79% (n=45) were able to identify what these were for their particular hospital. Most commonly (34%; n=19), child life specialists reported there was a specific child protection team within the hospital to handle cases of suspected child abuse and neglect. This team included doctors, nurse practitioners, nurses, social workers, and child life specialists. Secondly, many hospitals were required to report to the social workers in the hospital (32%; n=18), child protection services available outside of the hospital (9%; n=5), or the child's doctor or nurse (7%; n=4). Additionally, only seven child life specialists (13%) stated mandatory reporting was a part of their hospital's policy.

Another section of the survey identified problems the child life specialists encountered while taking actions on suspected cases of child abuse or neglect. Although

more than fifty percent of the respondents (57%; n=32) reported they had never encountered any difficulty taking action, the remaining participants' responses provided insight into some of the problems child life specialists experience (see Table 4).

Table 4

Problems Encountered Taking Action in Child Abuse Cases

Difficulty in taking action	*n*
I can never be certain that a situation is a case of child abuse or neglect.	11
I am not familiar with child abuse/neglect state/city or hospital procedures.	6
I am not familiar with child abuse/neglect hospital procedures.	5
I don't want to have to go to court.	2
The system won't do anything anyway.	5
I didn't know whom to call.	1
It is not my responsibility.	0
I am afraid of the consequences.	0
Other hospital professionals didn't agree with my suspicion.	6
Prior reports were not accepted by the state regulatory agency.	4
I have never encountered any difficulty taking action.	32
Other	9
Social workers are there to take action.	6
Cases have already been documented as abuse.	1
Revealing child will not be going home with primary caregiver is hard.	1
None of the above applies.	1

Of the child life specialists who did encounter difficulties in taking action, 46% (n=11) reported "I can never be certain that a situation is a case of child abuse or neglect." Additionally, several child life specialists who recorded "other" for this item believed the social work staff at their hospital was more appropriate for identifying and reporting abuse. Another child life specialist disclosed, "I think revealing to the child that they will not be returning home with their primary caregiver is always a very difficult situation; whether the child is thankful to be removed from the current environment or if the child screams and cries to be with their mother, the situation is always extremely difficult."

Confidence Working with Physically Abused Children

Child life specialists reported an overall mean confidence score of 2.87 (on a scale from 1 to 4, with higher numbers indicative of more confidence). Additionally, child life specialists reported the highest level of confidence in their ability to work with physically abused children in the hospital (mean=3.38) and the lowest confidence in their ability to assess suspected sexual abuse of a child (mean=2.52) representing a significant difference between these two scores (p<.001). A complete list of results for each confidence item can be found in Table 5.

Additionally, correlations were run assessing the relationship between confidence and age, years of experience as a child life specialist, number of child abuse courses taken, number of hours of continuing education or on-the-job training, and knowledge of child abuse. The number of child abuse courses (r=.352, p<.01) and number of hours of continuing education or on-the-job training (r=.457, p<.001) were the only variables that

Table 5

Child Life Specialists' Confidence in Working with Child Abuse

I feel confident in my ability to...	N	Min.	Max.	Mean	SD
Assess suspected physical abuse of a child.	60	1	4	2.87	.650
Assess suspected sexual abuse of a child.	58	1	4	2.52	.778
Assess suspected psychological abuse of a child.	60	2	4	2.82	.624
Assess suspected neglect of a child.	60	2	4	2.90	.576
Document my findings in suspected child abuse.	60	1	4	2.90	.896
Manage the family of a child who I suspect was abused.	60	1	4	2.57	.831
Work with physically abused children in the hospital.	60	2	4	3.38	.613
Mean of overall scores	58	1.57	4	2.85	.497

were significantly related to child life specialists' overall confidence in their ability to recognize and work with victims of abuse. Additionally, a simple regression showed that the number of courses taken specifically related to child abuse predicted 12.4% of the variance in child life specialists' overall confidence ($p<.001$).

Furthermore, a one-way ANOVA assessing the difference in confidence between child life specialists who had been involved in zero, one to two, three to four, or five more cases of suspected child abuse in the past 12 months, revealed that child life specialists who had been involved in five or more cases were significantly more confident than those who had been involved in 1-2 cases of child abuse (see Table 6). No differences were found between any other groups. In addition, no significant differences were detected between those who did and those who did not receive training during their internship.

Table 6

Comparison of Confidence by Number of Cases Worked

	N	*M*	$F_{(3,57)}$
Number cases involved in the last year			4.238**
1. Zero	15	19.87	
2. One to two	13	18.08[4]	
3. Three to four	7	18.29	
4. Five or more	23	21.65[2]	

**$p<.01$

Working with Physically Abused Children

When asked to describe the characteristics of physically abused children they had worked with in the hospital, the child life specialists reported a multitude of characteristics. Many of these characteristics could be categorized into larger themes as well. Specifically, these themes included withdrawn tendencies, body language, physical characteristics, aggression, behavioral problems, emotional characteristics, attachment issues, trust, fear of disclosure, fear in general, and social issues.

Withdrawn Tendencies

The most commonly reported characteristic child life specialists reported among physically abused children was their tendency to be withdrawn. In fact, almost half (48%; n=19) of those surveyed specifically stated "withdrawn" as a characteristic of these children, while others reported similar characteristics, such as shy, quiet, and reserved. These children were also described as passive and had a tendency to avoid conflict. One child life specialist reported these withdrawn tendencies made it "hard to assess both their developmental levels and the need for medical attention." Another child life specialist

reported this quality was one of the reasons it was harder to engage abused children in activities.

Body Language

The children's body language further illustrated their tendency to withdraw. For example, several child life specialists reported diminished eye contact with these children. Some comments included: "they tend to not look you in the eye," they "keep their head down," and they are "not comfortable with eye contact." Others reported the children's body language tended toward one of two extremes. The children either "cling tightly to anyone" or "cringe away from physical contact." One child life specialist reported this characteristic made it difficult to have normal physical contact, such as hugging.

Physical Characteristics

In addition to their body language, the child life specialists reported the children exhibited other physical characteristics as well. Obviously, physical signs of the abuse, such as bruises and broken bones, were noticed by the child life specialists. One child specialist worked with a four month old girl who had multiple broken bones healing at different stages. "Due to the pain she was having with the multiple breaks, she did not want to be touched or moved at all."

Child life specialists reported pain in much the same way they reported physical contact, as one of two extremes. The children were either hypersensitive to pain or had no reaction to pain. One child life specialist commented she had seen children "who block out high levels of pain like no other child does." In addition to the other problems these children encounter in the hospital setting, child life specialists also reported these

children oftentimes have trouble eating and sleeping which could cause further physical distress on the child.

Behavioral Problems

Child life specialists reported other behavioral problems among this population of patients as well. Several child life specialists reported behavior problems in general, while others were more specific about the problems exhibited by these children. One child life specialist reported the independence being sought by some of the older children "leads to non-compliance and can cause the medical staff to become frustrated with the patient, causing increased stress for all involved." These children were reported to push the boundaries set up by hospital staff because, as one child life specialist explained, "The children who need boundaries are often felt sorry for and are given the world."

Aggression

A specific example of a behavior problem observed by child life specialists was aggression. Similar to previous research, child life specialists found these children exhibited various forms of aggression while in the hospital. Some children were described as aggressive in nature, while others engaged in aggressive play with toys or staff. Child life specialists also described these children as angry, combatant, and violent. Furthermore, the children were reported to exhibit explosive tempers and self-destructive behaviors.

Emotional Characteristics

Obviously, the emotional problems caused by physical abuse are extensive. Most often, child life specialists reported these children exhibited anxiety. However, one child life specialist reported the children will generally exhibit "either too much or too little

anxiety." Child life specialists further described these children as constantly being "on guard" or "on edge." A multitude of other emotional characteristics were mentioned, although not often by more than one child life specialist. These children were described as lonely, needy, and inconsolable. One child life specialist noticed children "have episodes of falling apart over small things," as well as a low self-esteem. These children were also reported as having trouble understanding their feelings and what was happening to them in the hospital. One child life specialist mentioned, "The interventions for treatment might be considered to be like abuse to the child which further devalues the child's self-esteem." As another child life specialist explained, "Many children of abuse feel at fault for the actions that have taken place. They are scared, emotionally scarred, and timid in several ways."

Attachment Issues

Many of the child life specialists noticed attachment issues among the abused children in the hospital. Several child life specialists reported physically abused children were extremely clingy with the hospital staff. One child life specialist shared, "I have noticed at times children who are being examined for abuse will cling tightly to anyone and form bonds with whoever is spending time with them." Others reported these children often attach very easily to hospital staff, and tend to become overly attached to these individuals. Many of the child life specialists also reported instances they described as children showing indiscriminate affection to anyone who was caring for them at the time. Furthermore, some of the children had no anxiety towards strangers, and "they do not have any separation anxiety from their parents." Oftentimes attachment issues are

directly related to trusting one's caregivers; according to the respondents for this survey, for these children, trust was not there.

Trust

Trust was one of the most important themes discussed by child life specialists in this study, and is deeply interwoven into other themes such as attachment, fear, and social issues. One of the basic underlying causes of these trust issues is the gross betrayal of trust on the part of the parent or caregiver. As a result of this, the lack of trust exhibited by these children is obvious to the child life specialists working with them. Two-thirds of the child life specialists made some reference in their responses to either trust or the problems resulting from a lack of trust. One child life specialist explained:

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

Specifically, child life specialists commonly reported physically abused children do not know who they can trust, which makes it difficult for them to build a trusting relationship with the hospital staff, including the child life specialists.

Fear of Disclosure

One reason the child life specialists believed the children had difficultly trusting the staff was a fear of disclosure. Child life specialists reported the children were afraid to share information. Children were reported to fear several activities that had a possibility of ending in disclosure, such as befriending adults, engaging in play activities, or expressing any feelings in general. One child life specialist stated, "Sometimes the

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

Fear

Besides the fear of disclosure, child life specialists found children were dealing with many other sources of fear. Close to half of the child life specialists (44%; n=17) made some reference to the fear these children exhibited in the hospital. It was reported that the children were afraid of the hospital staff in general, as well as interactions with the staff. One child life specialist stated the children were "afraid of the simplest interaction with hospital staff" and "fearful of everyone." Another child life specialist reported the children were afraid of going home and afraid the perpetrator may come into the hospital. Another child life specialist found these children were afraid of being alone.

Social Issues

Child life specialists reported many social issues for the abused children they worked with in the hospital. Child life specialists reported these children had a difficult time engaging in activities or in conversation with others. Oftentimes, physically abused children did not want to be part of a group and were therefore resistant to group activities.

As a result, these children sometimes resorted to entertaining themselves, but more often isolated themselves from others. Child life specialists reported physically abused children were extremely cautious of others' motives, which served as a barrier to social interactions with peers. Furthermore, their lack of social skills resulted in inappropriate interactions with adults, including strangers.

How Child Life Specialists Work with Physically Abused Children

Trust building activities. Due to the trust issues most physically abused children experience, child life specialists report the most important thing they can do is work to establish trust between the child and the staff at the hospital. In fact, two-thirds of those surveyed reported the importance of activities that build trust and rapport. One child life specialist reported:

> With abuse patients, I have found that the most important thing is to attempt to establish a trusting relationship and to continue to reassure them that we are here to help them. Without accomplishing these things, it is usually very difficult, if not impossible, to have successful interactions with them.

Similarly, another child life specialist stated one must "try to establish a supporting relationship and go from there; you try the best you can."

One way child life specialists reported building this type of relationship with their patients was by being upfront and honest about painful treatments the child may receive at the hospital. For example, one child life specialist pointed this out by stating, "I do not want the kids to think they have just ended up in another abusive relationship." Furthermore, child life specialists recognized the importance of thoroughly explaining both their role in the hospital as well as the procedures the child will encounter in the

hospital. One child life specialist suggested, "You approach the child and let them know what you do and how you can help them using verbiage they understand." Another child life specialist agreed that one must "describe all interactions with the medical staff as necessary," and added it may be necessary for the child life specialist to explain to the child why his or her parents are not there if a separation has occurred.

Another way the child life specialists built rapport with physically abused children was by creating consistency. Most often, the child life specialists used this term to mean following through with things. One child life specialist explained, "Consistency is important for trust building and doing what we say we are going to do."

Child life specialists also used this term when referring to the consistency of caregivers for the child. Child life specialists suggested these children should have a primary caregiver in the hospital and limited volunteer contact as a way to reduce the number of individuals with whom a child is attempting to create a trusting relationship. One child life specialist found the best way to work with these children was to provide "clustering of care to decrease the amount of contact with the patient with procedures, provide a consistent RN [nurse] and volunteer to help foster trust and reliance." Another child life specialist found bedside work (one-on-one work with the child in his or her own room) was the best way to begin establishing a trusting relationship with the child:

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

Providing a safe environment. Not only did child life specialists want to create a trusting relationship, they also felt the need to create a safe environment for the children to combat their fears. In fact, 34% (n=12) mentioned working diligently to ensure the children felt safe while in the hospital. Child life specialists reported measures such as speaking in a gentle voice, creating a calm environment, and ensuring the staff explained their actions to the child. Additionally, child life specialists reported using a child-directed approach with these children. Examples included "I always let the child lead the way" and "I never initiate physical contact unless a child asks for it (wants a hug or a back rub)."

Focused attention on the child. In addition, one-third of the child life specialists mentioned the need to provide these children with more focused attention than they may generally give to other children. When referring to one abused child with whom she was currently working, one child life specialist reported, "I find myself spending a lot of time with him." Another child life specialist felt the best therapeutic tool for working with these children was simply "Honoring them by spending time with them doing activities that are age-appropriate- something that very likely is lacking in their own lives." Although all child life specialists agreed these children required more specialized attention from the staff, some felt as though this could become problematic. One child life specialist explained, "I think I might tend to overfunction in some of these cases, pay more attention to that child in the play room, maybe unknowingly create a "favored" child out of it." Another child life specialist mentioned her frustration in not being able to spend more time with the child:

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

Adjusting interventions. Furthermore, child life specialists reported it was extremely important to adjust treatment for the particular child so he or she would be more comfortable. Child life specialists also felt they must be able to interpret the signs children are presenting in order to adjust their inventions. For example, one child life specialist commented: "As a CLS, you always have to assess the situation quickly and adapt your interventions accordingly." Another child life specialist reported using the patient's interaction with herself and others to help determine the patient's state of mind and adjust interventions. This included a child's readiness for activity. One child life specialist explained, "Slowly move into activities the child feels comfortable doing so they can accomplish a task and feel confident. Then move into a more advanced activity and so on."

In addition, all children are different and how the child life specialist works with the child is directly dependent upon the child. One child life specialist mentioned the importance of careful consideration when sending these children to the playroom if there are large or rowdy groups in there before the patient's readiness to handle this type of situation has been assessed. Furthermore, child life specialists found listening closely to these children was a good way to assess how they are adjusting to their situation, "It is also vital to listen to and observe the patients to find out what level they are on." Another

child life specialist said she would "listen more intently to what [was] being told to [her]."

Expressive activities. As with all children in the hospital, child life specialists also reported the importance of providing activities for self-expression such as "art, music, or any other media that the child has interest in that they can channel their feelings into," but oftentimes these activities can serve as dual purposes with these children. For example, one child life specialist found it helpful to provide a child with just paper and markers, "Kids will draw out sometimes how they feel or what has happened." Child life specialists reported using expressive mediums of all kinds including arts/crafts, play-doh, music, and journal writing. One child life specialist suggested, "doing an All About Me Poster because this really lets them express how they feel in a non-threatening way." Another child life specialist found that art provided opportunities for "letting them express what they feel and remember and talking about it."

Furthermore, play provides a good opportunity for the child to both express what has happened and work through it. Child life specialists discussed using dramatic play, feeling games, dolls, dollhouses, and role playing. Child life specialists also mentioned the importance of providing outlets for aggression through play. One child life specialist found it incredibly important for "play, play, and more play. During our play sessions, we talk a little about what happened, but focus on the positives and the future and how things can change."

Working with the family. Another theme child life specialists reported regarding working with children who have been physically abused revolved around working with their families. One child life specialist felt the need to be incredibly cautious when

working with these families, "I feel like we have to tread lightly around these families so that we don't upset anyone or cause a caregiver to do something toward their child or a staff member." Other child life specialists found it difficult to work with the families who were present in the hospital. One child life specialist reported, "I think it is hard to treat the family under suspicion with openness if there is a strong presence of evidence. Yet, visitation and their rights for visiting are the same. It is challenging to remain neutral." Another child life specialist shared this same sentiment: "I have to work very hard on each case not to be judgmental and make assumptions. Get all the facts, and then, if you find it to be true, deal with your emotions." In cases such as these, child life specialists will sometimes seek outside sources in order to "deal with" their emotions. As one child life specialist shared, "I often seek supervision at those times, especially because of a long history of working in PICU [Pediatric Intensive Care Unit]. It is heartbreaking...and sometimes it is hard to put it aside."

Critical Experiences Working with Physically Abused Children

The types of experiences previously mentioned create critical experiences for child life specialists working with physically abused children. Unfortunately, there were only 17 respondents for this particular question. These respondents did, however, report more experience working with physically abused children than the total sample. Fifty percent of child life specialists responding to this question reported working with five or more cases of abuse in the past 12 months, whereas only 37% of the total sample reported working with this number of cases. Furthermore, only one of the child life specialists who reported a critical experience had not worked with any cases of physical abuse in the past

12 months compared to 27% of the total sample who reported working with no cases of abuse.

However, despite the small number of responses for this question, many of the stories described revolved around the same themes. First, after being faced with a case of physical abuse, especially when it involved families one would have never expected, some of the respondents felt they were almost "overly suspicious" of parents. One child life specialist's experience helped her realize perpetrators of child abuse could be anyone. This child life specialist found herself working with a mother who had attempted to kill her three children:

> She killed the first two, but permanently damaged the brain of the youngest; the appearance of the family was a typical middle-class family and opened up my eyes to the ability of anyone to commit these terrible acts on children despite my knowledge base of that fact.

Another child life specialist's experience helped her realize how easy it could be for parents to cover up this abuse and realized her responsibility to ensure it did not go unnoticed:

> I, to this day, cannot get out of mind a beautiful brain dead boy who was 10 months old, absolutely beautiful, but had scrapes all over his head. It looked like he could [have] accidentally fallen, which was the story the parents gave. The history and confirmed abuse was so atrocious; it impacted me greatly that it would be easy to hide abuse, especially with infants and toddlers. I easily believed the story the parents gave that had been passed on to staff and nursing. It was over the next few days that the other results and the parents' stories not aligning proved

> them wrong. It showed me that almost all things need to be fully investigated, and that given time, any inconsistencies or concerns should be brought forward to the appropriate personnel.

Another child life specialist working in the emergency room mentioned seeing obvious signs of abuse such as old scars and a past medical history of skull fractures and commented, "It always makes me wonder why these children were not caught sooner." This made her more aware of the surroundings in the emergency room and more prone to pay attention to signs of abuse and neglect.

Other child life specialists mentioned situations more specifically involving the parents. One child life specialist shared a worrisome moment working with a parent:

> I worked with a family in which the father was the abuser, and he was volatile and made all the staff nervous. Specifically, he came to me to request that one of the other child life staff not work with his child in the future and said that she made him so mad that he was ready to hit her, and I believed that he could have and would have done that.

Another child life specialist expressed her feelings of responsibility in helping parents prevent child abuse:

> I think that any parent, good or bad, can be pushed beyond their limits from time to time and that they can become angry. But what we as professionals taking care of children need to do is teach parents what to do with that anger. It's going to happen, but the difference is some people react where other react negative with awful results. This is not always the case, but you hear reports that the parent or

> caregiver just "snapped." We need to teach what to do before the "SNAP" period happens.

Another child life specialist's experience working with a child helped reinforce the feelings children have for their parents, even if they are abusing them. In an activity in which the child did not have to share her drawing with anyone, the child had written "I love you mom" on a paper and then angrily scribbled over it with many different colors. This experience encouraged the child life specialist to encourage her co-workers to be supportive of the fact that children will always love and want to be with their parents. She also reported, "Our jobs are to support them through the transition, not to change how they feel about their parents."

Ending on a positive note, child life specialists also shared stories of success in helping children become survivors of their horrific abuse. One child life specialist was working with a neglected child who had long-term medical needs. The child would initially hit the therapists who were there to help him:

> By the end of his years of treatment with the team, which included removing him from his family, he could express his love and thanks to the team for caring for him over the years. He even does not really remember ever hating us at the beginning. This case reminds us to be patient, steadfast, dependable, and persistent over time.

Another child life specialist vividly described a case of a four month old girl with multiple broken bones and oral bruising due to being force-fed:

> Due to the pain she was having with the multiple breaks, she did not want to be touched or moved at all. The patient did, after several days, begin to develop a

> rapport and was able to feed...Several doctors testified, and the parents were both convicted of physical abuse and neglect. The patient went into foster care and thrived.

The child life specialist saw the child again one year later when all the bones had healed and reported "She appears to be well now." This provides another example of how important the medical staff can be in cases of physical abuse.

Summary of Findings

Although most child life specialists (70%) never took a course specifically on child abuse, most respondents (75%) had taken coursework that included information regarding child abuse. Additionally, almost half (48%) of the child life specialists in this study received no training during their child life internship in regard to working with abused children. However, 74% reported receiving varying amounts of training outside of their formal education and internship experience. Yet, only 40% of child life specialists felt as though the education and training they had received adequately prepared them for working with abused children.

Despite the lack of education and training, child life specialists' knowledge regarding child abuse was considerably high. Child life specialists provided many correct answers in the areas of recognizing and reporting child abuse and signs and symptoms of child abuse, and were knowledgeable as to their own hospitals' standard operating procedures regarding child abuse. Additionally, child life specialists also reported high levels of confidence regarding their ability to work with children who had been abused.

In addition, child life specialists reported numerous characteristics they had noticed among physically abused children. These characteristics included being

withdrawn, body language, physical characteristics, aggression, behavioral problems, emotional characteristics, attachment issues, trust issues, fear of disclosure, general fear, and social issues. In regard to working with these children, child life specialists reported using techniques such as providing trust building activities, a safe environment, focused attention on the child, adjusted interventions, and expressive activities.

In regard to child life specialists' critical experiences working with physically abused children, there were few responses. However, responses reflected several themes such as encounters with unexpected victims, the need to be more aware of possible instances of abuse, experiences working with the families, and stories of successful transitions from victim to survivor.

CHAPTER 5

DISCUSSION

As shown in the quantitative analysis, child life specialists had little education or training to prepare them for working with physically abused children. Furthermore, almost half of the respondents stated, in their own words, that they had not had enough education or training. Yet, child life specialists reported fairly high levels of confidence in working with this population. There are several possible explanations for this discrepancy. First of all, as some child life specialists reported, they did not feel prepared to work with this population upon beginning their job as a child life specialist, but years down the road, they felt as though their on-the-job training and experiences prepared them for working with this population. This explanation is supported by the correlation between confidence and the number of hours of continuing education and on-the job training child life specialists had received.

Another possible explanation is social desirability bias. Child life specialists may have had a difficult time admitting they were not confident in their ability to work with this population, and consequently reported what they believed a child life specialist should report. On the other hand, it has been found that social desirability bias is usually balanced out by subjects also trying to remain modest when it comes to job competence (Tan & Hall, 2005).

Additionally, child life specialists reported the highest level of confidence in their abilities to work with physically abused children in the hospital compared to their confidence in recognizing and reporting various types of abuse. This is expected due to the fact this duty is most closely related to the child life specialist's general job description (Child Life Council, 1998-2003). Assessing and reporting suspected cases of abuse is not mentioned in the job description by the Child Life Council and was often described by the respondents as being more of the social worker's responsibility. However, as a part of the health care system, child life specialists are mandatory reporters (U.S. Department of Health and Human Services, 2004). Therefore, despite the fact it may be social workers' responsibility to follow-up on the child abuse case, child life specialists are required by law to report the child abuse. The fact that many child life specialists reported it was not their duty to recognize and report child abuse shows a significant need for improved education for child life specialists in regard to reporting policies.

Interestingly, although confidence in one's ability to assess suspected sexual abuse was the lowest (also perhaps seen as the social worker's responsibility), child life specialists reported the second lowest confidence in their ability to manage the family of a child who they suspected had been abused or neglected. Working with families is an integral part of child life (Child Life Council, 1998-2003), and if child life specialists do not feel confident in working with these families, steps should be taken to better educate child life specialists on how to work with families suspected of abuse or neglect.

Another interesting finding was that the only significant difference in child life specialists' confidence in working with abused children was between child life specialists

who had worked with one to two cases and those who had worked with five or more cases, with those who worked more cases reporting significantly more confidence. There were no other differences between the groups, including between those who never worked with an abuse case and those who worked with five or more cases. It is possible that child life specialists who have never encountered a case of child abuse have not had the opportunity to truly assess their skills and abilities to work in this situation and could have assessed themselves as more confident than those who have only been involved in one or two cases. In other words, child life specialists who have been involved in only one or two cases of child abuse may have realized they cannot confidently handle this situation compared to more experienced child life specialists who have been involved in more than five cases of child abuse in the past year. Because there has been no research to date on this concept, future studies should examine the possibility of this phenomenon.

The differences in knowledge between these groups were slightly more predictable. The only significant difference was between those who had not worked with any cases of abuse and those who had worked with five or more. However, the relationship between these two factors is still unknown. Child life specialists could have gained this knowledge through their work with abuse cases, or perhaps they are working with these cases because they have more knowledge about child abuse than others. Future research should explore the nature of this relationship.

Additionally, despite child life specialists' lack of education on child abuse, no relationship was found between education and the knowledge child life specialists have on the subject of child abuse. Overall, child life specialists were generally knowledgeable regarding child abuse. However, several items were answered incorrectly. For example,

88% incorrectly answered true to the following: "Early reporting is encouraged so that children may be removed from the home of the abusive parent." It is very likely those who answered "true" for this question were focusing on encouraging early reporting and may not have further assessed the primary purpose of reporting, which is to prevent the child from being injured or harmed in any way. Most child protection services seek to preserve the families and hope that through providing supportive services, the child will never have to be removed from the home, and the abuse will stop (Johnson, 1999).

Another commonly missed question referred to the appropriate methods for obtaining the history from a child suspected to be a victim of abuse or neglect. Seventy-five percent of the respondents incorrectly answered, "Tell the child he/she will be safe." Although child life specialists will be doing everything possible to ensure the child's safety, there is no way of knowing how the situation will evolve, and it is generally understood that an important aspect of building a trusting relationship is not making promises one cannot keep.

Furthermore, child life specialists reported barriers to taking action in child abuse cases similar to those reported by other health care professionals. The most common response from child life specialists who had encountered difficulties taking action was that they could never be certain whether a situation was a case of child abuse. Similarly, Russell and colleagues (2004) found that some health care professionals have a fear of misdiagnosing the situation as abusive when it is not (Russell et al., 2004). As a result, these health care professionals reported a perceived need for further education and training in this field, much like the child life specialists in this study.

Almost all child life specialists felt they could benefit from more education; only 9% felt as though they did not require any additional education on working with this group. Many of the areas of education in which child life specialists reported desiring more education were brought up in responses to open-ended questions. For example, close to half (47%) reported they could use more education regarding signs and symptoms of abuse, while many also mentioned this in their discussion of whether or not they felt they had received adequate education and training. Furthermore, nearly 40% of respondents would like more information on the possible characteristics of the abusive parent or caretaker and/or the abused or neglected child.

The child life specialists in this study reported abused children tended to exhibit characteristics similar to those reported in previous research. The most commonly reported characteristic noted in this study, withdrawn, was also reported by most researchers who have assessed the psychosocial characteristics of physically abused children (Hoffman-Plotkin & Twentyman, 1984; Kaufman & Cicchetti, 1989; Martin & Beezeley, 1976; Salzinger et al., 1991, 1993). Although described by some as a defense mechanism to avoid future abuse (Crosson-Tower, 2002; Horton & Cruise, 2001), there is also a possibility this characteristic is a way of avoiding disclosure. Child life specialists reported the children kept to themselves and did not open up or share their feelings. By doing this, the children protected themselves from disclosing their home situation.

Although child life specialists did not use the term "hypervigilance," as coined by Kempe and Kempe (1978), they did describe this characteristic in their responses. The children were reported as being constantly "on guard" or "on edge" and extremely

sensitive to changes in the environment. Additionally, previous researchers identified this as being a cause of the short attention span physically abused children tend to exhibit (Chan & Leff, 1988). Although the child life specialists in this study did not specifically mention any tools to use when working with children who have a short attention span, others have suggested breaking activities into smaller steps as well as utilizing a child-directed approach to activities (Chan & Leff, 1988).

Furthermore, the non-compliance discussed by Crosson-Tower (2002) was also reported by the child life specialists in this study when working with older adolescents who were attempting to assert their independence. Child life specialists reported using positive guidance techniques, as well as constant positive reinforcement, in dealing with these types of behavior problems. Additionally, the aggression child life specialists in this study reported seeing in abused children in the hospital is consistent with previous literature on physically abused children in other settings (Erikson & Egeland, 1987; Kaplan et al., 1999; Kendall-Tackett et al., 1993). In this study, child life specialists focused on providing outlets for this aggression in their work with physically abused children. Chan and Leff (1988) agree, providing opportunities to express angry feelings will not only relieve some of the internal tension felt by these children, but it also gives the children an opportunity to test the relationship with the child life specialist. The abused child is able to learn that his or her aggression towards the play materials is not met with counter-aggression by the child life specialist.

Because this aggression increases abused children's likelihood of starting more fights and showing less cooperation with others (Ammerman et al., 1996; Haskett & Kistner, 1991; Lane & Davis, 1987; Salzinger et al., 1993), this aggression is sometimes

viewed as a barrier to social interactions with others. However, the child life specialists in this study reported troubled social interactions were more the result of children resisting engaging with others and choosing to isolate themselves rather than being a result of aggression. One possible explanation for this incongruity could be the fact that because the child's hospitalization is so closely related to the abuse, the child is withdrawing completely. However, children outside of the hospital setting may be acting aggressively as a way of disclosing their abusive situation. Future research should be done to assess the difference in characteristics of physically abused children both before and after disclosure of the abuse to answer some of these questions.

A common theme presented in both this study and previous literature involves the blame children may put on themselves for the hospitalization. Because these children generally have a fear of being "bad," they often interpret the abuse as their fault (Horton & Cruise, 2001). Furthermore, they may believe the painful treatments and procedures they encounter in the hospital are a consequence of being "bad." Chan and Leff (1998) suggest using statements such as "I feel sad, too, when the needle hurts you. We care about you and want the medicine to make you better really soon" (p. 172) as a way to help the child understand what is happening.

Because physically abused children are more likely to misinterpret others' actions and intentions (Salzinger et al., 1993), child life specialists in this study believed it was important to prepare the children for painful procedures. By helping the child to distinguish between the pain of abuse and the pain that is a result of the treatment by a caring adult, the child life specialist is attempting to establish the trust that has been lacking in the child's previous relationships (Crosson-Tower, 2002).

As mentioned in the previous chapter, the characteristics child life specialists reported were slightly conflicting. Some children were reported to be both afraid of everyone, yet clingy to strangers. One child life specialist found the children were "quiet and withdrawn or more provocative and aggressive or assertive." Similarly, Chan and Leff (1988) discussed how, with some children, child life specialists could help establish trust by body comfort, just holding the child. However, other children will always need to maintain a "safe" distance from the adult. For these children, too much physical closeness would be an invasion of their space and will cause additional stress for the child (Jones, 1986). Some of the child life specialists in this study (almost 25%) also stressed the importance of recognizing that although these children do have something in common, they are all different and will react to the hospital experience differently. One child life specialist explained, "Every child that I have encountered is different, each coping in their own unique way. I have had children that want to open up and say everything that they have been through and others that never say a word."

Limitations

Although this study provided valuable information regarding child life specialists and their experiences working with abused children, there are several limitations. First, the sample was extremely homogenous (88.9% white and 97.8% female). In addition, the sample size was fairly small (although there were 90 responses, more than half of the respondents did not complete the entire survey). This low response rate may have been due to the nature of an online survey. In other words, the respondents may have felt little accountability in completing the survey.

Furthermore, because the initial contact information for the child life program was most often the director of the child life program, it is possible a large percentage of the sample may have had more education and training than other child life specialists; therefore, information may not be representative of the target population of child life specialists in general. At the same time, individuals are generally more likely to participate in research they personally find interesting or relevant to their own lives. Because subjects are essentially volunteering to participate in the study by choosing to complete the survey, it is possible that participants may not have had the same training, education, or experiences as those who chose not to participate. It is also possible, because the participants responded to the survey outside of a controlled setting, that they used outside resources in answering questions about their general knowledge of child abuse.

In addition, grounded theory, while appropriate for this study, is more efficient when methods of data collection can develop as the theory emerges. For instance, when using interviews, researchers can modify the interview guide as new themes emerge, whereas the survey questions in this study were concrete. Finally, because this is one of the first studies to assess these variables, there are no commonly used measures; therefore, the measures used in this study have no established validity or reliability.

Implications

Despite these limitations, this study provides several unique contributions to the literature in its field. First of all, due to the dearth of research in the field of child life, this study begins to bridge a large gap that is currently present in this field. Furthermore,

because this study utilized both quantitative and qualitative methodologies, the data provide a deeper understanding of the concepts being examined.

In addition, this study provides several important practical implications for both child life specialists and educators. This study determined what knowledge child life specialists possess regarding working with abused children. It also identified several areas in which child life specialists felt they needed more education in order to better work with this population. Educators can use this information to identify subject matter that should be added to the curriculum of child life classes and in creating additional educational resources for child life specialists.

Furthermore, this study provides child life specialists with a basic understanding of what to expect when working with children who have been physically abused. It provides possible characteristics to look for and how to deal with some of these characteristics. Child life specialists also provided several implications for working with abused children in the hospital: providing trust building activities, a safe environment, focused attention on the child, adjusted interventions, expressive activities, and issues surrounding working with the families.

As with any therapeutic relationship, the child life specialists in this study noted the importance of using trust building activities to build a trusting relationship in order to truly help the client. However, Mann and McDermott (1983) caution individuals working with physically abused children to use careful planning in the termination of these relationships. While it is necessary to build this relationship, child life specialists must be careful not to end it too abruptly as this has been found to lead to further withdrawal, lack of trust, and depression in the child.

In creating a safe environment, the child life specialists should create a calm environment and use a child-directed approach. Mann and McDermott (1983) suggest leaving a door open or providing a room large enough for the child to withdraw from the child life specialist in order to provide the child with a less intrusive environment. In this approach, child life specialists agreed that these children required more attention than others in the hospital not only to help establish a trusting relationship, but also because the parents are not usually present at the hospital. Because this abandonment further reinforces the child's fear that he or she is "bad" and deserves to be left alone in the new environment (Jones, 1986; Kempe & Kempe, 1978; Mann & McDermott, 1983), part of the child life specialists' attention should be focused on reinforcing the real reason the child is in the hospital.

Furthermore, child life specialists must adapt interventions to each specific child depending on their age and developmental level. Although this is the case with all children seen by child life specialists, Chan and Leff (1988) identify a few additional variables to take into account when working with abused children. For these children, child life interventions must also take into account: the nature of the injury; the age of the child; previous separations and hospitalizations; the number, severity, and age of onset of past abusive episodes; and the nature of the child's post-hospitalization environment. By adapting for all of these variables, child life specialists will be able to provide more developmentally appropriate care.

As a result, child life specialists reported using a variety of expressive play materials when working with abused children including art, music, play-doh, journals, feeling games, dolls, dollhouses, and dramatic play. Because the telephone is seen a

powerful tool for connecting with the world outside the abusive home (In & McDermott, 1983), Chan and Leff (1988) suggest using two play telephones as a more indirect way to initiate conversation with a quiet child. Additionally, other indirect methods of conversation, such as puppets, could be used to help facilitate conversation with the child (Kempe & Kempe, 1978).

In addition to working with the child, a child life specialist must also work with the family. In doing so, child life specialists should keep an open mind so they can truly help the family. Additionally, child life specialists must help the children and families, if appropriate, to work on the attachment issues displayed by the children. If children are returning to their own families, these issues can be addressed between the biological parent and child. For children not going home with their families, it may be up to the child life specialist and other caring individuals within the hospital to help the children to move toward a more secure attachment with their caregivers.

Although there were few responses to the question referring to critical experiences child life specialists experienced, the information presented is still beneficial. These responses provide child life specialists with a few case scenarios of real life situations they have personally encountered in the hospital. These scenarios give child life specialists the opportunity to pre-determine appropriate reactions to these types of situations.

In addition to the practical implications discussed above, this study also provides several implications for research. For example, future research should attempt to obtain a larger, more diverse sample in order to validate the results of this study as well as increase the generalizability of the findings. Furthermore, conducting in-depth interviews

with child life specialists who have had a significant amount of experience working with this population would add more to the current study's findings in regard to child life specialists' experiences working with physically abused children. Additionally, although it would be difficult to conduct, a study assessing the children's experiences of the hospital from their own point of view would provide priceless information for child life specialists who want to help them. Because this study was one of the first to look at child abuse in the realm of child life, the possibilities in this field of research are endless. Hopefully, this study will provide the appropriate initiative for future research in this field.

APPENDIX A

E-MAIL

Dear Certified Child Life Specialist:

My name is Jennifer Cerny, and I am a graduate student in Family and Child Studies at Texas State University-San Marcos. As a partial requirement for completion of this degree, I am currently conducting research for my thesis.

As you may know, it is common for children to be admitted to the hospital as a result of physical abuse. Child life specialists are oftentimes one of the most important professionals involved in the child's healthcare experience. Because of this, there is a need to identify the current levels of education and training for recognizing and treating children who have been physically abused. In addition, sharing past experiences you have had may help other child life specialists working with this population.

Within the next week, you will receive a request to complete a survey. You are receiving this survey because the child life program you work with is published in the Directory of Child Life (2003). Your participation in this study would involve answering an online survey. The survey will ask you about the education and/or training you have received in recognizing or treating physically abused children and about your experiences working with this population. Completion of this questionnaire will take approximately 30-60 minutes. I also ask that you forward this email to other child life specialists in your program.

Your participation in this study is voluntary. You are free to refuse to answer any questions and you may withdraw from this study at any time. Be assured that the information will be kept completely confidential; no names will be associated with your responses.

I realize your time is valuable, but you can provide information that will help other child life specialists and the children they serve. Your consideration of this request is greatly appreciated. If you desire additional information, please feel free to contact me at (512) 245-9779 or my thesis advisor Dr. Michelle Toews at (512) 245-2405.

Sincerely,

Jennifer M. Cerny, Graduate Student in Family and Child Studies
Texas State University- San Marcos

APPENDIX B

SURVEY

Experiences with Physically Abused Children

Section 1: Informed Consent

You are invited to participate in an on-line study conducted by Jennifer Cerny, a graduate student in Family and Child Studies at Texas State University-San Marcos, and supervised by Dr. Michelle Toews. We hope your participation will provide us with valuable information regarding child life specialists' experiences working with children who have been physically abused. You were selected as a participant in this study because the hospital you work at is listed in the Directory of Child Life Programs (2003). You are one of approximately 800 child life specialists chosen to participate in this study.

If you decide to participate, please click "I Accept" at the bottom of the page and then complete the on-line questionnaire. The questionnaire will take approximately 30-60 minutes to complete. We realize your time is valuable, but the information you can provide us is critical in identifying the educational needs for child life specialists entering the field.

Any information that is obtained for this study will remain confidential, and in no case will responses from individual participants be identified. The report of the research findings will be in summary form, reflecting the general responses of all participants. If you decide to participate, you are free to discontinue participation at any time without prejudice.

Your consideration of this request is greatly appreciated. If you have any questions, please contact Jennifer Cerny at (512) 245-9779 or Dr. Michelle Toews at (512) 245-2405.

You are making a decision whether or not to participate in this study. By clicking on the "I Accept" button at the bottom of the page, you are indicating that you have read the information provided above and have decided to participate.

I Accept

Section 2: Demographic Information

The following information will be used to describe the characteristics of the child life specialists who completed this study.

1. Sex
   - ☐ Male
   - ☐ Female

2. Race
   - ☐ African American or Black
   - ☐ American Indian or Alaskan Native
   - ☐ Asian American
   - ☐ Hispanic/Latino
   - ☐ Native Hawaiian or Pacific Islander
   - ☐ White
   - ☐ Other _____

3. Age

   _____

4. Highest level of education
   - ☐ Less than high school
   - ☐ High school diploma or equivalent (G.E.D.)
   - ☐ Some college
   - ☐ Associate's degree
   - ☐ Bachelor's degree
   - ☐ Master's degree or higher

5. Residential State

   _____

Section 3: Education and Training

1. Where did you attend college?

   _____

2. In what field did you receive your Bachelor's degree?

   _____

3. How many courses have you taken specifically on child abuse? Please list the names of the courses.

   _____

   _____

4. How many other courses included information regarding child abuse? Please list the names of the courses.

_____

_____

5. Where did you complete your child life internship?

_____

6. Did this internship include any training on child abuse? If so, please explain.

_____

_____

7. Have you had any additional training outside of your formal education on child abuse? If so, please explain.

_____

_____

_____

8. How long have you worked as a child life specialists?

_____

9. What department in the hospital to you work in?

_____

_____

Section 4: Child Abuse Knowledge

This is to determine your general knowledge regarding child abuse and neglect. Please do not use outside sources so that we can get an accurate representation of child life specialists' knowledge of child abuse.

1. Child abuse and neglect occur rarely.
   - ☐ True
   - ☐ False

2. Child abuse and neglect occur at about the same frequency.
   - ☐ True
   - ☐ False

3. Abused or neglected children may become abusive or neglectful parents.
   - ☐ True
   - ☐ False

4. The difference between abuse and neglect is that abuse represents an action against a child while neglect represents a lack of action for the child.
- ☐ True
- ☐ False

5. Abuse may be directed toward only one child in the family.
- ☐ True
- ☐ False

6. Neglect is most apt to involve children from infancy to six years of age.
- ☐ True
- ☐ False

7. Most abusive and neglectful parents suffer from mental illness.
- ☐ True
- ☐ False

8. Bruises on the elbows, knees, shins, or forehead are likely to be accidental in preschoolers.
- ☐ True
- ☐ False

9. Abused children usually will discuss the abuse in an effort to stop it.
- ☐ True
- ☐ False

10. Early reporting is encouraged so that the child may be removed from the home of the abusive parent.
- ☐ True
- ☐ False

11. You must have evidence of abuse or neglect before you report it.
- ☐ True
- ☐ False

12. If you report abuse or neglect, and your suspicions are unfounded, you are liable for civil or criminal suit.
- ☐ True
- ☐ False

13. An anonymous report of abuse and neglect will not be investigated.
- ☐ True
- ☐ False

14. Medical, health related, mental health and legal professionals are not legally required to report child abuse and neglect because of their responsibility to keep client confidentiality.
- ☐ True
- ☐ False

15. Abuse and neglected children are almost always from low income families.
- ☐ True
- ☐ False

16. A child may be abused without anyone ever being able to know.
- ☐ True
- ☐ False

17. If a family's income is over a certain level, the family will have to pay for services from the public children service agency.
- ☐ True
- ☐ False

18. If parents are having trouble coping with their children, they can contact the public children services agency for help.
- ☐ True
- ☐ False

Section 5: National Child Protection Education Project Questionnaire
This questionnaire was adapted from the Center for Pediatric Emergency Medicine's questionnaire for pre-hospital providers (including emergency medical technicians and paramedics), that resulted in the CD publication of Child Abuse and Neglect: A Continuing Education and Teaching Resource. This questionnaire has been modified for child life specialists.

1. How many hours of **CLASSROOM (COLLEGE) TRAINING** did you have in **CHILD ABUSE AND NEGLECT?**

0	1	2	3	4	5	6	7	8	9	10	10+

2 How many hours of CONTINUING EDUCATION or ON-THE-JOB TRAINING did you receive in the PAST TWELVE MONTHS **in CHILD ABUSE AND NEGLECT?**

0	1	2	3	4	5	6	7	8	9	10	10+

3. Does your hospital have protocols, guidelines, or standard operating procedures in the recognition and management of suspected child abuse/neglect? Please explain.

_____

_____

4. *(Check the phrase that most closely matches your feelings about the statement)*

I FEEL CONFIDENT IN MY ABILITY TO:

	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**
Assess suspected *physical* abuse of a child				
Assess suspected *sexual* abuse of a child				
Assess suspected *psychological* abuse of a child				
Assess suspected *neglect* of a child				
Document my findings in suspected child abuse/neglect				
Manage the family of a child who I suspect was abused/neglected				
Work with physically abused children in the hospital				

5. *(Check all those that apply)* As a child life specialist, please indicate the professional(s) with whom you can discuss questions of suspected child abuse/neglect?
   - ☐ Physician
   - ☐ State or other governmental regulatory agency or hotline
   - ☐ Child life co-worker
   - ☐ Nurse
   - ☐ Hospital social worker
   - ☐ There is no one
   - ☐ Other_____

SCENARIOS: Please read each of the following scenarios and then choose ONE statement that best reflects your appraisal of the situation.

6. A 6-month-old female is brought into the ER. Her father says that she fell from her crib with the rail up. Upon examination she has purple, brown, and yellow bruises on her inner thighs and buttocks.
   - ☐ suspicious of abuse
   - ☐ suspicious of neglect
   - ☐ not abuse/neglect
   - ☐ more information needed

7. A 13-year old boy, with a history of asthma from birth, is brought to the hospital wheezing and gasping for air. The mother states she ran out of his asthma medication three weeks ago, and he's had breathing problems just like this for two days.

   ☐ suspicious of abuse
   ☐ suspicious of neglect
   ☐ not abuse/neglect
   ☐ more information needed

8. A four-year-old child is brought into the ER with an injured extremity. The father says that the child climbed up on the father's bicycle rode the bike down the street. The bicycle fell over. On physical exam the child has a swollen/deformed thigh.
   ☐ suspicious of abuse
   ☐ suspicious of neglect
   ☐ not abuse/neglect
   ☐ more information needed

9. A 2-month old infant is brought into the ER unresponsive. Her mother says the baby rolled off the couch, onto the rug, and she wouldn't wake up after the fall, but was fine before.
   ☐ suspicious of abuse
   ☐ suspicious of neglect
   ☐ not abuse/neglect
   ☐ more information needed

10. You are working a 2-year old boy who has scald burns with irregular borders on his face, neck, arms, and upper chest. The child's parents tell you that he reached up over his head and grabbed a cup of hot tea that was on the edge of the kitchen table, spilling it on himself.
   ☐ suspicious of abuse
   ☐ suspicious of neglect
   ☐ not abuse/neglect
   ☐ more information needed

11. While working with a 10-year-old patient, you notice his 5-year-old sister playing with her dolls. She takes off the clothes of the doll and touches the genital area and says, "I know it hurts, but it's okay."
   ☐ suspicious of abuse
   ☐ suspicious of neglect
   ☐ not abuse/neglect
   ☐ more information needed

12. (Check all answers that apply). Typical bruising locations suspicious of physical abuse in a preschool child include:

- ☐ multiple ages of bruises on shins and elbows
- ☐ hand-shaped bruise on cheek
- ☐ multiple ages of bruises over upper arm and chest
- ☐ forehead bruises

13. (Check all answers that apply). Typical burns suspicious of physical abuse include:

- ☐ pattern of hot object (brand) on skin
- ☐ irregular depth
- ☐ blisters on the forearm
- ☐ bilateral, symmetric (stocking/glove distribution)
- ☐ splash pattern

14. (Check all answers that apply). In gathering history, possible indicators for suspected child abuse/neglect include:

- ☐ mechanism of injury/child's developmental capability don't match
- ☐ child and parent/caretaker give similarly worded history
- ☐ child and parent(s)/caretaker give different stories
- ☐ mechanism of injury and child's developmental capability match
- ☐ significant delay in seeking EMS assistance
- ☐ parent(s)/caretaker change story

15. (Check all answers that apply). When obtaining a history from a child you suspect to be a victim of abuse/neglect:

- ☐ Comfort the child
- ☐ Promise not to tell anyone
- ☐ Listen to what is being told to you
- ☐ Push the child to share more than he/she is willing
- ☐ Tell the child he/she will be safe
- ☐ Use age appropriate vocabulary
- ☐ Maintain your composure

16. The responsibilities of a child life specialist in Child Abuse/Neglect include:

a. recognition of signs and symptoms of abuse and neglect ☐True ☐False
b. informing the parent that a report will be made of suspicion of child abuse upon arrival at hospital ☐True ☐False
c. provision of medical stabilization and treatment ☐True ☐False
d. documentation of all findings accurately and legibly ☐True ☐False
e. asking the suspected victim probing investigative questions concerning the alleged abuse ☐True ☐False

17. *(Check all that apply)* In documenting suspected child abuse/neglect a child life specialist should:
    - ☐ describe the interaction between parent and child
    - ☐ record statements from parents using quotation marks
    - ☐ document by interpreting statements/behavior of child/parent
    - ☐ document to whom you report your suspicions or findings
    - ☐ record your opinions of the family interactions

18. *(Check all that apply)* In my role as a child life specialist, I have encountered the following difficulties in taking action on suspected cases of child abuse/neglect:
    - ☐ I can never be certain that a situation is a case of child abuse or neglect
    - ☐ I am not familiar with child abuse/neglect state/city regulatory or hospital procedures
    - ☐ I don't want to have to go to court
    - ☐ The system won't do anything anyway
    - ☐ I didn't know whom to call
    - ☐ It is not my responsibility
    - ☐ I am afraid of the consequences
    - ☐ Other hospital professionals didn't agree with my suspicion
    - ☐ Prior reports were not accepted by the state regulatory agency
    - ☐ I have never encountered any difficulty in taking action
    - ☐ Other_____

19. *(Check all that apply)* In order to report suspected child abuse/neglect to appropriate regulatory agencies one must have:
    - ☐ Substantial proof
    - ☐ Suspicion
    - ☐ Proof to establish the claim beyond a reasonable doubt in court
    - ☐ Physical evidence

20. In my opinion, all child life specialists should be mandated to report suspected child abuse/neglect to their state regulatory agencies, in addition to alerting their supervisor.

    ☐ Yes ☐ No ☐ Not sure

24. As a child life specialist, how many times during the past 12 months have you been involved in a case of suspected child abuse/neglect?

None	☐
1 - 2	☐
3 - 4	☐
5 or more	☐

25. Do you have children or are you responsible for the ongoing care of a child? ☐ Yes ☐ No

26. *(Check all that apply)*

I WOULD LIKE MORE EDUCATION IN THE FOLLOWING CHILD ABUSE/NEGLECT AREAS:

- ☐ Definitions of child abuse/neglect
- ☐ Signs and Symptoms
- ☐ Interviewing techniques with children and parents/caregivers
- ☐ protocols/guidelines/standard operating procedures
- ☐ Town/City and State regulatory requirements
- ☐ Documenting methods (medical/legal)
- ☐ Possible characteristics of abusive parent/caretaker and/or abused/neglected child
- ☐ Interacting with children and families
- ☐ Interacting with law enforcement and social services agencies
- ☐ Environmental assessment
- ☐ Cultural diversity and child abuse/neglect
- ☐ Economic status and child abuse/neglect
- ☐ Developmental capabilities of children at different ages
- ☐ Resources available to deal with feelings arising from handling this issue
- ☐ I do not need any additional education

Section 6: Working with Physically Abused Children

The more in-depth information you provide, the more we will know about these children in the hospital setting. Please feel free to write as much as you like to answer the following questions. Also remember, you do not have to answer any question that makes you uncomfortable.

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

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

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

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

5. Describe any critical or significant experience that has had a significant effect on you and/or your approach to working with physically abused children.

6. Overall, do you feel that your education and training adequately prepared you for working with children who have been physically abused? Please explain.

Section 7: Thank you.

Thank you for your participation in this study. You have provided valuable information regarding child life specialists' experiences working with children who have been physically abused.

If you are interested in receiving a summary of the findings of this study, please provide your email address below. This email address will not be connected to your responses, nor will it be used for any purpose other than to send you a summary of our results.

APPENDIX C

FOLLOW UP E-MAIL

DATE

Dear Certified Child Life Specialist:

Within the last two weeks, you received an online survey regarding your experiences working with physically abused children. If you have not had the opportunity to fill this out yet, please do so by [date].

I realize that your time is valuable, but you can provide information that will help other child life specialists and the children they serve. Your consideration of this request is greatly appreciated. If you desire any additional information about this study, please feel free to contact me at (512) 245-9779 or my thesis chair Dr. Michelle Toews at (512) 245-2405.

Sincerely,

Jennifer M. Cerny, Graduate Student in Family and Child Studies
Texas State University- San Marcos

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