

EXAMINING CHILD LIFE'S
ROLE IN PEDIATRIC
SAFE CASES

by

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ABSTRACT

A P-SAFE is a Pediatric Sexual Assault Forensic Examination. Children who are sexually abused and meet the criteria for a SAFE undergo this stressful examination. Certified Child Life Specialists provide psychosocial care to such patients to help minimize negative outcomes, but little is known about the role of child life specialists in this population. This study sought to address the gap in the literature concerning the role of child life specialists with P-SAFE patients. In this study, 21 child life specialists were recruited through the Association of Child Life Professionals' online forum and answered an online survey. The main research questions asked were: 1. What are Certified Child Life Specialists' roles in the pediatric SAFE population? 2. What are Certified Child Life Specialists' perspective of the stressors they see children experience during a SAFE? 3. What are the stressors Certified Child Life Specialists experience working in SAFE population? 4. What training do Certified Child Life Specialists have to work with this population? Data was analyzed through SPSS; any text data was analyzed through semantic analysis. In summary, the results showed child life specialists feel their role is beneficial and they utilize a variety of interventions such as preparation, distraction, and play during P-SAFEs. The child life participants reported the most difficult part of working with this population is hearing their stories; whereas, the most rewarding part is being able to help the children cope with the exam. They also perceived that the greatest stressors for the children are the possibility of re-traumatization as well as the lack of knowledge. Lastly, the child life specialists were trained through a variety of ways such as informal on the job training but lacked

formalized training. These findings indicated that CCLS perceive that their role is beneficial and important to P-SAFE patients and there needs to be more research and training within this ar

DEDICATION

This thesis is dedicated to all the children that are victims of Child Sexual Abuse and the professionals that aid them.

LIST OF ABBREVIATIONS

<i>CSA</i>	Child Sexual Abuse
<i>CCLS</i>	Certified Child Life Specialist
<i>P-SAFE</i>	Pediatric Sexual Assault Forensic Examination
<i>ACLP</i>	Association of Child Life Professionals
<i>SPSS</i>	Statistical Package for the Social Sciences

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CHAPTER ONE

LITERATURE REVIEW

Child Sexual Abuse

In the United States, it is estimated that 1 out of every 5 girls and 1 out of 6 boys is a victim of sexual abuse (American Psychological Association, 2014). Of the cases of child abuse and neglect, in 2016, 8.5% were cases of sexual abuse which totaled to about 57,329 cases (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2018). Children who experience such abuse are vulnerable to negative outcomes associated with the abuse. For example, individuals who have experienced the trauma of Child Sexual Abuse (CSA) are more likely to have emotional regulation difficulties (Ehring & Quack, 2010). Emotional regulation has been found to be related to a greater severity of Post-Traumatic Stress Disorder for sexual abuse victims (Chang, Kaczurkin, McLean & Foa, 2018). Furthermore, children who have experienced CSA are more at risk for developing psychopathology (Whiffen & MacIntosh, 2005), and females who have experienced CSA have higher suicide attempts (Daray, Rojas, Bridges, Badour, Grendas, Rodante, Puppo, & Rebok, 2016). Such findings highlight the experience of a sexual assault is a traumatic one for children that requires sensitive care and mindful procedures.

If CSA is disclosed, it is mandatory to report the abuse. When a CSA is reported, necessary steps are taken to review the report and determine if a pediatric-sexual abuse forensic

examination (SAFE) is necessary (U.S Department of Justice Office on Violence Against Women, 2016). In fact, many hospitals have protocols and algorithms in place to determine if the child needs the examination. According to Children's Mercy Hospital (2015) in Kansas City, suspected sexual abuse patients meet with medical staff as well as social work. Social work then gathers information on the patient. They may talk to the caregiver or Children's Division worker with the child to get an account of the alleged abuse. Once social work has compiled the facts, it is then determined if the on-call Pediatric-Sexual Assault Nurse Examiner (P-SANE) should be called. For patients that do not need to be seen urgently, a follow up clinic appointment can be offered to the patient, if needed. Per P-SANE criteria, to meet the criteria for a SAFE on a prepubescent patient there must be a disclosure of the assault or a witness to the assault, the assault or last contact should have happened within the past five days, and the assault involved skin to skin contact with the patient's anogenital area (i.e., area around the anus and/or genitalia). If the patient meets these criteria, they are seen for a forensic exam (Children's Mercy Hospital, 2015).

During the exam, the P-SANE may collect forensic evidence, such as clothing and swabs from the child's mouth and anogenital area. They collect swabs to test for the perpetrators' DNA. Additionally, the provider will examine the patient's anogenital areas with a camera looking for injury (e.g., bruises, cuts) and swab for sexually transmitted diseases (Lahoti, 2001).

This process can be one that causes anxiety, distress, and/or pain for pediatric patients (Tener et al., 2012; Berenson et al., 1998). Furthermore, throughout the process of waiting for an exam, multiple medical professionals will talk to the child and their caregiver. The child may be asked about the suspected abuse and will be told about the exam. He/she may be apprehensive about being in the hospital, emergency department or clinic, and may not fully understand why

he/she are there (Thompson, 2009). The child is not usually in a hospital environment and depending on his or her age, may not have been exposed to a variety of medical equipment; this unfamiliarity influences the child's emotional responses to hospitalization (Johnson, Jeppson, & Redburn, 1992; Skipper and Leonard, 1968). Additionally, hospitalization includes stressful events such as separation from loved ones, experience of pain, and loss of control (Wong, Perry, & Hockenberry, 2002). These stressful experiences influence how a child will respond to the hospitalization, such as increased medical fears (Rennick, Johnston, Dougherty, Platt, & Ritchie, 2002).

It is also important to note that during a SAFE body parts that were recently abused are examined. Therefore, the patient may experience stress, anxiety, and possibly traumatization of the abuse. Berson, Herman-Giddens, and Frothingham (1993) examined children's perceptions of the SAFE and found that children see the exam as intrusive and have a negative view of the doctor afterwards. Additionally, children reported restraining during the exam was reminiscent of their previous sexual abuse (Berson, et al, 1993). Since hospital staff are working with this vulnerable population, it is important to consider the best practices in making sure that the SAFE does not re-traumatize the patient. In the U.S. Department of Justice Office on Violence Against Women (2016) protocol for pediatric sexual forensic examinations, the importance of the exam being child-centered, victim-centered, and trauma- informed during the care for CSA victims is emphasized. Examples of different victim-centered techniques include preparation and distraction, which have been shown to be beneficial in easing the stress and anxiety and increasing coping in pediatric patients (U.S. Department of Justice Office on Violence Against Women, 2016).

Preparing Children for SAFE

When a child is in the hospital, they may have to undergo multiple procedures or may see and experience events that are unfamiliar to them. There is a vast basis of research providing support that when children are prepared, and ideas are explained to them in child friendly terms, they have decreased anxiety (Margolis, Ginsberg, Dear, Ross, Goral, & Bailey, 1998; Edwinston, Arnbjornsson, & Ekman, 1988; Melamed & Siegel, 1975; Felder-Puig, Maksyy, & Noestlinger, 2003; Brewer, Gleditsch, Syblik, Tietjens, & Vacik, 2006; Moore, Bennett, Dietrich & Wells, 2015). According to Koller (2008) preparation allows children to know what will happen during the procedure or treatment and identify appropriate coping techniques.

Preparation has been found to be beneficial for children who are experiencing anogenital exams (Rheingold, Danielson, Davidson, Self-Brown, & Resnick, 2013; Gulla, Fenheim, Myhre, & Lydersen, 2007; Rheingold, Davidson, Resnick, Self-Brown, & Danielson, 2013). Rheingold et al. (2013) studied the effectiveness of providing a psychoeducation video educating the children and their caregivers about the upcoming anogenital procedure and found the education decreased stress during the exam for the families. Similarly, another study found preparation before the exam and providing a supportive atmosphere during the exam helped to decrease stress for the child (Gulla et al., 2007). Furthermore, children that are more aware of what the exam entails appear to be less anxious during the exam (Rheingold, Davidson, Resnick, Self-Brown, & Danielson, 2013). Such findings emphasize the importance of preparing children for sexual abuse exams; when they are prepared, they exhibit less anxiety and stress.

One way of preparing children for procedures is through play. Play is child centered, pleasurable, and promotes well-being and normal development (Koller, 2008; Haiat, 2003). It allows children to express their emotions and process through information in a developmentally

appropriate manner (Brown, 2003). For example, preparation may include children playing through the procedure and rehearsing roles through dramatic play (McCue, 1988). Children are able to process the information they have been given and demonstrate their understanding and feelings about it during such play experiences. Moore et al. (2015) found that children who were prepared for a burn dressing change through medical play were not as distressed during the procedure when compared to children that did not receive medical play intervention. Including play during preparation for the exam has the potential for benefits for sexual abuse patients because previous research has shown play helps abused children express their feelings and open up (Tornero & Capella, 2017; Gil, 1991) and the relationship formed between the adult and child experiencing sexual abuse during play is seen to be beneficial for healing (Moustakas, 1997).

Distraction

Distraction is a type of nonpharmacological support provided to children during different treatments and examinations. It helps to take the focus away from the distress of the procedure to a more neutral stimulus, such as toys (Chambers, Taddio, Uman, McMurtry, & HELPinKIDS Team, 2009), bubbles, books (Cavender, Goof, Hollon & Guzzetta, 2004), music (Sinha, Christopher, Fenn, & Reeves, 2006) and tablets (Sinha, Christopher, Fenn, & Reeves, 2006); this in turn leads to a decrease of stress (Stevenson, Bivins, O'Brien, & Gonzalez del Rey, 2005).

Distraction has also been seen to reduce fear and anxiety during sexual abuse exams. Tener, Lang-Franco, Ofir, and Lev-Wiesel (2012) found distraction by a clown induced laughter in the children during the exam and decreased anxiety and stress during the exam. Berenson, Wiemann, and Rickert (1998) provided video eyeglasses to children during the anogenital examination as a tool for distraction and found the eyeglasses were effective in decreasing the children's anxiety and fear during the examination. Such findings begin to support the use of

distraction during pediatric SAFEs; however, additional research is needed to fully understand the psychosocial benefits of distraction to this population.

Child Life Interventions

Each day, there are children experiencing a hospitalization ranging from emergency visits and inpatient stays to routine clinic visits. According to Koller (2008), children may experience different unfamiliar procedures, unknown environments, and new people during a hospitalization. These experiences can induce stress and anxiety in the child (Koller, 2008). Many pediatric facilities employ Certified Child Life Specialists (CCLS) to help address such stressors and anxieties. Certified Child Life Specialists are certified professionals with extensive backgrounds in development and the psychosocial variables of children's hospitalizations, as well as clinical experiences with children (Lookabaugh & Ballard, 2018). They have, at minimum, a bachelor's degree with specific training in child development, play, loss and bereavement, and psychosocial care of hospitalized children, and have completed a 600-hour clinical internship and passed a rigorous certification exam (Association of Child Life Professionals, 2018). The American Academy of Pediatrics (2018) states that a CCLS is an essential role in pediatric care as they focus on the development of every child and care for their wellbeing while trying to minimize the harmful effects of a hospitalization on a child. In other words, child life interventions reduce stress and increase coping and understanding when children are faced with a hospitalization. "Child life specialists believe in the inner strength of children and that they can cope and adapt effectively with adversity when provided with appropriate child-centered supports suited to their development level, temperament, and coping style" (Humphreys & LeBlanc, 2016, p. 156). The psychosocial care that assists in helping children to cope includes preparation, normalization through play, procedure support, and

education. Research suggests that a CCLS can help relieve anxiety and promote coping in a variety of settings and different medical diagnoses (Burns-Nader, Joe, & Pinion, 2017; Brewer, Gleditsch, Syblik, Tiejens, & Valik, 2006).

A Certified Child Life Specialist's role is to provide information to the child and explain different aspects of the procedure, hospitalization, or experience to them. This can be through interventions, such as diagnosis teaching and or procedure preparation. These interventions allow for emotional expression, and the CCLS can address any fears and anxieties that the child expresses. Additionally, it helps to build a trusting relationship between the medical staff and the child (Koller, 2008). Brewer, Gleditsch, Syblik, Tietjens, and Vacik (2006) found that children who were prepared for surgery prior to surgery had lower anxiety scores than children who were not prepared for surgery. In other studies it was found that CCLS preparation was related to success during procedures, a decrease in pain and anxiety experienced (Brewer et al., 2006; Li & Lopez, 2008; Chambers, 2014; Gursky, Kestler, & Lewis, 2010), an increase in understanding (Li & Lopez, 2008), and an increase in satisfaction from the patient and parent (Li & Lopez, 2008; LeBlanc, Naugler, Morrison, Parker, & Chambers, 2014; Gursky, Kestler, & Lewis, 2010). LeBlanc et al. (2014) found that 94.8% of parents whose children received preparation were satisfied with this intervention. The benefits of child life intervention go beyond the child and reaches the family as well. Through preparation and other child life interventions, CCLS are successfully providing quality family centered care.

Another intervention that Certified Child Life Specialists use is play to help normalize the hospital environment. Play has been found to help decrease the amount of pain experienced and decrease negative physiological responses to medical procedures (Cassell, 1965; Kaminski, Pellino, & Wish, 2010; Moore et al., 2015). In a review, Burns-Nader and Hernandez-Reif

(2016) found that play helps children handle their stress and anxiety in a controllable way; specifically, therapeutic play allowed children to express their emotions and promote positive psychosocial wellbeing. Li and Lopez (2008), tested the effectiveness of therapeutic play interventions in children that are preparing to go to surgery. They found that therapeutic play was extremely effective, and that play is important in a child's life even when in the hospital (Li & Lopez, 2008). The CCLS use of play in the hospital is a main facet of their role, and as the research has emphasized, it is beneficial in promoting development and decreasing anxiety in the hospital. The use of play with children coming into the hospital for sexual abuse, though not researched, can have the ability to provide these benefits that the aforementioned research articles describe.

Aside from preparations for procedures, child life specialists also provide distraction during a child's procedure. When assessing the patient and the procedure that the patient will be having, they will determine the best type of distraction. This assessment is based off the child's age, stage of development, procedure, and interests. Multiple researchers have examined the child life specialist's use of distraction and its effectiveness. Burns-Nader, Joe, and Pinion (2017) found that using a tablet as distraction during a burn treatment reduced the children's pain and anxiety. Additionally, Hylan, D'cruz, Harvey, Moir, Parkinson, and Holland (2015) found that when the CCLS helped in adapting the environment during a burn dressing change and used distraction the children experienced lower amounts of pain. These findings highlight the benefits of using distraction to decrease pain and anxiety in children during the procedures.

Certified Child Life Specialists work in areas throughout the hospital including the Emergency Department, Inpatient units (i.e. Neonatal Intensive Care Unit, Pediatric Intensive Care Unit (PICU), Hematology and Oncology), and Outpatient Clinics (i.e. Ear, Nose, Throat

(ENT), Orthopedic). In some hospitals, they are also working with the SAFE patients as well, either in the Emergency Department or Outpatient clinics that specialize in SAFE exams. Not only can they be found working with this population, but they should, because of the vulnerability of the situation. In fact, the American Academy of Pediatrics (2018) states “Child life programs are an important component of pediatric hospital– based care to address the psychosocial concerns that accompany hospitalization and other health care experiences” (p. 1472).

Current study

Children who are sexually abused undergo stressful and upsetting procedures as part of their care. Child life specialists provide psychosocial care to such patients to help minimize negative outcomes. Previous studies have shown psychosocial interventions, such as distraction and procedure support, are effective in minimizing negative effects for this population. Although child life specialists are often the healthcare professionals providing psychosocial support to CSA patients, there is very little known about the role of child life in this population. The purpose of this study was to address the gap in the literature and gain more information about the role of Certified Child Life Specialists within the child sexual abuse population. Specifically, the study examined the following research questions:

1. What are Certified Child Life Specialists’ roles in the pediatric SAFE population?
2. What are Certified Child Life Specialists’ perspective of the stressors they see children experience during a SAFE?
3. What are the stressors Certified Child Life Specialists experience working in SAFE population?
4. What training do Certified Child Life Specialists have to work with this population?

CHAPTER TWO

METHODS

Procedure

With Institutional Review Board approval, the survey was disseminated through the Association of Child Life Professionals (ACLP) forum. The ACLP forum is an online place where ACLP members (i.e. CCLS, students, retirees, and community members) are able to share information with each other and have discussions on topics related to the child life profession. An initial post was made informing ACLP members of the study, where they were able to participate using a link. Follow up reminders were sent to encourage participation. Participants provided electronic consent and then completed a survey on their demographics and experiences working with the SAFE pediatric population.

Participants

A total of 24 Certified Child Life Specialists were recruited from the ACLP forum. The inclusion criteria to participate was participants had to 1) be at least 18 years old, 2) have at least 4 months experience working with the sexual abuse population, 3) be English speaking, and 4) work in the United States. If a person was non-certified, non-English speaking, and not working in the United States, they were excluded. Of the 24 surveys submitted, 3 were excluded due to being incomplete.

Participants ($n=21$) ranged in age from 24 to 51 ($M= 31.29$, $SD=6.9$). All of the participants were female, and most were Caucasian. Additionally, participants' work experience with this

population ranged from 9 months to 240 months (M=54.9, SD:), with a majority working with the SAFE population in the Emergency Department and/or Abuse Clinic ($n=18$, 85.6%). For additional information on demographic information, see Table 1.

Table 1

Participant Demographic Frequencies and Percentages

Variable	<i>n</i>	%
Age (M, SD)	31.29	6.9
Education (%)		
Bachelors	12	57.1
Professional-Masters	9	42.9
Hospital size (%)		
Small Children's Hospital	5	23.8
Medium Children's Hospital	13	61.9
Large Children's Hospital	2	9.5
Large Adult Hospital	1	4.8
Unit Worked in with SAFE Population		
ED	12	57.1
ED and Abuse/Clinic	4	19.0
Inpatient	2	9.5
ED and other Units	2	9.5
Child Protection Program	1	4.8

Ethnicity (%)	
Caucasian	19 90.5
Middle Eastern	1 4.8
Biracial	1 4.8
Gender (%)	
Male	0 0
Female	21 100

Measures

Background Questionnaire. The background questionnaire asked participants for demographic data, including age, ethnicity, and gender. The questionnaire gathered information about the participants' history as a CCLS, including how long they have been a CCLS, how long they worked/ have worked with SAFEs, years of schooling, and unit in which they currently worked.

The CCLS's Perceived Role in Sexual Abuse Examinations Survey. This survey examined the roles and needs of CCLSs serving pediatric sexual abuse examinations. This survey was created by two Certified Child Life Specialists, with each contributing specific knowledge and experience to the survey development. The primary author is a CCLS with two years' experience, including training and clinical work specific to the P-SAFE population. The second CCLS was Dr. Sherwood Burns-Nader, an Assistant Professor at the University of Alabama. Dr. Burns-Nader has been a CCLS for over 14 years and is a preeminent scholar in the field. The survey questions were based on their training in child life and experiences working with the P-SAFE population, as well as empirical based knowledge from the literature of the

child life field. After the survey was created by the two, the survey was distributed to a CCLS with expertise with the P-SAFE population for feedback and critique. The survey was finalized with consideration of the third CCLS's input.

The survey consisted of questions in three domains: (1) Exploring the CCLS role with sexual abuse population: (i) Interventions with SAFE patients (ii) CCLS roles, (iii) CCLS responsibilities and job duties; (2) Training received prior/while working with sexual abuse population; and (3) Specific stressors in sexual abuse population. The survey had a total of 46 questions. Questions, such as how valued the CCLS felt as part of the multidisciplinary team and what training the CCLS has participated in, were asked using a Likert scale. Another question rating the importance of interventions used was asked using a subscale. Additionally, qualitative questions asked participants to further explain answers; these questions included explaining the resources they use, reasoning for using or not using interventions, benefits they see in CCLS intervention, why they feel valued or not valued as part of the multidisciplinary team, and their thoughts on advocating for the child during the exam.

Data Analysis

Statistical Package for the Social Sciences (SPSS) version 24 was used to analyze the descriptive data. Furthermore, for the two questions which asked what the most rewarding aspects of working with this population and what were the most difficult aspects, a thematic analysis was conducted with a semantic approach to analyze the qualitative data from the survey.

During the analysis of these questions, two researchers reviewed the data together and discussed themes, coming to an agreed consensus. The data was then sent to a third researcher who independently generate themes and then were agreed upon with the first researcher. The data was coded and an inter-rater reliability around 76% was reached.

CHAPTER THREE

RESULTS

What are Certified Child Life Specialists' roles in the pediatric SAFE population?

To assess this question, the survey gathered information on job duties and responsibilities, where they provided support, the types of preparation, distraction, and play used, how they feel their role is beneficial, how they advocate for the patient, and how they perceive the multidisciplinary team views them. First, CCLS reported numerous job duties and responsibilities with the SAFE population through direct intervention or outside of the intervention job duties. As seen in Table 2, when asked to select their required job duties, the duties selected the most were procedure support, play, building rapport with patients, charting, assessment, education, and supporting co-workers. When asked to list their top 5 duties, there was no clear top duty; 6 CCLS (28.6%) listed assessment as their top duty, 7 (33.3%) listed procedure support as their 2nd duty of importance, and 5 listed (23.8%) listed rapport as their 3rd top duty. See table 4 for additional information of the top 5 jobs duties that were listed.

Table 2

Required CCLS Job Duties and Responsibilities

Required Job Duties and Responsibilities	<i>n</i>	%
Procedure Support	20	95.2

Play	20	95.2
Building rapport with patients	19	90.5
Charting	18	85.7
Assessment	17	81
Education	17	81
Supporting co-workers	12	57.1
Child life department roles	10	47.6
Rounds/in-services	10	47.6
Planning	6	28.6
Other	2	9.5

Table 3

Top Duties

Duty	1 st Duty	2 nd Duty	3 rd Duty	4 th Duty	5 th Duty
Procedure Support	2	7	3	2	2
Education	2	3		2	
Rapport	3	2	5	1	1
Preparation	3	2	1	1	
Assessment	6	1	2	1	2
Collaboration	1	3	4	3	1
Planning	1				
Play			3	4	2
Normalization				1	

Coping	1
Follow-up	
Child Life Dept. Roles	1
Charting	1
Support to Siblings	1
Support to Caregivers	1
Support to co-workers	1

Participants were also asked where they provided support to pediatric SAFE patients. The participants provided support to patients during interviews with other medical staff ($n=17$, 81%), prior to the exam ($n=19$, 90.5%), preparation for the exam ($n=21$, 100%), during the exam ($n=21$, 100%) and post exam ($n=20$, 95.2%). Some also provided support at other areas of admission as seen in Table 3. Participants reported providing support through play, preparation and distraction. All of the CCLS provided play and preparation to SAFE patients. For distraction, of the 21 participants, only 1 said they did not provide distraction to the population. When providing preparation, all participants provided information to the child. The top ways of providing preparation are as follows: information to the child ($n=21$, 100%), information to the adult caregiver ($n=19$, 90.5%), medical teaching dolls ($n=12$, 57.1%), comfort position ($n=18$, 85.7%), and familiarization with equipment ($n=19$, 90.5%). The top distractions technique utilized are the iPad ($n=18$, 85.7%), breathing exercises ($n=18$, 85.7%), relaxation techniques ($n=17$, 81%), music ($n=17$, 81%), and conversation ($n=20$, 95.2%). Play was primarily used to normalize the hospital environment ($n=20$, 95.2%) and to build rapport ($n=20$, 95.2%). Only 11 (52.4%) CCLS chose medical play as a form of play that they use.

Table 4

Where CCLS Provide Support

Location/time of support	<i>n</i>	%
Preparation	21	100
During Exam	21	100
Post Exam	20	95.2
Prior to exam in Patient Room	19	90.5
During Interviews	17	81
Vital Signs	10	47.6
Waiting Room	6	28.6
Admission	5	23.8
Check-in	4	19
Other	1	4.8

Furthermore, when asked about how beneficial they saw their role, participants felt that it was beneficial. The CCLS's role was reported to be beneficial in a number of ways, such as, increased coping ($n=20$ 95.2%), increased procedure cooperation ($n=21$, 100%), return to baseline ($n=18$, 85.7%), and decreased anxiety and stress ($n=20$, 95.2%). Another beneficial role of a CCLS is to minimize re-traumatization. All of the Certified Child Life Specialists in the study felt they helped minimize re-traumatization for the SAFE patient. They reported to help minimize re-traumatization by advocating for the presence of a caregiver ($n=15$, 71.4%), using a less threatening position ($n=18$, 85.7%), slowing down the examination ($n=18$, 85.7%), respecting the privacy of the patient ($n=21$, 100%), and stopping because of re-traumatization ($n=10$, 47.6%). Only 10 of the 21 participants had experience advocating for the stopping of an

exam. There were mixed results on the question that examined if as a CCLS they were comfortable advocating for an exam to stop: 10 were very comfortable (47.6%), 4 were somewhat comfortable (19%), 2 were neutral (9.5%), and 4 were somewhat uncomfortable (19%).

In relation to the multidisciplinary staff, all of the CCLS felt valued by the staff ($n=11$, 52.4%) or strongly valued ($n=10$, 47.6%), and they felt that the multidisciplinary team's perception of them is primarily as a procedure supporter ($n=10$, 47.6%), educator ($n=5$, 23.8%), and facilitator of coping ($n=4$, 19%).

What are CCLS' perspectives of the stressors they see children experience during a SAFE?

To address this question, participants were asked to select the stressors that they perceive this population experiences. The two greatest stressors that the Certified Child Life Specialists in this study perceived children in this population experience were re-traumatization ($n=17$, 81%) and lack of information/understanding ($n=11$, 52.4%). This compares to the similar results for their perception of the most common stress points. Participants listed the pre-procedure events ($n=14$, 66.7%) and the exam itself ($n=16$, 76.2%) as the most common stress points. One CCLS expanded and stated, "depending on the age, but I think they often feel shame and fear of being bad. They often regress in behaviors. Trust is a major issue, so I think the first step is always to help the child feel safe and have some controls."

What are the stressors CCLS experience working in SAFE population?

The CCLS were asked about the most rewarding and difficult parts of working with this population as well as if they practiced self-care; only 14 (66.67%) of the 21 participants responded to these questions. Nine (42.9%) stated that hearing the children's stories was the most difficult part of working with this population. One CCLS stated that "some of the stories

can be heartbreaking and seeing how traumatized the patients can be is difficult.” Where another CCLS said, “hearing the stories of why children came in, and trying not to carry that home with me” was a difficult part. One participant stated that it is hard especially if they don’t have a “supportive team” or another CCLS who works with this population. Other difficult parts of working with this population included seeing the fear ($n=3$, 14.3%) and possibility of trauma from the exam ($n=4$, 19.1%). Another CCLS said that it’s hard when she hears the patients frequently say, “just be gentle.” In addition, to these difficult parts, two (9.5%) other participants brought up the point that it is hard to balance the length of time involved with these cases with other duties and responsibilities. Of the 21 participants, 15 (71.5%) practiced self-care often, somewhat often or very often. Whereas, 4 (19.1%) did not practice it or it was somewhat unoften.

When asked about the rewarding parts of working with this population, the majority of the CCLS reported helping the children cope and seeing their fear and anxiety dissipate was rewarding ($n=8$, 38.1%). One CCLS stated that one of the most rewarding parts of working with this population was “Working with a team of people who are dedicated to helping victims of sexual abuse/assault cope and move forward on a journey of healing.”

What training do CCLS have to work with this population?

To gain information on this research question, participants were asked about how trained and prepared they felt, trainings that prepared them for this role, trainings they lacked, and trainings that are important to continue to visit as part of this role. A majority felt that they were at least trained and prepared ($n=15$, 71.4%), whereas 4 (19%) felt somewhat trained and prepared and 1 (4.8%) felt not trained or prepared at all. A majority of the Certified Child Life Specialists’ felt that the training that best prepared them for this role was informal on the job

training from other healthcare professionals ($n=19$, 90.5) and the second most training they felt prepared them was self-taught methods ($n=11$, 52.4%). When asked about the training they feel they lacked or needed more of many stated the need for formal workshops for professional development units ($n=13$, 61.9%) and information through Association of Child Life Professionals' resources ($n=42.9\%$). The CCLS also stated that it is important to continue visiting various trainings and resources as part of this job. Those trainings include formal updated literature ($n=16$, 76.2%), workshops ($n=13$, 61.9%), information through the Association of Child Life Professionals' resources ($n=12$, 57.1%), and informal on the job training from other healthcare professionals ($n=11$, 52.4%).

CHAPTER FOUR

DISCUSSION

This study sought to examine the CCLS's role in pediatric SAFE and understand their views within this role. Results suggest Certified Child Life Specialists provide support in multiple ways during a P-SAFE, including through the use of preparation, play, and distractions, and how providing these interventions can be difficult and/or rewarding. Furthermore, results provided insight into the training that Certified Child Life Specialists receive for this role that was helpful, training that is needed, and training that they lacked.

Role and Responsibilities

The first research question sought to understand more fully the specific roles the Certified Child Life Specialists have within the hospital and at what point do they start to provide support to the patients. It was found that Certified Child Life Specialists have many duties outside of supporting the patient during the exam, such as procedure support, play, rapport building, charting, assessment, and education. When ranked, procedure support, education, rapport, and assessment were the only required duties that make the top two as well as were in the majority on required duties. Play, though listed as important, was only ranked by the CCLS as the 3rd, 4th, or 5th, duty of importance. This means that even though CCLS are required to engage in play, it is not considered as important as providing procedure support, education, rapport, and assessment to this population.

The interventions provided can start at admission but primarily are just before the exam, during the exam, and post exam. At these points is when the possibility of re-traumatization is increased. During these points the patients aren't just waiting, but they are talking to medical staff about the exam, being prepared for the exam, undergoing the exam, and trying to cope after the exam. During these periods is when the interventions of preparation, play, and distraction are used throughout the CCLS's interventions with the patients.

Preparation. When utilizing preparation with the patients, all of the CCLS stated giving information to the child and caregivers was the most important. Previous studies found that information given to the child and caregiver was beneficial in decreasing stress and increasing cooperation (Rheingold, Danielson, Davidson, Self-Brown, & Resnick, 2013; Gulla, Fenheim, Myhre, & Lydersen, 2007; Rheingold, Davidson, Resnick, Self-Brown, & Danielson, 2013). Additionally, familiarization with the equipment and utilizing comfort positions as preparation was also utilized the most.

Distraction. When utilizing distraction, most of the Certified Child Life Specialists provided the iPad, breathing exercises, relaxation exercises, music, and conversation. These techniques are used to support the patient during the procedure, which is an important duty of the CCLS. These distraction techniques have been found to be beneficial in other settings (Burns-Nader, Joe, and Pinion, 2017; Hylan et al., 2015). Future research should examine if these distraction techniques are beneficial to patients during P-SAFEs.

Play. The participants primarily used play to normalize the environment and build rapport rather than medical play. When relating back to the duties of importance, the CCLS stated that building rapport was one of their top duties. So even though play didn't come in as a 1st or 2nd duty of importance, play is still utilized, but not for the sake of play but the underlying

motive of building rapport. Alcock et al. (1985) found that patients showed fewer negative behaviors and engaged in play more often when a CCLS was present. Previous studies and reviews have noted the importance play has in helping build rapport between the adult and the patient (Burns-Nader & Hernandez-Reif, 2014).

Over all, in the U.S. Department of Justice Office on Violence Against Women (2016) Protocol on P-SAFEs experts exercise the importance of preparing and utilizing distraction techniques to help ease the stressors experienced. The present study found that Certified Child Life Specialists who work with this population recognize this need and provide interventions that can allow for information to be given and interventions that ease stressors. They prioritize preparation and distraction, thus aligning with the national protocol and the healthcare professionals that helped to produce that document.

Child Stressors and Benefits CCLS Provide. The Certified Child Life Specialists in the study viewed their role as beneficial. Since CCLS have a strong background in development, they understand the typical stressors that children experience but also, they are able to assess for the stressors that the children experience during hospitalization (Lookabaugh & Ballard, 2018). In the current study, Certified Child Life Specialists thought their role helped to increase coping and cooperation, lower anxiety/stress, and minimize re-traumatization. Although previous studies have not examined the benefits of a CCLS's support during a P-SAFE, previous studies have shown the presence of child life specialists minimize children and family's anxiety (Li & Lopez, 2008; Burns-Nader, Joe, & Pinion, 2017), promote coping (Burns-Nader and Hernandez-Reif, 2016), and promote procedure compliance (Tyson, Bohl, & Blickman, 2014) during a variety of procedures, such as medical imaging (Tyson, Bohl, & Blickman, 2014), burn treatments (Burns-Nader, Joe, & Pinion, 2017), and laceration repairs (Gursky, Kestler, & Lewis, 2010). Future

studies should examine the benefits of a CCLS presence during a P-SAFE for the pediatric patient, family, and healthcare team.

Certified Child Life Specialists provide interventions during the points they assess as being the greatest stressors; in the current study, this was viewed as during the exam to prevent re-traumatization and lack of information while waiting for the exam. In their role, the Certified Child Life Specialists reported to advocate for the prevention of re-traumatization by including the caregiver, using different positions, slowing down the exam, respecting the privacy, and stopping the exam if necessary. The American of Pediatrics (2018) stated several of these interventions are beneficial and important to be utilized in the hospital setting to reduce the patient's distress. They affirmed that Certified Child Life Specialists have the knowledge, training, and ability to provide these interventions. Interestingly, although the Certified Child Life Specialists recognized their role in advocating for the exam to stop, only half had experience in is the stopping of an exam, and only a few felt comfortable with advocating for the stopping of an exam. Additional information is needed to further examine the CCLS's role in advocating for the patient during the P-SAFE and the stressors in advocating for the stopping of a P-SAFE in order to prevent re-traumatization of the patient.

Do they feel valued? The Certified Child Life Specialists in the current study reported to feel valued by the multidisciplinary team. In an older article from Gaynard (1985), she found that in different units of the hospital, Certified Child Life Specialist's may not be seen as part of the health care team. In a more recent study by Cole, Diener, Wright, and Gaynard (2001), the multidisciplinary team thought Certified Child Life Specialists were important for psychosocial well-being of pediatric patients. This current study highlights the increasing perceived positive attitude towards the child life specialist's role. In this specific population and the intensity of the

situation, the multidisciplinary staff may understand that Certified Child Life Specialists are there to help the patient cope and cooperate during the examination, thus providing care for the psychosocial well-being of the patient. Future studies are needed to examine the multidisciplinary team's view of child life's role in P-SAFEs and the benefits of their care during such examinations.

CCLS Stressors and Rewards

Working as a member of the healthcare team that provides support to victims of abuse or trauma can be an emotionally taxing job (Meadors & Lamson, 2008; Bride, 2007; Baird & Jenkins, 2003). The Certified Child Life Specialists, in the current study, stated stressors they often experience is seeing the fear that these patients have and hearing their traumatic stories. Previous articles have talked about compassion fatigue and how it is prevalent amongst healthcare professionals that work with higher stress populations (Van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015). Maslach, Schaufeli, and Leiter (2001) found that burnout can lead to numerous negative outcomes such as poorer job performance and mental health concerns. It is important for healthcare professionals to engage in self-care, as self-care is recommended to be a solution to burnout and compassion fatigue (Newell & MacNeil, 2010). Some of the CCLS reported they do not engage in self-care; therefore, it is important for a CCLS working with this population to have the resources and knowledge to be able to cope in a healthy way. However, beyond these stressors CCLS find it rewarding when they are able to help the children cope and see their fears dissipate. There is a good amount of research on secondary trauma and compassion fatigue (Van Mol, et al., 2015; Newell & MacNeil, 2010; Meadors & Lamson, 2008; Bride, 2007; Baird & Jenkins, 2003). However, many of the articles do not focus on healthcare workers such as nurses, social workers, and CCLS that work with P-SAFEs. Additionally, there

is not much information out there on the rewards of working with this population. Over all, the CCLS has an important role in helping the child cope, but the CCLS themselves also have to cope so they don't experience burn-out.

Training

In relation to the CCLS's training to work with this population, most of the Certified Child Life Specialists were trained primarily through informal job training and self-taught methods and felt they lacked formal workshops and professional resources. When looking at the training that other professionals receive with this population, there is a stark difference in the specific training required. For Pediatric Sexual Assault Forensic Nurse Examiners, they are required to go through a sexual assault nurse examiner education program with contact hours and examination beyond what is required of a basic nursing degree (Nursing Commission for Forensic Nursing Certification, 2019). Unless the CCLS was trained to provide P-SAFEs during their internships, most of the helpful training comes from other staff on the job. While this training is important, having the CCLS feel trained prior to being on the job is also important. A P-SAFE can be a traumatic healthcare experience for a pediatric patient. Therefore, Certified Child Life Specialists need resources to best support these patients. This suggests a greater need for current research on the best interventions for this population. Additionally, our findings suggest that Certified Child Life Specialists do not receive specialized training prior to working with this population, as it is primarily through informal on the job training. Additional training is needed so that child life specialists can best support these patients and families, such as webinars provided by ACLP or specific trainings at the annual conference of child life professionals.

Implications and Future Research

This is the first study to look at the role of Certified Child Life Specialists with the Pediatric-SAFE population. The current study found the CCLS's role seeks to support SAFE patients during a stressful period through the use of play, preparation, and distraction; but their role goes beyond these specific interventions. Based on previous research and the findings of this study CCLS have the ability to provide positive interventions with these patients; therefore, more hospitals that complete P-SAFEs should consider utilizing child life services. However, to be the best support for these children, training is needed. More formalized training specifically is needed so that the CCLS can provide the best care, but also be able cope with their own personal experiences working with this population. There is a lack of resources for CCLS who work with this population. Creating a group of child life specialists that work in this population should be a priority so that they can help each other grow professionally and support one another. Furthermore, updated research about the most effective interventions for P-SAFE patients would be helpful. However, the likelihood of this occurring may be difficult due to ethical issues involving research with victims of sexual abuse. Further research could ask other healthcare professionals such as doctors, P-SANE, and social workers about their views of the CCLS's role.

Limitations

There are limitations to this study. Of the 21 respondents, a few did not answer all of the questions or questions that they did answer were only answered partially. Due to the quantitative nature of the study and the desire to have a shorter survey, free response questions were limited. Due to this, some of the data gained was not able to be explained further, which could have helped clarify some of the results. This study was limited to the CCLS's perception of their role in P-SAFE; therefore, there are limitations for the generalizability of the findings.

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APPENDIX A: DEMOGRAPHIC SURVEY

1. Age: _____

2. Gender: Male Female Prefer not to disclose

3. Ethnicity:

Caucasian African American Asian Hispanic Other _____

Prefer not to disclose

4. How much experience have you had working with patients who have been sexually abused?

_____ years _____ months

5. What unit do you work in as a child life specialist when working with sexual abuse population? _____

6. What unit do you work in currently? _____

7. What type of hospital did you work at when working with sexual abuse population?

Small Children's Hospital (<100 beds) Medium Children's Hospital (100 to 499 beds)

Large Children's Hospital (>500 beds)

Small Adult Hospital (<100 beds) Medium Adult Hospital (100 to 499 beds)

Large Adult Hospital (>500 beds)

Other _____

8a. Do you have the child life specialist certification? Yes or No

8b. If yes, how many years have you been a Certified Child Life Specialist?

9. Education:

Four Year College Graduate

Professional-Masters

Professional-PhD

Other _____

APPENDIX B: THE CERTIFIED CHILD LIFE SPECIALIST'S PERCEIVED ROLE IN
SEXUAL ABUSE EXAMINATIONS SURVEY

(1) Roles

a. Interventions

1. Approximately how many patients being seen for sexual abuse exams do you provide services to in a week?

2. Where do you provide support to this population? (Select all that apply)

- Waiting Room
- Check-in
- Vital Signs
- Admission
- During Interviews with other Medical Staff (i.e. social work, physician)
- Prior to exam in Patient Room
- Preparation
- During Exam
- Post Exam
- Other _____
- Other _____

3. What services do you use with this population? Select all that apply

- Preparation
- Distraction
- Play
- Comfort Positions
- Procedure Support
- Coping Support
- Other _____
- Other _____

4. Do you utilize preparation with this population? Yes or No

4b. What preparation do you provide? Select all that apply

- Information to the child
- Information to adults accompanying the child
- Information to siblings
- Handouts
- Medical teaching dolls
- Comfort positions
- Preparation book/digital book
- Familiarization with equipment

- Video
- Pictures
- Other _____

5. Do you utilize distraction with this population? Yes or No

5b. What distraction do you provide? Select all that apply

- iPad
- Breathing
- Relaxation
- Positive Imagery
- Music
- Bubbles
- Sensory (i.e. light spinners)
- Books
- Talking/conversation
- Other _____

6. Do you utilize play with this population? Yes or No

6b. What play opportunities do you provide?

- Medical Play
- Play to normalized hospital environment
- Play to build rapport
- Other _____

7. Do you feel the Certified Child Life Specialists' role with this population is beneficial? Yes or No?

7b. If year what are the benefits you see? Select all that apply

- Decreased anxiety/stress
- Increased procedure cooperation
- Increased coping
- Decreased length of procedure
- Helpful to return to baseline
- Increased satisfaction of adult caregiver
- Increased understanding by sibling
- Other _____
- Other _____

b. Child Life Specialist Roles

1. Please select the response that represents how valued you feel as part of the multidisciplinary team?
 - Strongly Valued
 - Valued
 - Neutral
 - Not Valued
 - Strongly Not Valued

2. What do you think other multidisciplinary team's perception is of you as a child life specialist working with this population? Select 1
 - Entertainer
 - Educator
 - Procedure supporter
 - Provider of coping
 - Other _____

3. One goal of the sexual abuse exam is minimizing the potential for retraumatization for the child during the exam. Do you feel child life services can help minimize this? Yes or No

4. Do you feel it is your role to advocate for the patient during the exam? Yes or No

5. If yes, how do you advocate for the patient? Select all that apply
 - Presence of caregiver
 - Use of a less threatening position
 - Slowing down the examination to give child time to adjust
 - Stopping because of retraumatization
 - Respecting privacy of patient
 - Other _____

6. Do you have experience advocating for the stopping of an exam because it is too difficult for the child to experience? Yes or No

7. How comfortable would you/are doing this?
 - Very comfortable
 - Somewhat comfortable
 - Neutral
 - Somewhat uncomfortable
 - Not at all comfortable

c. Responsibilities and job duties

1. What are your required job duties and responsibilities with this population? Select all that apply
 - Charting

- Education
- Procedure support
- Sibling Support
- Collaboration with multidisciplinary team
- Supporting co-workers
- Child life department roles (i.e. staff meetings, interns)
- Rounds/in-services
- Planning
- Assessment
- Building rapport with patients
- Play
- Other _____

2. Thinking of the amount of time and importance of the duties and responsibilities above, list in order your top 5 duties.

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

(2) Training

1. In your work with this population, how adequately trained and prepared did you feel to begin providing interventions to this population?
 - Very well trained and prepared
 - Well trained and prepared
 - Trained and prepared
 - Somewhat trained and prepared
 - Not trained or prepared at all

2. What training (i.e., courses, sessions) did you have that you feel prepared you for this role? Select all that apply.
 - Formal workshops for professional development units
 - Informal workshops not for professional development units
 - Updated literature
 - Self-taught methods (reading, watching videos, etc.)
 - Informal on the job training from other healthcare professionals
 - Information through academic coursework
 - Information through Association of Child Life Professionals' resources (Forum, Bulletin, resource library)
 - Other _____

3. What training did you feel you lacked or need further as preparation for this role? Select all that apply
 - Formal workshops for professional development units

- Informal workshops not for professional development units
 - Updated literature
 - Self-taught methods (reading, watching videos, etc.)
 - Informal on the job training from other healthcare professionals
 - Information through academic coursework
 - Information through Association of Child Life Professionals' resources (Forum, Bulletin, resource library)
 - Other _____
4. What trainings do you feel are important to continue visiting as a part of this role? Select all that apply
- Formal workshops for professional development units
 - Informal workshops not for professional development units
 - Updated literature
 - Self-taught methods (reading, watching videos, etc.)
 - Informal on the job training from other healthcare professionals
 - Information through academic coursework
 - Information through Association of Child Life Professionals' resources (Forum, Bulletin, resource library)
 - Other _____

(3) Stressors

1. What do you think are the primary stressors for children in this population? Select 3
- Lack of information/understanding
 - Privacy
 - Re-traumatization
 - Fear of pain
 - Separation anxiety
 - Stranger anxiety
 - Unfamiliar environment
 - Other _____
2. What do you think are the primary stressors for caregivers in this population? Select 3
- Lack of information/understanding
 - Worry of child's coping
 - Self-blame
 - Privacy
 - Seeing child in pain
 - Unfamiliar environment/people
 - Other _____
3. What are the most common stress points that you assess for patients in this population? Select 2

- Admission
- Waiting
- Pre-procedure events (i.e. talking with social work/nurse to recount story)
- Pre-procedure events (i.e. preparation, dressing gown, moving to bed)
- Procedure
- Other _____

4. List the most rewarding parts of working with this population?

- _____
- _____
- _____
- _____
- _____
- _____

5. List the most difficult parts of working with this population?

- _____
- _____
- _____
- _____
- _____
- _____

6. How often do you practice self-care to help prevent burnout/toxic stress?

- Very often
- Somewhat often
- Often
- Somewhat un-often
- Not often at all

OTHER

Any additional information you would like to provide?

*If you would like to have your name in the drawing for a free webinar please answer the question below and then provide your email.

What does CCLS stand for?

- A. Classified Child Life Specialist
- B. Child Care Learning Specialist
- C. Certified Child Life Specialist

D. Cultural Care Life Specialist

o Email: _____

*Would you be interested in participating in a 15-20-minute interview? If so you will be put into a drawing to win 1 Professional Membership to ACLP for a year.

Yes or No

In order to participate in the interview please answer the following question

What age group do child life specialists primarily work with?

- A. 0-18 years of age
- B. 99-120 years of age
- C. 50-98 years of ages
- D. 24-49 years of age

By clicking agree below you agree to the following statement:

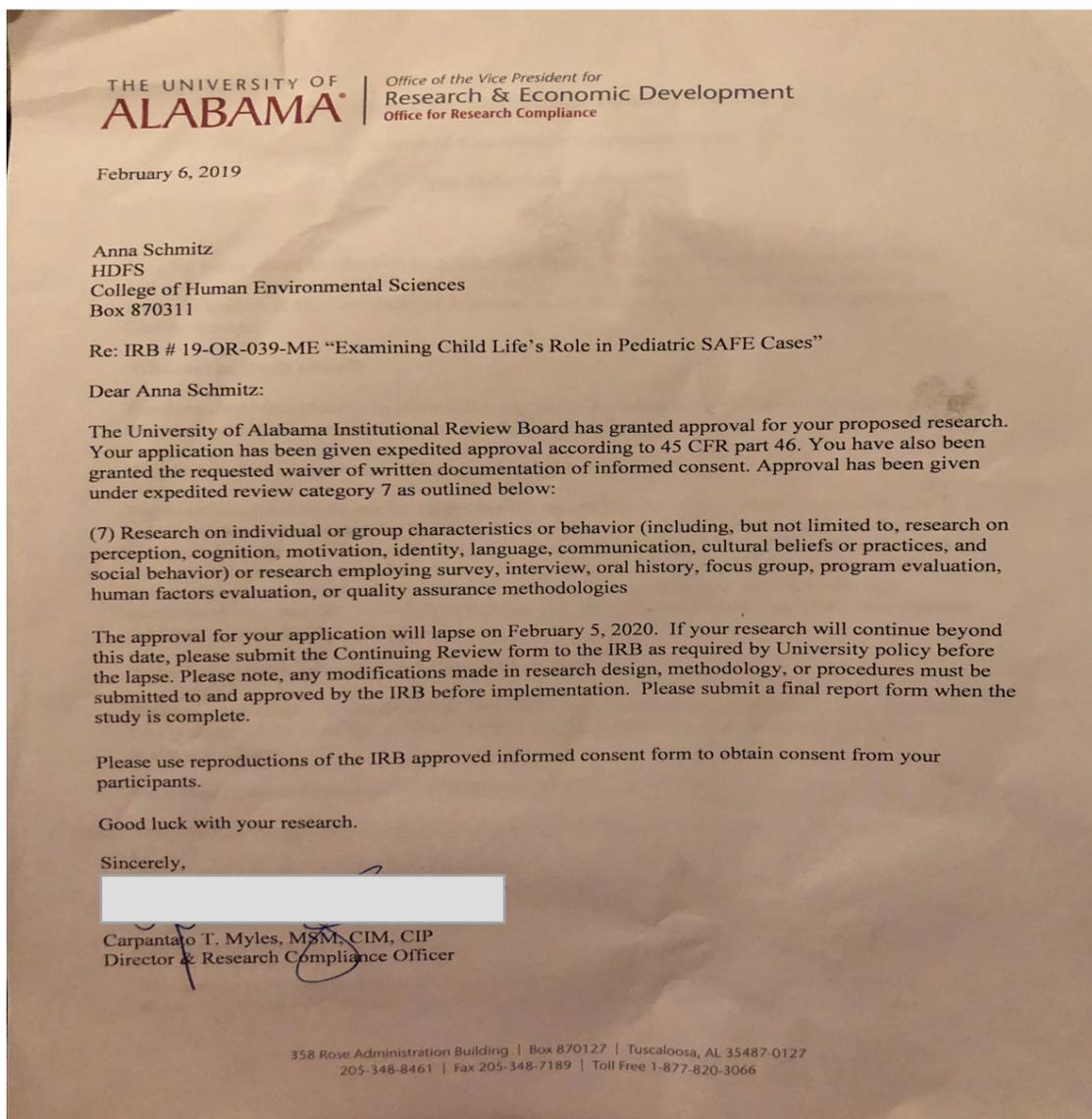
“I consent to be contacted for an interview out of my own free will and will provide my email below in order to be contacted.”

Yes I Agree

No I do not agree

Email: _____

APPENDIX C: IRB CERTIFICATION



APPENDIX D: TABLES

Table 5

Preparation Interventions Provided

Preparation	<i>n</i>	%
Information to the child	21	100
Information to caregiver	19	90.5
Familiarization with equipment	19	90.5
Comfort Positions	18	85.7
Medical teaching dolls	12	57.1
Preparation book/digital book	10	47.6
Information to siblings	7	33.3
Pictures	7	33.3
Other	1	4.8
Handouts	0	0
Video	0	0

Table 6

Distraction Interventions Provided

Distraction	<i>n</i>	%
Talking/Conversation	20	95.2
iPad	18	85.7
Breathing	18	85.7
Relaxation	17	81
Music	17	81
Books	16	76.2
Sensory	15	71.4
Bubbles	13	61.9
Positive Imagery	7	33.3
Other	1	4.8

Table 7

Play Interventions Provided

Play	<i>n</i>	%
Play to normalize hospital environment	20	95.2
Play to build rapport	20	95.2
Medical Play	11	52.4
Other	2	9.5

Table 8

How do CCLS Advocate for SAFE Patients?

Advocate	<i>n</i>	%
Respecting privacy of patient	21	100
Use of a less threatening position	18	85.7
Slowing down the examination to give child time to adjust	18	85.7
Presence of caregiver	15	71.4
Stopping because of re-traumatization	10	47.6
Other	2	9.5

Table 9

Primary Stressors for Children

Stressors	<i>n</i>	%
Re-traumatization	17	81
Lack of Information/Understanding	11	52.4
Fear of pain	9	42.9
Privacy	7	33.3
Unfamiliar Environment	6	28.6
Stranger anxiety	5	23.8
Separation anxiety	1	4.8
Other	1	4.8

Table 10

Common Stress points within the hospital

Stress points	<i>n</i>	%
Procedure	16	76.2
Pre-procedure events (preparation for exam)	14	66.7
Waiting	4	19
Pre-procedure events (interviews)	3	14.3
Other	1	4.8
Admission	0	0

Table 11

Training CCLS felt prepared them for this role.

Training that prepared	<i>n</i>	%
Informal on the job training from other healthcare professionals	19	90.5
Self-taught methods	11	52.4
Information through academic coursework	7	33.3
Informal workshops not for PDU	7	33.3
Formal workshops for PDU	6	28.6
Updated Literature	4	19
Other	2	9.5
Information through ACLP resources	1	4.8

Note: Professional Development Unit (PDU) and Association of Child Life Professionals (ACLP)

Table 12

Training CCLS felt they lacked as preparation for this role.

Training lacked	<i>n</i>	%
Formal workshops for PDU	13	61.6
Information through ACLP resources	9	42.9
Informal workshops not for PDU	6	28.6
Updated Literature	6	28.6
Information through academic coursework	5	23.8
Self-taught methods	2	9.5
Other	2	9.5
Informal on the job training from other healthcare professionals	1	4.8

Note: Professional Development Unit (PDU) and Association of Child Life Professionals (ACLP)

Table 13

Training CCLS felt it is important to continue visiting as part of this role.

Training to continue visiting	<i>n</i>	%
Updated Literature	16	76.2
Formal workshops for PDU	13	61.9
Information through ACLP resources	12	57.1
Informal on the job training from other healthcare professionals	11	52.4
Self-taught methods	9	42.9
Informal workshops not for PDU	8	38.1
Information through academic coursework	7	33.3

Other	1	4.8
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Note: Professional Development Unit (PDU) and Association of Child Life Professionals (ACLP)