Section 9
Play, Recreation and Education

Play has been acknowledged as more important than merely being a frivolous pastime for children. It has been recognised as essential, enabling children to understand and cope with the world around them. Since the 1940s, play has consistently been cited as a way to prevent anxiety, depression and feelings of helplessness, and the loss of control associated with the experience of being hospitalised (Bolig, 1990; Burstein & Meichenbaum, 1979; Thompson & Stanford, 1981).

Some children may have difficulty in expressing or articulating their feelings about the hospital experience. Play activities can therefore provide and promote opportunities to rehearse and express feelings directly related to the health care experience (Cassell, 1965; Erikson, 1963; Goldberger, 1988; Schwartz, Albino & Tedesco, 1983; Visitainer & Wolfer, 1975; Wolfer & Visitainer, 1975). It gives young children and adolescents the opportunity to express, in an appropriate and familiar way, some of their apprehensions arising from the stress of illness.

Another simple, yet very important, function of play in the hospital setting is to provide a 'normal' everyday activity as a diversion from health care issues (Thompson & Stanford, 1981). Play also serves to calm children's fears, and provides emotional 'time out' from their illness. As noted by one author, 'Play is one of the few elements of normal life in an abnormal situation' (Barnes, 1995)

Often, the hospitalised child's mobility is restricted, the environment is unstimulating and the natural motivation to play and learn is generally reduced (Burstein & Meichenbaum, 1979; Thompson & Stanford, 1981; Tisza, Hurwitz & Angoff, 1970). Due to staffing pressures, medical and nursing staff often lack the time, training or resources to play with a child (Olds, 1988). A play therapist can greatly encourage a child's motivation and provide the catalyst to self-expression for the child. Play therapists are important members of a multidisciplinary paediatric team, offering a complementary service to medical and nursing care (Barnes, 1995).

The presence of a non-threatening and responsive play facilitator, who gives psychological permission to play and who actively initiates and maintains constructive play, is essential (Ispa, Barret & Kim, 1988; Pearson et al., 1980). Simply providing access to toys is insufficient. Cross & Swift (1990) observed that children were happy, involved, stimulated, engrossed and content when activities were provided by experienced non-medical staff. Without the support of a play specialist, children were often unhappy, bored, aimless, and sometimes placed themselves in dangerous situations.

Play therapy aims to involve children in activities and personal relationships appropriate to their needs. It should not be a program for a select group of children, but a program for all children, based on child growth and development principles, and paying particular attention to the needs of hospitalised children (Wilson, 1984). The benefit of enabling children through play to understand and master their own emotions is extremely therapeutic and a valuable, even essential, part of all treatment plans.

Separate playrooms and outdoor play areas, which provide a variety of age-appropriate toys and activities, will help stimulate children to play. Within the hospital, play areas represent a normal and neutral place where no medical treatments are performed. Play areas also promote social interaction and communication with other children (Piserchia, Bragg & Alvarez, 1982).

A number of play activities are particularly relevant for the child in hospital and require a trained play specialist:

- *Expressive* play enables children to express the complex feelings associated with illness, injury and hospitalisation, and can provide forms of expression that have a calming, soothing effect. This is important for young children who are developmentally unable to express their feelings verbally. Other children may have the required verbal skills, but are unable to convey their feelings (Erikson, 1963; Gaynard et al., 1990).
- *Medical* play gives children the opportunity to become familiar with medical equipment, through manipulation and exploration activities. It is often part of the preparation process and incorporated in dramatic play, which refers to guided or spontaneous role-play focused on medical issues (Gaynard et al., 1990). These forms of play help to provide developmentally appropriate information, correct any misconceptions and make procedures more predictable. Medical play is also useful following medical procedures, as children can then explore and express what has happened to them, while also potentially providing an opportunity for them to regain a sense of control (Bolig, 1985; McCue, 1988; Rae, et al., 1989).

- *Domestic* play links the child back to their home environment and provides a familiar setting, within which the child may express his/her fears and concerns. Playing house, a dolls' corner and cooking are all familiar settings in which children may find relief from the clinical hospital environment.

Using these specific, interactive techniques, the play therapist can extend the channels for normative play and inventiveness and help to elevate the play into a way of learning. This is achieved not only through normal play experiences, but also in medical play and preparation for medical treatments. In this way, play serves as a form of communication that facilitates learning (Bergen, 1987; Sutton-Smith, 1976) and may be used in the hospital school setting.

Hospital schools have their origin in the days of long-term illnesses, such as poliomyelitis, when large numbers of school-aged children spent extended periods of time (months to years) in hospital. Although these children were physically out of action, they were mentally alert and able. The focus of such schools was to keep children up to date with their schoolwork. More recently, hospital schools aim to meet social and play needs, as well as the educational needs of hospitalised children. Unfortunately, often only the larger paediatric hospitals can offer hospital schooling, and the responsibility for ensuring that schoolwork is not missed often remains with the parent. This is due in part to the decreased length of stay in hospital and limited resources within the health care system.

Play in hospital has a special significance for healthy child development. It promotes the continuation of a child's normal development, and helps them cope with the unique stresses and problems arising from hospital admissions. Scarcity of funds for play is of particular concern during this time of financial restraint. Lack of uniform standards in the provision of play staff and facilities means this important activity remains vulnerable to cost cutting.

Survey results

Play areas and toys

Just over half of respondents provide a separate playroom in or near the ward for child patient play, 40.6% of hospitals provide an outdoor play area, and both options are made available by 29.4%. Around 18% provide a playroom, an outdoor play area and floor space on the ward for play. Floor space only is the case in 18.8% of hospitals, with 31% of private and 17% of public hospitals offering this as the only available play area. Of concern is the fact that 14.9% of those surveyed do not provide any separate play space whatsoever for child patients.

Adequate toys, play materials and recreation equipment for all age ranges is provided by 37.9% of hospitals. This figure can be broken down into the pre-school (78.4%), school-aged (67.4%) and adolescent (42.1%) age ranges. Compared with public hospitals, private facilities are more likely to consider their toy, play and recreation facilities as adequate (33.6% vs 48.3%).

Play staff

Play or recreation staff are available in 24.7% of surveyed hospitals, with provision for adolescent-specific activity in 11.2% of hospitals. Arrangements for adolescent play are considered adequate by 24.4% of surveyed hospitals. For those hospitals reporting inadequate arrangements for adolescent play, approaches to rectifying the situation included improving facilities (84%), providing more space (75%), and increasing staffing levels (71%).

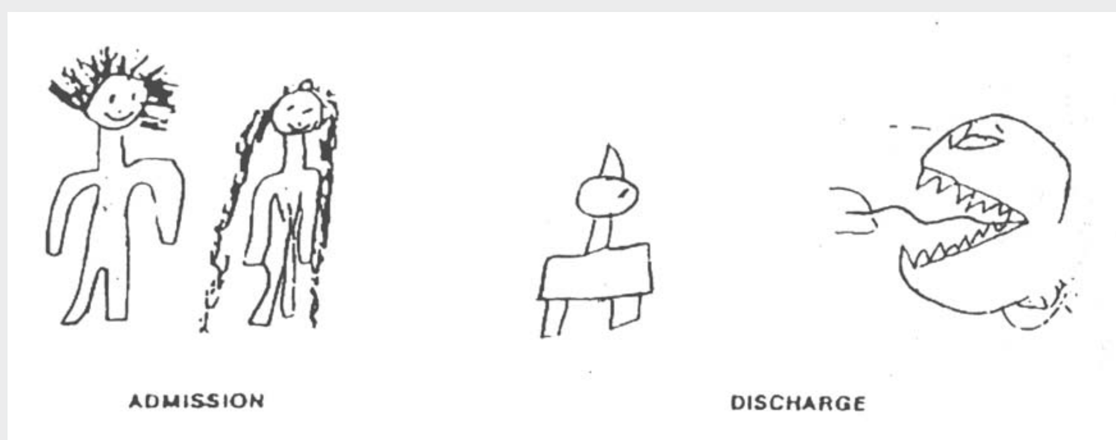
Educational arrangements

In hospitals with school-aged patients, 18.8% have facilities where children can attend a school within the hospital or have teachers from the school unit visit. Correspondence lessons are arranged in 15.7% of surveyed hospitals; where no formal arrangements are made by the hospitals, parents, in 63.5% of cases, make informal arrangements for their child's continuing education. This may be due to shorter admissions and lower numbers of paediatric beds.

CASE STUDY

Reggie is a 7-year-old boy who was hospitalised for 4 days because of a history of vomiting and dizziness. It was Reggie's third hospitalisation in the last 2 years. He had a history of tuberculous meningitis and a ventriculoperitoneal shunt 6 months prior to the present admission. His symptoms subsided shortly after admission, but he remained hospitalised for observation. Although Reggie had few medical procedures, a few hours prior to discharge he was given a lumbar puncture. During his hospitalisation, Reggie was not engaged in any structured play or counselling activities. For the most part, Reggie tended to be quiet and well behaved, but he had considerable difficulty expressing his feelings.

The drawing below shows Reggie's admission and discharge drawings in the Draw-A-Person technique. Upon admission, Reggie drew a picture of his parents. That drawing appears to be developmentally appropriate for a 6-year-old child; it contains clearly differentiated facial features, hair, and limbs. Reggie described the people as being "happy." Upon discharge, Reggie drew a picture of himself "fighting the PacMan monster." He described his affect as being "angry." Reggie described himself as having no arms, but he had armor. His discharge drawing of himself is developmentally regressed from the admission drawing. Reggie is fighting the PacMan monster with its big teeth and threatening approach. Reggie's emotional tone is clearly more distressed and vulnerable between his admission and discharge drawings.



Analyzing Drawings of Children Who are Physically Ill or Hospitalised Using the Ipsative Method.
William A. Rae.
Children's Health Care Journal
of the Association for the Care of Children's Health 1992

Section 9 Recommendations

- Hospitals admitting paediatric patients should allocate a suitable space for play and recreation activities
- Hospitals providing care for paediatric patients should employ appropriately qualified staff to conduct play activities, preparation for specific medical tests and procedures, medical play and distraction
- Hospitals providing care for paediatric patients should allocate appropriate play space, as recommended by the American Academy of Pediatrics
- In areas where children are required to wait, suitably qualified play staff and/or suitable play or recreation space should be available to provide developmental, medical and preparation activities
- Hospitals providing care for paediatric patients should ensure that those children are able to maintain their education, easing their transition back to school.