PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Child Life Services

Child Life Council and Committee on Hospital Care

Pediatrics 2006;118;1757
DOI: 10.1542/peds.2006-1941

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

POLICY STATEMENT

Child Life Services

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Child Life Council
Committee on Hospital Care

ABSTRACT

Child life programs have become standard in most large pediatric centers and even on some smaller pediatric inpatient units to address the psychosocial concerns that accompany hospitalization and other health care experiences. The child life specialist focuses on the strengths and sense of well-being of children while promoting their optimal development and minimizing the adverse effects of children's experiences in health care or other potentially stressful settings. Using play and psychological preparation as primary tools, child life interventions facilitate coping and adjustment at times and under circumstances that might prove overwhelming otherwise. Play and age-appropriate communication may be used to (1) promote optimal development, (2) present information, (3) plan and rehearse useful coping strategies for medical events or procedures, (4) work through feelings about past or impending experiences, and (5) establish therapeutic relationships with children and parents to support family involvement in each child's care, with continuity across the care continuum. The benefits of this collaborative work with the family and health care team are not limited to the health care setting; it may also optimize reintegration into schools and the community.

CHILD LIFE PROGRAMS

Most hospitals specializing in pediatric care have child life programs,[1] and the number of these programs has doubled since 1965. There are now more than 400 child life programs in the United States and Canada.[2] A 2001 survey by the National Association of Children's Hospitals and Related Institutions found that 95% of 118 responding hospitals employed child life specialists (S. Dull, RN, MSN, MBA, National Association of Children's Hospitals and Related Institutions, verbal communication of unpublished data, June 30, 2005). Child life services are offered in inpatient pediatric health care settings as well as ambulatory clinics, emergency departments, rehabilitation settings, hospice programs, and even some dental and physician offices.[2–4] The provision of such services is a quality benchmark of an integrated child health delivery system and an indicator of excellence in pediatric care.[5,6] Child life programs and the kinds of services they provide are a component of family-centered care.[7,8] Child life services are also recommended for community hospitals with pediatric units.[9] Some states have identified the importance of child life services through the regulatory process; for example, a 1999 California statute allowed for the reimbursement of bereavement services by a certified child life specialist for someone who experienced trauma.[10] In addition, hospital licensing standards in New Jersey require the services of a child life specialist in PICUs.[11]

A ratio of 1 child life specialist to 15 or 20 inpatients has been used successfully in some institutions; however, the patient's age and mobility, the patient popula-

www.pediatrics.org/cgi/doi/10.1542/peds.2006-1941

doi:10.1542/peds.2006-1941

Key Words
child life, play, preparation, psychological preparation, family-centered care, medical home

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

tion on the unit, and the institution's needs should influence actual staffing allocation.[12,13] An increasing number of child life specialists are employed in outpatient settings. There are no standardized ratios for outpatient areas, but the same factors should be considered as those for inpatient settings, and thought should be given to providing maximal services during peak visit hours (eg, the emergency department may be busier in the afternoon and evening, and the perioperative area may be more active in the early morning). Child life specialists are generally supervised by a child life manager who, in turn, may report to the hospital or division leadership.

The credentials of a certified child life specialist include the minimum of a bachelor's degree in child life, child development, human development, or a closely related field; the successful accomplishment of a 480- to 600-hour child life internship under the supervision of a certified child life specialist; and the satisfactory completion of the standardized certification examination. The child life specialist should have an understanding of children of all ages and the family, good communication skills, experience with diverse groups of patients, developmental assessment expertise, and collaborative teamwork abilities. Child life specialists often develop specific areas of expertise related to the patient population they serve, such as infants, toddlers, elementary school–aged children, adolescents, oncology patients, critically ill children, radiology patients, technology-dependent children, etc. They recognize the developmental issues specifically related to illness and health care experiences and understand how to mitigate fears, fantasies, and concerns through adaptive role play, education, and behavior-management techniques. Information about the child life profession and certification of child life specialists is available from the Child Life Council (see "Additional Resources").

An effective child life program provides developmentally appropriate play, offers informative and reassuring psychological preparation before and during procedures, and helps children plan and rehearse coping skills.[14] Child life specialists are part of an interdisciplinary and family-centered model of care, collaborating with the family, physicians, and other members of the health care team to develop a plan of care.[8,15] The child life component of this plan is based on the individual patient's perception and understanding of the anticipated health care experience with the goal of enhancing coping.[16,17] Child life specialists support these goals by, for example, teaching the child coping strategies for adjusting to a life-changing injury or dealing with impending death, offering nonpharmacologic pain-management techniques, and communicating the child's developmental and individual needs and perspective to team members.

The therapeutic interventions of child life staff are most effective when delivered in collaboration with the attending physician, primary care physician, and other members of the health care team as part of the medical home* for the hospitalized child. Child life programs offer services that support the medical home, defined by the American Academy of Pediatrics as care that is "accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective."[18(p184)]

PLAY AND NORMALCY

Play is the primary modality of a child life program because it is both familiar and reassuring for children. It helps make the health care experience less intimidating and more comfortable.[19–22] Experts state that play is believed to be "used by children as a means of reducing anxiety produced by stressful conditions."[17(p213)] Child life programs provide opportunities for play in inpatient medical and surgical areas, ICUs, outpatient clinics, emergency departments, presurgical waiting areas, radiology departments, laboratory waiting rooms, and sibling care centers. Play is adapted to the many age groups in pediatrics. Young children are given opportunities for make-believe play, whereas school-aged children enjoy games with rules.[23] Adolescents will seek to continue their relationships with peers outside the hospital through Internet access and must be provided with opportunities to form new friendships within the hospital. This is particularly important for adolescents with chronic illnesses who may have multiple hospitalizations.[24,25] Activities that promote self-esteem are vital, as is continuation with schooling.

Engaging in developmentally appropriate play, creative or expressive arts (including music therapy, art therapy, drama, video work, and creative writing), and reading activities all help moderate children's anxiety and decrease the possibility that health care encounters will disrupt their normal development.[3,26–28] Auxiliary programs, such as animal-assisted therapy, therapeutic clowning, or electronic networks for hospitalized children, when used in conjunction with child life services, provide additional supportive activities for all ages of pediatric patients.[29–31]

To help children cope with their feelings, a child life specialist often uses health care play or "medical play." This child-directed play allows children to be active and exert control over their experiences.[1,12,31–34] These exercises may offer insight into the patients' concerns and levels of understanding of the health care events. Some examples of child-directed medical play are the exploration of medical equipment, dramatic (or dress-up) play,

* The American Academy of Pediatrics believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the "medical home.[18(p184)]"

games or puzzles depicting medical themes, and the creation of artwork using health care materials such as bandage strips, tongue depressors, and syringes.[1,3,20,34–36] Such activities allow pediatric patients of all ages to approach a threatening situation with greater familiarity and gain a sense of mastery of the experience, which will help build a basis for future difficult experiences.[37]

PSYCHOLOGICAL PREPARATION

Preparing children for hospitalizations, clinic visits, surgeries, and diagnostic/therapeutic procedures is a second important element of a child life program.[38] Psychological preparation is a "process of communicating accurate and developmentally appropriate information, identifying potential stressors, as well as planning and practicing coping strategies."[37(p18)] Many hospitals and other health care facilities have developed preparation programs on the basis of this process that familiarize the children and their families with the circumstances and procedures they will encounter. These developmentally supportive programs help reduce emotional disturbances in hospitalized children.[1,8,39,40] Two studies with children in a perioperative setting indicated that preparation programs before surgery lowered the children's anxiety and increased their comfort levels.[35,41] Oncology clinics, day surgery units, radiology departments, dialysis units, primary care clinics, emergency departments, eating disorder programs, dental clinics, and other health care settings have used child life specialists to help children anticipate and manage health care experiences.[38,42–55] An emergency department study reported that child life specialists play a major role in calming fears of children, particularly 11- to 14-year-olds requiring sutures, and lead to a higher parent satisfaction rating of the entire care experience.[52]

The child life role in children's perioperative experiences is important. When preparing children and families for procedures, child life specialists not only share accurate descriptions of the experiences children will have but assist children in expressing what they think is going to happen.[37] Plain body-outline dolls and other dolls are useful tools of the child life specialist during psychological preparation before procedures occur.[33,56] Misconceptions can be corrected, and a child's understanding can be clarified. In addition, child life specialists provide opportunities for children to examine equipment and give them developmentally appropriate explanations of their use.[8,20,55] Information and opportunities to handle equipment help make the unpredictable events more manageable, reduce anxiety, and enable the child to plan and rehearse coping strategies.[57,58] Strategies used may include relaxation, visualization, guided imagery, and pain-management techniques. Such observations are shared with the rest of the health care team so that all are better prepared to respond supportively to the individual patient.

A child life specialist who is present with a parent during a procedure also can enhance the parent's ability to support the child. This can contribute to a patient's ability to cope more effectively, often resulting in greater cooperation and success during the procedure.[59] In the absence of parental support, a child life specialist can provide support, enabling staff members to use their time more efficiently.

FAMILY SUPPORT

The third major area of child life services involves education and support of parents and family members, including siblings. Because the presence of family members has an important positive effect on a child's adjustment to the health care experience, pediatric health care teams encourage family involvement in patient care.[60] Parents and other family members may be highly anxious about the child's illness or the various diagnostic and treatment regimens, and such anxiety can be transmitted easily to the patient.[20,39] Child life specialists and other members of the health care team collaborate to facilitate the family's coping with and adjustment to the child's illness and health care experience. Child life specialists help family members understand their child's response to treatment and can help parents maintain their caregiving roles by promoting parent/child play sessions and by sharing strategies for comforting their children during medical procedures, for example. Well siblings can be helped to comprehend a brother's or sister's illness via developmentally appropriate teaching sessions and by offering support during visits to ICUs. In collaboration with the primary care physician and other members of the interdisciplinary team, child life services may be integrated within some palliative care teams, hospice services, and home care programs. Specially trained child life specialists can offer grief support activities for siblings in the event of catastrophic injury or death. They also have assisted children during episodes of terrorism.[8,61–64] It is important to protect children and families from prolonged or repeated exposures to situations in which they feel overwhelmed, unable to escape, or unable to have choices. The health care experience can become complicated by these scenarios, and child life specialists can help ameliorate the effects that these adverse experiences have on children and families.

CHILD LIFE SERVICES IN A CHANGING HEALTH CARE ENVIRONMENT

There are almost twice as many hospitalized children in the 0- to 4 year-old age group as there are in the 5- to 14 year-old age range.[65] In addition, although fewer children are hospitalized, the children who are admitted are more seriously ill and often require longer stays.[66] Child life programs have had to adapt to younger, less mobile patients who have more complex medical problems. As

a result, fewer group interactions are possible, and greater individualization of care is needed. Child life staff members are challenged to meet each child's emotional, developmental, and educational needs more quickly and efficiently than before and to provide as many normal life experiences as possible. In a continued effort to create "normalcy" for patients, child life specialists often assist parents in arranging for tutoring services for children.[9]

The adolescent population must also be considered. The increased survival rate of chronically ill patients has resulted in an expanded need for child life specialists in adolescent care. Teenagers with spina bifida, cystic fibrosis, and other chronic diseases are living longer now.[67] A new challenge has emerged as more chronically ill adolescents are making the transition to the adult health care system.[67,68] Child life specialists have often played a role with the health care team in helping with that transition.

The expansion of outpatient care has resulted in more demands for ambulatory child life activities as their value and benefits have become recognized. Both direct and indirect interventions are used to support patients and families across the continuum of care. For example, posters may be mounted in treatment areas to educate staff and parents about effective positioning or coping techniques to use with children of different ages. In some cases, a telephone consultation made by a child life specialist can help parents prepare their child for an outpatient procedure.

As health care costs escalate, there is an ongoing effort to justify the cost of child life services. It is clear that more empirical data are needed to explore the value and effectiveness variables of child life services. An experimental evaluation of one child life program model showed that its presence had a significant positive effect on the pediatric patients.[39] Specifically, the children in the experimental study had less emotional distress, better overall coping during the hospital stay, a clearer understanding of the procedures, and a more satisfactory posthospital adjustment and physical recovery. The children spent less time on initial pain-management narcotics, the length of stay was slightly reduced, and parents were more satisfied. In another study, child life specialists taught parents in the emergency department how to use distraction and "positioning for comfort" before their child's venipunctures. The combination of interventions resulted in lower fear and distress scores.[69]

ADDITIONAL CONTRIBUTIONS

Child life services contribute to an organization's efforts to meet the standards of the Joint Commission on Accreditation of Healthcare Organizations such as developmentally appropriate care, effective communication for patient education, safety issues, age-appropriate environments, and assessment of patients. These specialists assist health care team members to communicate with patients and families on the basis of the child's developmental and individual needs.[70] Child life programs can assist in the education of students and professional staff in medical, nursing, and other fields regarding psychosocially sound and developmentally appropriate care.[53,71,72] The role and competence of pediatric unit volunteers are enhanced when they are educated, guided, and supervised as part of a child life program.[73]

Child life specialists are keenly aware of the perspective and concerns of children and the benefits of family-centered care and, thus, are valuable consultants regarding the physical environment of pediatric settings and the effect of these settings on the behavior and adaptation of children. Child life specialists offer a useful perspective on hospital committees such as ethics or bereavement committees.

Child life expertise has applications beyond conventional hospital care. Child life interventions can help children transition back to home, school, and community. Child life specialists can actively help with school reentry and facilitate a variety of support groups for patients and their siblings.[74,75] In addition, child life specialists in pediatric programs located within larger adult-oriented institutions often are called on to work with children of adult patients.[76] They are able to help children deal with a parent's illness or impending death. Child life specialists also use their skills and training for positions in disease-specific camps, hospice programs, supplemental child care for technology-dependent children, programs for high-risk infants, and courtrooms for pretrial support of juvenile victims.[13]

CONCLUSIONS

Child life services make a difference in pediatric care. Although more research is needed, there is some evidence that child life services may help to contain costs by reducing hospital length of stay and decreasing the need for analgesics.[39,59] Observation and consumer satisfaction feedback further confirm the positive effects of child life programs on children, families, and staff. It remains essential for child life specialists to adapt and grow with the changing health care system in support of the emotional well-being of children and families.[77,78]

RECOMMENDATIONS

1. Child life services should be considered an essential component of quality pediatric health care and are integral to family-centered care and best-practice models of health care delivery for children. Child life services should be performed in collaboration with and give support to the child's medical home.
2. Child life services should be provided directly by or in consultation with qualified child life specialists in pediatric inpatient units, ambulatory areas, emergency

departments, and chronic care centers to the extent appropriate for the population served.

3. An appropriate ratio of child life specialists to patients should be developed for inpatient and ambulatory areas. Both inpatient and ambulatory ratios should be adjusted as needed for the severity and acuity of illnesses of the patients served.
4. Child life services should not be withheld for lack of reimbursement. Advocacy for financing of child life services should occur at the facility, local, state, and federal levels.
5. Home health, hospice, and bereavement programs should be encouraged to include child life services.
6. Additional research should be conducted to validate the effect of child life services on patient care outcomes with attention to outcomes of specific interventions as well as cost-effectiveness.

*Lead author

REFERENCES

1. Thompson RH, Stanford G. *Child Life in Hospitals: Theory and Practice*. Springfield, IL: Charles C. Thomas; 1981
2. Child Life Council. *Directory of Child Life Programs*. 12th ed. Rockville, MD: Child Life Council; 2003
3. Brown CD. Therapeutic play and creative arts: helping children cope with illness, death, and grief. In: Armstrong-Dailey A, Zarbock S, eds. *Hospice Care for Children*. 2nd ed. New York, NY: Oxford University Press; 2001:250–283
4. Hemmelgarn AL, Glisson C, Dukes D. Emergency room culture and the emotional support component of family-centered care. *Child Health Care*. 2001;30:93–110
5. National Association of Children's Hospitals and Related Institutions. *Pediatric Excellence in Health Delivery Systems*. Alexandria, VA: National Association of Children's Hospitals and Related Institutions; 1996:9–10
6. Sangiorgio MP. The best children's hospitals in America. *Child*. 2003;February:102–114
7. American Academy of Pediatrics, Committee on Hospital Care;. Family-centered care and the pediatrician's role. *Pediatrics*. 2003;112:691–697
8. Desai PP, Ng JB, Bryant SG. Care of children and families in the CICU: a focus on their developmental, psychosocial, and spiritual needs. *Crit Care Nurs Q*. 2002;25:88–97
9. American Academy of Pediatrics, Committee on Hospital Care. Facilities and equipment for the care of pediatric patients in a community hospital. *Pediatrics*. 2003;111:1120–1122
10. Child Life Specialist Pilot Program, California Assembly Bill 606 (Jackson), Chapter 584, Statutes of 1999, added Government Code Section 13968.5 (1999)
11. New Jersey Department of Health and Senior Services, Division of Healthcare System Analysis, Certificate of Need and Acute Care Licensure Program. Hospital Licensing Standards (N.JA.C. Title 8, Chapter 43G, Pediatrics, Authority N.JS.A. 26:2H-1 et seq p 158)
12. American Academy of Pediatrics, Committee on Hospital Care. Staffing patterns for patient care and support personnel in a general pediatric unit. *Pediatrics*. 1994;93:850–854
13. Child Life Council. *Guidelines for the Development of Child Life Programs in Healthcare Settings*. Wilson J, Palm S, Skinner, L eds. 4th ed. Rockville, MD: Child Life Council; 2006
14. Thompson RH. Child life programs in pediatric settings. *Infants Young Child*. 1989;2:75–82
15. American Academy of Pediatrics, Committee on Hospital Care. Physician's roles in coordinating care of hospitalized children. *Pediatrics*. 2003;111:707–709
16. Rennick JE, Johnston CC, Dougherty G, Platt R, Ritchie JA. Children's psychological responses after critical illness and exposure to invasive technology. *J Dev Behav Pediatr*. 2002;23:133–144
17. Thompson RH. *Psychosocial Research on Pediatric Hospitalization and Health Care: A Review of the Literature*. Springfield, IL: Charles C. Thomas; 1985
18. American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. The medical home. *Pediatrics*. 2002;110:184–186
19. Thompson RH. Documenting the value of play for hospitalized children: the challenge of playing the game. *ACCH Advocate*. 1995;2:11–19
20. Solnit A. Preparing. *Psychoanal Study Child*. 1984;7:613–632
21. Southall DP, Burr S, Smith RD, et al. The child-friendly healthcare initiative (CFHI): healthcare provision in accordance with the UN convention on the rights of the child. *Pediatrics*. 2000;106:1054–1064
22. Rollins JA, Bolig R, Mahan C. *Meeting Children's Psychosocial Needs: Across the Health-Care Continuum*. Austin, TX: Pro-Ed; 2005
23. Berk LE. *Infants, Children, and Adolescents*. 5th ed. Boston, MA: Allyn and Bacon; 2004
24. Johnson KB, Ravert RD, Everton A. Hopkins teen central: assessment of an internet-based support system for children with cystic fibrosis. *Pediatrics*. 2001;107(2). Available at: www.pediatrics.org/cgi/content/full/107/2/e24
25. Mathews A. An argument for evaluating the therapeutic im-

plications of graphical multi-user environments. Available at: www.game-research.com/art_therapeutic.asp. Accessed May 16, 2005
26. Cameron CO, Juszczak L, Wallace N. Using creative arts to help children cope with altered body image. *Child Health Care.* 1984; 12:108–112
27. Freeman M. Therapeutic use of storytelling for older children who are critically ill. *Child Health Care.* 1991;20:208–215
28. Froehlich MAR. *Music Therapy With Hospitalized Children*. Cherry Hill, NJ: Jeffrey Books; 1996
29. Battles HB, Wiener LS. STARBRIGHT World: effects of an electronic network on the social environment of children with life-threatening illnesses. *Child Health Care.* 2002;31:47–68
30. Kaminski M, Pellino T, Wish J. Play and pets: the physical and emotional impact of child-life and pet therapy on hospitalized children. *Child Health Care.* 2002;31:321–335
31. Stephens M. When healing becomes child's play. *AAP News.* 1997;13:14–15
32. Tyc VL, Klosky JL, Kronenberg M, deArmendi AJ, Merchant TE. Children's distress in anticipation of radiation therapy procedures. *Child Health Care.* 2002;31:11–27
33. Gaynard L, Wolfer J, Goldberger J, Thompson R, Redburn L, Laidley L. *Psychosocial Care of Children in Hospitals: A Clinical Practice Manual*. Rockville, MD: Child Life Council; 1998
34. McGrath P, Huff N. "What is it?": findings on preschoolers' response to play with medical equipment. *Child Care Health Dev.* 2001;27:451–462
35. Zahr LK. Therapeutic play for hospitalized preschoolers in Lebanon. *Pediatr Nurs.* 1998;23:449–454
36. McCue K. Medical play: an expanded perspective. *Child Health Care.* 1988;16:157–161
37. Fortunato G. Preparing your child for urologic surgery. *Fam Urol.* 2000;1:18–21
38. Vernon DTA. *The Psychological Responses of Children to Hospitalization and Illness: A Review of the Literature*. Springfield, IL: Charles C. Thomas; 1965
39. Wolfer J, Gaynard L, Goldberger J, Laidley LN, Thompson R. An experimental evaluation of a model child life program. *Child Health Care.* 1988;16:244–254
40. McDonald C. Ask the doctor: meet the professional child life specialists—making the tough times a little easier. *Exceptional Parent Magazine.* 2001;84:80–82
41. Ellerton ML, Merriam C. Preparing children and families psychologically for day surgery: an evaluation. *J Adv Nurs.* 1994; 19:1057–1062
42. Williams YB, Powell M. Documenting the value of supervised play in a pediatric ambulatory care clinic. *J Assoc Care Child Health.* 1980;9:15–20
43. Klein D. Rx for pediatric patients: play while you wait. *Young Child.* 1979;34:13–19
44. Pearson JE, Cataldo M, Tureman A, Bessman C, Rogers MC. Pediatric intensive care unit patients: effects of play intervention on behavior. *Crit Care Med.* 1980;8:64–67
45. Alcock D, Goodman J, Feldman W, McGrath PJ, Park M, Cappelli M. Environment and waiting behaviors in emergency waiting areas. *Child Health Care.* 1985;13:174–180
46. Krebel MS, Clayton C, Graham C. Child life programs in the pediatric emergency department. *Pediatr Emerg Care.* 1996;12: 13–15
47. American Academy of Pediatrics, Committee on Hospital Care and Section on Surgery. Pediatric organ donation and transplantation. *Pediatrics.* 2002;109:982–984
48. Breiner S. An evidence-based eating disorder program. *J Pediatr Nurs.* 2003;18:75–80
49. American Academy of Pediatrics, Committee on Hospital Care, and Society of Critical Care Medicine, Pediatric Section. Guidelines and levels of care for pediatric intensive care units. *Pediatrics.* 1993;92:166–175
50. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. Guidelines for pediatric emergency care facilities. *Pediatrics.* 1995;96:526–537
51. Stashinko EE, Goldberger J. Test or trauma? The voiding cystourethrogram experience of young children. *Issues Compr Pediatr Nurs.* 1998;21:85–96
52. Alcock DS, Feldman W, Goodman JT, McGrath PJ, Park JM. Evaluation of child life intervention in emergency department suturing. *Pediatr Emerg Care.* 1985;1:111–115
53. American Academy of Pediatrics, Section on Hematology/Oncology. Guidelines for the pediatric cancer center and role of such centers in diagnosis and treatment. *Pediatrics.* 1997;99: 139–141
54. Eckle N, MacLean SL. Assessment of family-centered care policies and practices for pediatric patients in nine US emergency departments. *J Emerg Nurs.* 2001;27:238–245
55. McGee K. The role of a child life specialist in a pediatric radiology department. *Pediatr Radiol.* 2003;33:467–474
56. Gaynard L, Goldberger J, Laidley LN. The use of stuffed, body-outline dolls with hospitalized children and adolescents. *Child Health Care.* 1991;20:216–224
57. Goldberger J, Gaynard L, Wolfer J. Helping children cope with health care procedures. *Contemp Pediatr.* 1990;7:141–162
58. Hatava P, Olsson G, Lagerkranser M. Preoperative psychological preparation for children undergoing ENT operations: a comparison of two methods. *Paediatr Anaesth.* 2000;10: 477–486
59. Wilson JM, Goldberger J. Children in the process of becoming. *Arch Pediatr Adolesc Med.* 1996;150:1234–1235
60. Johnson BH, Jeppson ES, Redburn L. *Caring for Children and Families. Guidelines for Hospitals*. Bethesda, MD: Association for the Care of Children's Health; 1992
61. Armstrong-Dailey A, Zarbock S, eds. *Hospice Care for Children*. 2nd ed. New York, NY: Oxford University Press; 2001
62. American Academy of Pediatrics, Committee on Bioethics and Committee on Hospital Care. Palliative care for children. *Pediatrics.* 2000;106:351–357
63. Azarnoff P. Child life in disasters. *Pediatr Ment Health.* 1995;14: 1–2
64. Lewindowski L, Baranowski MV. Psychological aspects of acute trauma: intervening with children and families in the inpatient setting. *Child Adolesc Psychiatr Clin N Am.* 1994;3:513–529
65. US Bureau of the Census. *Statistical Abstract of the United States: 2002*. Washington, DC: US Bureau of the Census; 2002
66. National Center for Health Statistics. *Health, United States, 1995*. Hyattsville, MD: Public Health Service; 1996
67. Blum RW. Transition to adult health care: setting the stage. *J Adolesc Health.* 1995;17:3–5
68. American Academy of Pediatrics, American Academy of Family Physicians; American College of Physicians-American Society of Internal Medicine. A consensus statement on health care transitions for young adults with special health care needs. *Pediatrics.* 2002;110:1304–1306
69. Cavender K, Goff M, Hollon E, Guzzetta C. Parents' positioning and distracting children during venipuncture: effects on children's pain, fear, and distress. *J Holist Nurs.* 2004;22:32–56
70. Joint Commission on the Accreditation of Healthcare Organizations. *Hospital Accreditation Standards 2004*. Oakbrook Terrace, IL: Joint Commission on the Accreditation of Healthcare Organizations; 2004
71. American Academy of Pediatrics, Division of Graduate Medical Education and Pediatric Workforce. AAP comments on the program requirements for residency education in pediatrics. 2001. Available at: www.aap.org/gme. Accessed August 2, 2006

72. Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Pediatrics. Chicago, IL: Accreditation Council for Graduate Medical Education; 2006. Available at: www.acgme.org/acWebsite/downloads/RRC_progReq/320pr106.pdf. Accessed August 18, 2006
73. Kiely AB. *Volunteers in Child Health: Management, Selection, Training and Supervision*. Bethesda, MD: Association for the Care of Children's Health; 1992
74. Towne M. The role of child life in pediatric end of life care. *Child Life Focus*. Fall 2001;3(3):1–4
75. Bishop B, Gilinsky V. School reentry for the patient with burn injuries: video and/or on-site intervention. *J Burn Care Rehabil.* 1955;16:455–457
76. McCue K, Bonn R. *How to Help Children Through a Parent's Serious Illness*. New York, NY: St Martin's Press; 1994
77. Wilson JM, Chambers EB. Child life can (and must) adapt to the new healthcare environment. *ACCH Advocate.* 1996;2:36–37
78. Cole W, Diener M, Wright C, Gaynard L. Health care professionals' perceptions of child life specialists. *Child Health Care.* 2001;30:1–5

ADDITIONAL RESOURCES

Blankenship J. A little bit of laughter goes a long way (therapeutic clowning). *Child Life Council Focus*. 2001;2:1–4
Bolig R, Gnezda MT. A cognitive-affective approach to child life programming for young children. *Child Health Care*. 1984;12:122–129
Bolig R, Weddle KD. Resiliency and hospitalization of children. *Child Health Care*. 1988;16:255–260
Brenner A. *Helping Children Cope With Stress*. San Francisco, CA: Jossey-Bass; 1984
Child Life Council, Inc, 11820 Parklawn Dr, Suite 202, Rockville, MD 20852; Web site: www.childlife.org; e-mail: clcstaff@childlife.org
Child Life Council. *Anthology of Focus*. Rockville, MD: Child Life Council; 2003
Child Life Council. *Child Life Position Statement*. Rockville, MD: Child Life Council; 1995
Hughes FP. *Children, Play, and Development.* 3rd ed. Needham Heights, MA: Allyn and Bacon; 1999
Lamberg L, Goldsmith M. "Blood soup" and bear examinations acquaint kids with hospitals. *JAMA*. 1998;297:1597–1598
Petrillo M, Sanger S. *Emotional Care of Hospitalized Children: An Environmental Approach*. 2nd ed. Philadelphia, PA: JB Lippincott; 1980
Plank EN. *Working With Children in Hospitals*. Chicago, IL: Year Book Medical Publishers Inc; 1971
Rubin S. What's in a name? Child life and the play lady legacy. *Child Health Care*. 1992;21:4–13
Seid M, Sherman M, Seid A. Perioperative psychological interventions for autistic children undergoing ENT surgery. *Int J Pediatr Otorhinolaryngol*. 1997;40:107–113

Child Life Services

Child Life Council and Committee on Hospital Care
Pediatrics 2006;118;1757
DOI: 10.1542/peds.2006-1941