

Handbook of Research on Play Specialism Strategies to Prevent Pediatric Hospitalization Trauma

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Chapter 1

Defining Play in the Healthcare Setting: A UK Perspective

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ABSTRACT

Over the course of the past 60 years, the endorsement of therapeutic play and play-based services have transformed the healthcare experience of children, young people, and their families around the globe. Play and recreational activity are now recognized as essential to the provision of ‘the highest attainable standard of health’, advocated in Articles 24 and 31 of the United Nations Convention on the Rights of the Child. This chapter examines the scope of therapeutic play provision in pediatric healthcare settings in the UK, using Moyles’ tripartite pedagogy of play to differentiate the form and function of play in the context of modern healthcare delivery, while highlighting some of the challenges to defining play in the healthcare setting. The chapter endorses the principles of evidence-informed practice by drawing on a range of sources to demonstrate the evolving role of therapeutic play in the healthcare context.

INTRODUCTION

Over the course of the past 60 years, the endorsement of therapeutic play and play-based services has enriched the healthcare experience of children, young people and their families in the UK and around the globe (Association of Child Life Professionals, 2022; National Association of Health Play Specialists [NAHPS], n.d.; Perasso et al., 2021). The descriptor *therapeutic* is used here to refer to play that is beneficial to health in that it helps to heal, to restore, or to promote health and *therapeutic play* will be used throughout the chapter to refer to play-based services in hospitals and other healthcare settings in the UK. The generic term therapeutic play has been adopted in preference to *healthcare play specialism* (the descriptor in current use in the UK) for greater fluency and sense-making by an international readership. It is not to be confused with *play therapy* which derives from the psychotherapeutic tradition

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and is a treatment modality which focuses on a child's internal conflicts and their expression in daily life and relationships (American Psychological Association, 2022).

Numerous studies testify to the benefits of therapeutic play for children in hospital in terms of establishing trust (Godino-Iáñez et al., 2021; Li et al., 2016), meeting developmental needs (Nijhof et al., 2018), assessing psycho-social needs (Burns-Nader & Hernandez-Reif, 2016), and reducing negative emotional behaviors (Williams et al., 2021), all of which are summarized in a policy statement on Child Life Services issued by the American Academy of Pediatrics (2021). Hospitalization for illness or injury in childhood may be experienced as traumatic (Murray et al., 2008) which can impede recovery (Moss et al., 2019) and lead to ongoing psychosocial difficulties (Meentken et al., 2021). There is evidence that engagement with therapeutic play can ameliorate the impact of trauma (Godino-Iáñez et al., 2021) by promoting health literacy (Koukourikos et al., 2015) and as a medium for self-expression and emotional release (Witt et al., 2019).

The actual and potential contribution of therapeutic play is susceptible to being overlooked or undetermined due to the ambiguity surrounding play as a concept (Sutton-Smith, 2009), and to the paucity of hard evidence to support its therapeutic benefits (Cho & Choi, 2021). This tendency to discount the unique contribution made by therapeutic play to the pediatric healthcare experience can be attributed, at least in part, to the dearth of statistical evidence of its positive impact on clinical outcomes (Kennedy, 2010; Perasso, 2021) which is a constitutive requirement of the *Evidence Based Practice* model which predominates clinical research (Nevo & Slonim-Nevo, 2011).

The premise underlying this chapter is that the benefits of therapeutic play may be more effectively demonstrated using the parallel concept of *Evidence Informed Practice*, which integrates evidence from a wider range of sources (empirical evidence, case studies and clinical insights) and which draws on the collective experience of both professionals and service-users (Nevo & Slonim-Nevo, 2011). Therapeutic play practice is as much an art as it is a clinical activity and, as in the case of other therapeutic disciplines, "the wisdom appropriate to it is practical wisdom rather than that of scientific rationality" (Nevo & Slonim-Nevo, 2011, p. 1178).

Background

The first hospital play scheme in the UK was established at St Bartholomew's Hospital in London in 1963, at the initiative of Susan Harvey, advisor to Save the Children Fund (SCF). During the postwar years, SCF had created play centers in the inner cities and launched 'Hopscotch', the first ever play group in Britain, which was to become a model for the hospital play schemes which followed (Save the Children Fund, n.d.). Harvey recognized that children admitted to hospital experienced psychological trauma comparable to that of children separated from home and family through displacement or bereavement as a consequence of war.

In 1961, the public release of James Robertson's film, *A Two-Year-Old Goes To Hospital* (Robertson Films, n.d.), which vividly portrays the anguish of a small child separated from her mother during a hospital admission, ignited a widespread demand for the reform of pediatric care. Two years previously, a report by Harry Platt on behalf of the British Government's Ministry of Health had made fifty-five recommendations which included: unrestricted parental visiting; the separate nursing of children and adult patients; and the appointment of healthcare professionals specifically trained to work with children (Ministry of Health, 1959). The Platt Report proposed that hospitals should incorporate playrooms and access to education, and that child patients should be prepared for hospital admission in a manner ap-

Defining Play in the Healthcare Setting

appropriate to their developmental level (Davies, 2010). However, it would take another thirty years and the publication of another report, *Quality Management for Children: Play in Hospital* (Hogg & Rodin, 1990), before the provision of hospital play services achieved full recognition as a key component of pediatric healthcare.

The first training course for play specialists¹ working in hospitals was launched in 1973 at Chiswick College, London. Trainees were typically drawn from those with a professional background in art or music therapy, nursing, teaching, social work, and nursery nursing. A gradual expansion of hospital play schemes led to the birth, in 1975, of the National Association of Hospital Play Staff and, by 1980, a third of all children's wards in the UK had a salaried play specialist. The formation of the Hospital Play Staff Education Board (HPSEB) in 1985 saw the introduction of a nationally recognized qualification for the profession and, in 1992, following discussions with the Department of Health, 'Hospital Play Specialists' were officially recognized as a distinct staff group within the National Health Service (NAHPS, n.d.)

As pediatric healthcare provision evolved from being purely hospital-based, HPSEB changed its name to the Healthcare Play Specialist Education Trust (HPSET) in recognition of play specialists working in hospices, in the community, and in other healthcare contexts. Graduates from professional training in Healthcare Play Specialism (currently at Foundation Degree level) are presently known as Health Play Specialists (HPS) and, at the time of writing, the UK boasts a workforce of almost 700 registered play specialists, with almost another 200 in training. Today, qualified HPS are expected to maintain professional registration with HPSET in line with other health professions, to adhere to a Code of Professional Conduct, and to work to an agreed set of National Standards (Healthcare Play Specialist Education Trust, 2021).

In the UK, play and recreational activity are acknowledged to be essential to the provision of "the best healthcare possible", as advocated in Articles 24 and 31 of the United Nations Convention on the Rights of the Child (UNCRC) (Tonkin, 2014). However, despite strong advocacy for the value of therapeutic play and for its positive contribution to children's experience of healthcare, play services are afforded low priority in healthcare budget allocations and are especially vulnerable at times of fiscal austerity (Voce, 2016) and when health services find themselves under pressure (Starlight, 2021). A recent report by Starlight Children's Foundation identified that "more than half of all hospitals in the UK have no budget for play and a third of hospitals do not have dedicated play professionals" (Starlight, 2021, p.1). Health Play Specialists in many parts of the UK, like play specialists elsewhere, face an ongoing struggle to achieve professional status recognition comparable to that of other allied health disciplines, with consequent implications for staffing and resources (Whitaker, 2020).

DEFINING PLAY IN THE HEALTHCARE SETTING

Children are born to play. De Koven (2016) writes that, "Kids play because they have to. It's how they learn the world, how they grow, how they cope. For kids, play is life" (p.41). All children are driven to play, whoever and wherever they are: at home, in school, in hospital, in the community. Play is a multi-modal phenomenon, encompassing an infinite variety of experiences, behaviors, and activities, but at its heart are the elements of freedom and choice – characteristics which do not sit comfortably alongside something as serious as healthcare.

One of the main challenges to the provision of therapeutic play remains one of conceptual definition in the healthcare context (Godino-Iáñez, 2021; Perasso, 2021). Play is commonly regarded as a uniquely

frivolous activity or trivial pastime (Gray, 2009) and its successful promotion in healthcare hinges on finding new ways to define, describe, and evaluate its role in child health and development (Nijhof et al., 2018). An Evidence Informed Practice model, which involves the integration and application of established play theory, relevant clinical research, professional expertise, and patient experience, may facilitate a wider understanding of the cruciality of therapeutic play provision for achieving the “best healthcare possible” for all children (Tonkin, 2014).

The promotion of therapeutic play in hospital mirrors the evolution of play’s status in education and other contexts. Play has long been accepted as the starting point for early education (Whitaker et al., 2014) and gathered momentum during the early decades of the twentieth century through the early work of educational pioneers such as Montessori (1870-1952) and Dewey (1859-1952), who emphasized the experiential nature of learning; and of developmental theorists such as Erikson (1902-1994), Piaget (1896-1980) and Vygotsky (1896-1934), who claimed beneficial effects of play for children’s holistic development. The resulting progressive approach to education is described as a child-centered approach which recognizes each child as an individual with the capacity to make choices and decisions. Children are now widely understood to be complete human beings whose lived experiences have validity in the here-and-now as well as for their future life course (James & Prout, 2015).

The emerging concept of child-centered healthcare reflects these broader societal changes in the perception of childhood by affording children a more prominent and central position in relation to their health, recognizing their active agency and right to participate in all decisions relating to their care (Ford et al., 2018). A rights-based approach to child health acknowledges the synchronicity between the child’s right to active involvement in their healthcare under Articles 12 and 13 of the UNCRC, and their right to play under Article 31 (United Nations Children’s Fund [UNICEF], 1989), inviting a re-examination of the nature and status of therapeutic play in healthcare services for children from birth to 18.

Play is central to developmental processes: the repetitive, consistent and predictable elements of play help to organize and build neural systems, resulting in the realization of the more complex cognitive, motor, social, and emotional skills (Perry et al., 2000). In this sense, play is a profound biological process (Brown & Vaughn, 2009), yet the interplay between the child’s inherent predisposition for play and their lived experience is key to optimal brain development and functioning (Britto, 2014). In the case of a child who is admitted to hospital, or who has a chronic health condition or developmental disability, a knowledge and understanding of these developmental processes is essential for the design and delivery of play services matched to individual need (Kennedy & Binns, 2014), with positive implications for resilience and coping potential in the face of challenges to health and wellbeing.

In the following discussion, the form and function of therapeutic play is framed using Moyles’ (2010) tripartite pedagogy of play. This model differentiates between the characteristic features of *pure play*, *playful learning* and *playful teaching* and in so doing acknowledges and informs the delicate balance in the healthcare context between *pure* or *free* play which is self-initiated and open-ended, and play-based initiatives which are deployed for therapeutic/pedagogic purposes with externally defined outcomes. Exemplar case scenarios are used to illustrate these themes, underlining how the role of the play specialist working in a healthcare setting in the UK has evolved and diversified since its inception in the middle of the last century.

Pure Play

Pure (or free) play is play which is intrinsically motivated, self-initiated, and developed by the child, with an unspecified outcome (Moyles, 2010). Pure play is intuitive and meaningful in that it satisfies a personal drive to make connections (de Koven, 2016), with the external world or with different parts of the self, and may also be a means of achieving mastery over thoughts and feelings in relation to the social context. The child in hospital is drawn to the familiar aspects of play which reinforce a sense of self and a connection with everyday life external to the healthcare experience and, in this sense, pure play can be said to normalize the healthcare setting, creating a bridge between home and the unfamiliar clinical environment (Hubbuck, 2009).

Permission to play, in the form of environmental cues, inspirational design (Boex, 2016), evidence of play, or by direct invitation, may be necessary before the child's inclination to play can be exercised, and the play specialist acknowledges this in the arrangement of the play space (Tonkin, 2015). A mural of recognizable characters from popular culture, the judicious placement of familiar books and games, and the sight of other children playing normalizes the clinical environment, extending a message of welcome to the novice patient. The child may not yet have the 'rule-book' for how to be themselves in this strange setting, but they can start to make a connection with it through something familiar to them - their play. Sigman (2015) contends that children may be hardwired to play, but for play to happen in any context, it needs time, space and opportunity.

Pure play hinges on the accompanying mental disposition, rather than being defined by the activity itself. Huizinga (1949) explained this disposition – what he called the *play-element* – in terms of the innovation and improvisation that derives from an open outcome: pure play is undertaken freely and in the absence of any pre-determined goal. Accepting the notion of play as a disposition, rather than an activity, means that “almost anything can allow play to occur within its boundaries” (Sutton-smith, 2009, p. 3) which is significant in the healthcare context where play may assume a different guise from play which takes place in other settings.

Billie, aged ten years, attends the Outpatients clinic for a first appointment. In the busy waiting area, she ignores the other children, the art materials, the puzzles, and the cartoons showing on a big screen and settles at a low table to play with a simple cause and effect toy aimed at a much younger child. She is quickly absorbed in a game which involves pressing a sequence of differently colored pegs to elicit the sudden appearance of a Jack-in-a-Box. As she plays, she hums a little tune to herself. After several minutes of this play, Billie's mother urges her to move on to something else, saying, “That's a game for babies ...” Billie ignores her mother's intervention and continues in her reverie until called to see the doctor.

Pure play is a fluid state, relying on a continuous process of engagement and withdrawal, and can therefore be difficult to capture through observation or description (Howard, 2010). In the healthcare setting, engagement with the disposition to play may be inhibited by the unfamiliar, clinical nature of the environment (Hubbuck, 2009) and by the physiological and psychological concomitants of ill-health. The child may appear to regress to an earlier developmental stage (Li et al., 2016) or, conversely, may not display any inclination for play. In the words of Winnicott (1968), “If the patient cannot play, then something needs to be done to enable the patient to play”.

Research evidence suggests that children are inclined to spontaneously engage in make-believe or imaginary play relating to stressful or traumatic situations arising in their experience, including a healthcare encounter (Berk et al., 2006; Delvecchio et al., 2019), and that they recognize play to be a way of coping with these experiences (Salmela et al., 2010). Therapeutic play practice is informed by

the findings of such research and the hospital play space is commonly furnished with appropriate props such as dress-up clothes, dolls, puppets, and small world scenarios which will encourage imaginary play (O'Connor et al., 2015).

Seven-year-old Adam is a regular visitor to the cardiac unit of the children's hospital where he has undergone several surgeries. A visit to the playroom invariably starts with Adam seeking-out the box of assorted super-hero action figures. Selecting the same figures each time, he devises a fight scene during which his favorite character collapses from a 'heart attack' and is pronounced 'dead.' Following the collapse, the game is brought to an abrupt end and Adam solemnly returns the surviving figures to their box. The heart attack victim is ignored until the closing minutes of the play visit when Adam announces his revival and, with much fanfare, replaces him in the box with the other figures.

The play specialist's role in relation to pure play, is one of interested observer (Moyles, 2010), joining the play only if invited to do so - but positioned to learn a great deal about the child: their play style and preferences, developmental stage, and adaptive capacity (Weldon and Peck, 2014). The play specialist is interested in the child's pure play as it informs and guides the therapeutic/pedagogical stance (Spencer-Little, 2017; Whitaker, 2014). This is not to say that the play specialist's role is a passive one; the quality of 'being present' in relation to the child's pure play is integral to the therapeutic relationship. Paying purposeful attention and accepting the child's play for what it is, without judgement, confirms the child's personhood and creates a connection based on mutual trust and empathy (Haley, 2014).

The pure play of the older child or adolescent may be the least observable in the healthcare context. In the community, adolescent play commonly occurs within a social group or finds expression in an organized activity such as sport, dance, or music – opportunities for which are limited in most healthcare settings. However, the fact that the play disposition of the older child is less visible does not imply its absence or that it has a lesser role than play during the younger years. While the availability of Information and Communication Technology allows for the continuation of some social play in hospital (Sawyer et al., 2021), the adolescent's disposition for play may also find expression in the privacy of their internal world. Poerio et al. (2015) suggest that daydreaming, which occupies a substantial proportion of waking thought, may substitute for a lack of actual social connection by simulating the positive feelings associated with a desired interaction.

Playful Learning

Social learning theory (Bandura, 1986) purports that all learning takes place in a social context through the observation and imitation of the behavior of others, as well as by direct instruction. Play supports and reinforces the attention-retention-reproduction-motivation model of learning (Bandura, 1986) as it applies both to the child's acquisition of information about a new experience as well as to the play specialist's acquisition of information about the child and about what may or may not be helpful to them.

Playful learning relates to opportunities for learning which engage the child in a playful interaction which they may or may not perceive as play (Moyles, 2010). In the pediatric healthcare context, the playful learning interaction may be initiated by either the child or the play specialist and may also include peer-learning and therapeutic play with siblings (Gulyurtlu et al., 2020).

On admission for surgery, twelve-year-old Eva ignores repeated invitations to remove her coat and hat; eyes downcast, she replies in monosyllables to the friendly questioning of the nurse and snarls in response to her parents' attempts to start a conversation.

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It is Valentine's Day, and a group of children are gathered around the craft table in the playroom, busily making greetings cards for their loved ones. The play specialist negotiates for Eva to be allocated a bedspace from where she might observe this lively scene while playing a video game, and her parents are encouraged to take the opportunity to visit the hospital cafeteria. Freed from adult demands, and in a position to observe the way other children negotiate the hospital experience, Eva gradually relaxes, her attention diverted from the video game and towards the chatter coming from the playroom. By the time Eva's parents return to the ward, she has abandoned her gaming to join the crafting group where she can be observed helping a small child to use scissors to cut out the shape of a heart. During Eva's short stay on the ward, she reveals a talent for art and design, and by the time of her discharge the playroom walls are adorned with examples of her artwork which have been created during a sequence of therapeutic interactions with the play specialist.

Curiosity is an innate feature of most young primates and Perry et al. (2000) recognize curiosity as the main driver for the exploratory play of the young child. The natural curiosity of the child motivates exploration of their environment and, if the exploratory process results in pleasurable discovery, the child is motivated to repeat the process in a cycle of curiosity, pleasure and play. Perry et al. (2000) write that, "all learning – emotional, social, cognitive and motor – is accelerated and facilitated by repetition fuelled by the pleasure of play" (p. 9). The author has described elsewhere the case of an infant who, having resisted engagement with a physical therapy program, was motivated to mobilize by the desire to explore the detritus left on the playroom floor following a craft session (Whitaker, 2014). It is through the pleasurable satisfaction of such self-motivated curiosity that most children acquire the personal resources necessary for adaptation to a constantly changing environment (Piaget, 1971), including the demands of a hospital stay or course of treatment.

The play specialist working in the pediatric setting exploits the natural curiosity of the child by creating play environments which serve to inform and explain the nature of the healthcare setting and related experiences (Moore et al., 2015). Hospital role-play or a medical play-box, for example, invite the child to explore real medical equipment and its use and to communicate their understanding of their own circumstances and their feelings about what is happening to them (Whitaker, 2014). Painting with syringes conveys meaningful information about liquid weight and volume and the conservation of properties while giving the child a sense of mastery over their own clinical experiences, and is a playful way of helping children to cope with intravenous medication or venipuncture (Malchiodi, 1999).

At an early age, Mo was taught to self-administer regular intra-muscular injections by practicing the technique on an orange. Now in his early teens, experienced and capable in the self-injection technique, Mo still likes to visit the playroom when he attends the hospital for medical review, and he often asks to repeat the playful learning exercise of giving an injection to a piece of fruit. In the same way that a young child returns repeatedly to a familiar storybook (Horst, Parsons & Bryan, 2011) each repetition of this playful learning reinforces Mo's confidence and competence in the technique, accompanied by a sense of agency and empowerment. When the play is witnessed by other patients, the associated learning becomes an opportunity for peer education, extending the reach of the playful learning exercise.

Pediatric patients typically gather information about how to behave during a healthcare encounter through the observation and imitation of the actions and activities of others and may derive support and encouragement through identification with a peer group (NHS Worcestershire Anaesthesia, 2013). Novice patients can glean useful information about the hospital routine, including how to play in this strange and unfamiliar setting, by observing the behavior of their more experienced co-patients, a benefit denied those nursed in isolation or single rooms (Abad et al., 2010). Patients incapacitated by illness or

injury can experience some of the benefits of playful learning in a virtual capacity, deriving pleasure through observational participation in the play of others.

Immobilized by the use of traction to treat a fractured femur, nine-year-old Salma is helped to explore different ways to continue playing during an extended hospital stay. A basketball hoop is fixed to the end of her bed, she can paint and make models, play games and listen to stories. But her greatest source of pleasure is any opportunity to observe and passively participate in the jokes and antics of her fellow patients. Another patient of a similar age assumes the role of court jester, amusing Salma with slapstick humor and impersonations of the medical team. This playful connection involves learning for both children in terms of the mutual gratification which can be derived from a benevolent act and the healing benefits of fun and laughter.

The play behaviors of both child and play specialist are determined by expectancies and incentives: expectancies in terms of what is perceived likely to happen, as well as anticipated outcomes, and perceived self-efficacy in influencing that outcome (Bandura, 1986). The play specialist observes the child in self-initiated pure play and then uses the information gleaned in relation to certain expectancies to choreograph a playful interaction through which they might demonstrate an empathic stance and develop the rapport necessary for playful learning to occur (Weldon & Peck, 2014). The play specialist selects or creates play resources which reflect the child's own preferences and learning style, and which will be helpful to them in their management of their illness or treatment. For example, the child's identification with a favorite toy or cartoon character may be utilized as a form of puppet play to facilitate learning through reciprocal information exchange (Athanasidou et al., 2009). Observational assessment in advance of a clinical intervention allows the play specialist to learn about the child's primary communication and learning styles and to design the playful learning accordingly.

Three-year-old Eden likes to suck her thumb (or the ear of her teddy bear) and to twiddle her hair. She is observed to occupy herself by removing and replacing toys in a bag, and dressing and undressing a doll. The play specialist identifies Eden's preference for kinesthetic play and gathers a selection of differently textured items for the child to explore while clinical observations are performed. Eden's parent is shown how this strategy can be applied in a number of different scenarios when it is necessary or desirable to engage or re-focus Eden's attention.

Playful Teaching

Moyles (2010) defines playful teaching as a playful intervention which has a pre-determined outcome identified by the 'teacher', in the context of what is expected of, or needed by, the subject or learner. In the healthcare context, the role of the play specialist is to ensure that the teaching task is planned and implemented in a way that is both pleasurable and meaningful to the patient - within the frame of a playfully creative interaction (Hubbuck, 2009).

Play has been described as the language of childhood (Play Scotland, 2013) and exists as the child's primary means of receiving, processing, and communicating thoughts and feelings (Pellegrini, 2009). Acting on the premise that the child has the right, under Article 17 of the UNCRC (UNICEF, 1989), to receive communications in a language they understand, the play specialist strives to connect with the patient by presenting essential information relevant to their personal circumstances in a developmentally congruent and playful way, such that they can know and understand what is being expected of them and can make informed choices about available options (Kleye et al., 2021). This playful teaching, sometimes called play preparation, might take the form of storytelling with props, including adapted dolls

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and real medical equipment, puppet play (Reid-Searl et al., 2016), or a devised multi-sensory experience (Whitaker, 2014).

It is widely accepted that children cope better with a hospital admission or medical intervention, and are less likely to experience post-event trauma, when they have been given developmentally appropriate information about what is going to happen in advance (Ben Ari et al., 2019). There are ethical reasons for sharing information with children (Hudson et al., 2019) and these are reinforced by Articles 13 and 17 of the UNCRC (UNICEF, 1989) which confer every child with the right of access to information about what is happening to them.

Various strategies are used to inform and prepare children for a hospital stay or treatment procedure, including pre-admission clinics where children have the opportunity to meet the play specialist (individually or as part of a group) along with various members of the clinical team. The child may have an orientation to the ward or day-unit and its play facilities, and the play specialist uses age-appropriate language to inform the child what will happen during the admission, using a photo-book, digital application, and/or genuine medical equipment to reinforce understanding. The playful teaching facilitates rapport between the child and play specialist and fosters a trusting relationship within which the child can ask questions and express worries (Manning, 2021).

One of the most challenging and fearful aspects of healthcare for many children is having to undergo a needle procedure such as venipuncture or injection (Salmela et al., 2009). As well as using play to prepare the child for the event, the play specialist typically also uses play to teach the child distraction or alternative focus techniques to help them manage the procedure. Distraction techniques might include blowing soap bubbles, manipulating an interactive toy, viewing cartoons or looking at a book, telling jokes, or listening to music while the procedure is underway. The play specialist coaches the child to re-direct their attention away from the painful or fearful procedure, such that they might develop a repertoire of coping skills applicable across a range of future encounters. This purposeful deployment of play behavior as a means of managing fear and pain is well supported by the literature (Cho & Choi, 2021).

Guided Imagery, as used in pediatrics, is a collaborative distraction technique which involves a therapeutic conversation between patient and play specialist, during which the child's attention is directed away from a problematic situation towards a new focal point (Brown, 2017).

Casey, aged fifteen years, is brought to the Emergency Department following a mental health crisis. He is distressed and agitated: crying, hyperventilating and threatening to run away. Following social introductions, the play specialist suggests guided imagery as a 'brain game' which could facilitate the return to a calm state. Casey enjoys a television series about the lives of popular celebrities, and the play specialist invites him to imagine 'running away' to a luxury hotel where his every need is catered for. Casey engages readily with this fantasy and prompted by a sequence of multi-sensory questions he is able to describe in detail the opulent hotel suite, the delicious restaurant food, the tranquil swimming pool and relaxing jacuzzi. Within a brief period, Casey has stopped crying, his breathing is regulated, and he agrees to an interview with a doctor.

Involving the child in their own healthcare, by providing them with relevant information in a playful manner appropriate to their developmental level and experience, and by allowing them a reasonable degree of choice, not only increases self-confidence and a sense of agency in relation to their healthcare (La Banca et al., 2020) but has also been shown to improve clinical outcomes (Wijngaarde et al., 2021) with associated time and cost benefits.

The effectiveness of therapeutic play and play-based strategies as a means of coping with cognitive, social, and emotional challenges is well-established (Capurso et al., 2021). A study by McInnes and

Howard (2012) found that children demonstrate increased emotional wellbeing when they perceive an activity as play rather than not play, which fits with Huizinga's (1949) original proposition that play represents a state-of-mind as much as an observable behavior or activity. The playful teaching of children in healthcare settings may not be immediately recognizable as play per se but may serve the same function in terms of emotional regulation as pure play, in that it is designed to be both pleasurable and involving while communicating information in a language the child understands (Vilas, 2017).

ISSUES, CONTROVERSIES, PROBLEMS

The Play Environment

Hospitals and other healthcare settings are not natural playgrounds, and the play that takes place therein needs to accommodate to a unique set of terms and conditions. Healthcare environments pose distinct challenges for children due to the unique sensory characteristics and their emotional associations: bright lighting, noise, and a distinctive aroma accentuate sensory perception, with an impact on how the patient thinks, feels and subsequently behaves (Tonkin, 2015). Children intuitively know how to operate in a playful environment, and a healthcare setting which signals that it invites, permits, and values play can positively influence both a child's perception of the healthcare experience and their relationship to it (Tonkin, 2015).

Healthcare providers have a responsibility to ensure that the environment meets the needs of children of all ages and situations where they are cared for, including access to opportunities for play and people to play with (European Association for Children in Hospital [EACH], 2016, p. 20). Increasingly, new hospital design, including pediatric provision, has incorporated a higher proportion of single room accommodation. This is a major contribution to infection control measures and offers greater privacy for patients that want it. However, single rooms can also lead to feelings of isolation and loneliness which may inhibit play, depriving children of its therapeutic potential (Abad et al., 2010).

The social isolation of children during the global pandemic has provided new insights into the impact on children and adolescents of separation from their peers. Research by Miller and Kuhaneck (2008) identified that peers are a primary motivator of children's play: a young subject of the research states, "If I'm not playing with my friends, I can't play" (Matt, cited in Miller & Kuhaneck, 2008, p. 411). A recent study by Sawyer et al. (2021) highlights the importance of maintaining contact between children in hospital and their peers and of the need to orchestrate opportunities for social interaction when children are nursed apart from others, to ensure that patients in single room accommodation can access the benefits of social play, peer-to-peer learning, and a shared experience of fun.

Play and Risk

Children are intrinsically motivated to take risks, both physical and emotional, as they grow up, regardless of their culture or personal circumstances (Sandseter & Kennair, 2011). The relatively recent concept of *risky play* delineates play which satisfies the desire for excitement and uncertainty, and which includes the subjective experience of managed danger (Sando et al., 2021). The experience of having an influence over what and where to play, and who to play with, is regarded as essential to children's overall wellbe-

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ing (Sandseter & Seland, 2016) and myriad studies support the importance of risky play for children's development, learning, physical and mental health (Brussoni et al., 2015).

Risky play is most strongly associated with physical play (Sando et al., 2021) but its benefits for health and wellbeing are also evident in play which has a transgressive element (Cowan, 2020). Play which contravenes the norms and values of a given context, or which challenges the status quo, can evoke feelings of excitement and exhilaration similar to those derived from play which includes the physical thrill of possible danger. In the healthcare context, *messy play* with sand, water, clay, and slime incorporates an element of risk in that it poses a challenge to perceptions of the clinical environment as an uncontaminated space. In a similar way, the playful use of medical equipment, such as syringes and oxygen tubing, for non-medical purposes affords the young patient the experience of 'taking back control' in a setting in which their sense of autonomy is typically compromised (Martakis et al., 2018).

Any play in the context of healthcare is a risky activity, both for the player and for the play specialist, in that it challenges the rule-dominated mores of the clinical environment – although therein lies its value, since the open-ended play narrative provides a necessary balance between the linearity of the recovery process (unwell > well) and the uncertainty inherent in any medical/clinical encounter. The incentives for any behavioral choice, made by either the child or the play specialist, include: the perceived value of the outcome of the chosen course of action, including reduced pain or anxiety (Wente, 2013); earlier discharge (Department of Health, 2003); and improved health status/raised professional status. The process is not devoid of risk in that the outcome of any intervention is always uncertain: the play specialist must make an informed judgement that there will be payback for the patient (understanding and freedom from anxiety), for the clinical team (swift patient cooperation/positive clinical outcome), and for themselves (professional recognition, self-promotion and job satisfaction).

During a period of rapid and continuous scientific and technological advancement in medicine, the unpredictability inherent in a playful healthcare encounter serves as a reminder that it is the humanistic qualities of empathy and compassion (NHS England, 2016) that transform clinical experience into medical progress (Hegde, 1999). In the words of Sicart (2015) "Play matters because it's a balancing act between order and chaos, and by dancing that dance, by playing, we are human".

Play and Purpose

Play is a universal feature of the mammalian brain (Panksepp, 2004) and from infancy to old age humans are hardwired to engage in play purely for the pleasure and satisfaction it offers (Perry et al., 2000). Despite the many ambiguities surrounding its definition (Sutton-Smith, 2009), there is general agreement that central to play is its intrinsic motivation and the freedom to engage without "any goal that would bring it to an end" (Gadamer, 1975, p. 93). Straeubig et al. (2016) assert that, "For the player, play must remain inherently purposeless or it is not recognized as play but as work, learning or other activities that aren't pursued for their own sake" (p. 6).

Play is of its very nature purposeless, yet the healthcare environment is not given to purposeless activity. Not only must all health-related activity have a purposeful outcome, but its purpose and value must be demonstrable in both clinical and economic terms (The Kings Fund, 2017). Play specialists in hospitals and in the community are increasingly being asked to provide evidence of clinical effectiveness and economic return (Cooper et al., 2016), while simultaneously striving to maintain their play integrity: a frequently tricky balancing act. Frohlich et al. (2013) caution that any attempt to justify play for a therapeutic purpose risks undermining its specific attributes of intrinsic motivation and free engagement

“as a health-inducing socio-cultural behavior in practice” (p. 14) by repackaging it as simply another healthcare intervention. The challenge for healthcare play services is to synchronize the pure play of the child with its as yet undefined role in human adaptation (Straeubig et al., 2016), and the purposeful play recognized by service providers and fund-holders. Finding new ways to define and differentiate the form and function of therapeutic play may be one way to ‘rescue’ the pleasure of play in the healthcare setting (Da Silva et al., 2015).

CONCLUSION

There is an undisputed body of evidence for play as a key contributor to optimum physical health and mental wellbeing in childhood and beyond; for its protective function in the face of adversity; and for its potential as an agent of recovery from physical, mental, and social stress (Whitaker and Tonkin, 2021). Play is such an important aspect of children’s lives that it has long been regarded as a human right of all children from birth to 18 years (UNICEF, 1989), and nation states are held accountable for making provision for children’s play. EACH (2016) stipulates the child’s right to play when they are engaged with healthcare services. Yet, despite this broad advocacy for play, therapeutic play remains a Cinderella service in many healthcare settings. The apparent triviality, purposelessness and risky nature of play means that it is commonly overlooked in budget allocations and is often the first service to fall victim to austerity measures or service reorganization. Sixty years after the foundation of the first hospital play schemes in the UK, many pediatric patients do not have free access to play when they are sick or in hospital, despite what is known about its therapeutic benefits (Starlight, 2021).

Medical advances over the last half century have achieved previously unimaginable results, but progress has come with a price. In the drive for mastery over the human machine, there is a risk of ignoring the fundamental truth that health and wellbeing are more than a matter of mechanics. The wisdom of play (Fleming & Whitaker, 2019) is essentially a creative, practical wisdom and it does not readily lend itself to statistical measurement or economic justification. A reliance on conventional evidence-based value measures leaves play vulnerable to marginalization and neglect. An evidence-informed practice model which matches clinical research findings to specialist expertise and patient experience opens the way for more effective advocacy for play in the healthcare setting. Reviewing and refining the definitions relevant to therapeutic play, in conversation with all stakeholders - children, their families, play specialists, service providers and policymakers – has the potential to re-invigorate the play debate and transpose therapeutic play “from its current status as an afterthought ... to that of a necessity” (Sigman, 2015).

The uncertainty associated with a playful intervention in the context of something as serious as healthcare underlines the fact that play is an inherently risky endeavor. Shapiro (2019) describes play as “the beginning of civic participation” (p. 14) which presents a challenge to healthcare providers who must acknowledge the child as an active decision-maker. A healthcare encounter offers the pediatric patient little opportunity for free choice (Bricher, 2000), but play returns freedom and choice to the child patient and thus fosters a sense of autonomy and of personhood. The healthcare setting which signals that it not only permits, but invites, encourages and celebrates play, conveys the message that it is a place which respects and values children as people first and patients second, and as stakeholders in their personal healthcare encounters. Pediatric services which are designed around opportunities for self-directed pure play, and for playful learning in a social context, are of equal importance to the playful teaching strategies which may be used to facilitate information exchange and patient cooperation, and which may be

more readily accessed by conventional outcome measures. A truly progressive, effective, and efficient healthcare system is one which is informed by, and which applies, the evidence for therapeutic play as an essential component of pediatric provision, with the patient at the heart of the healthcare process.

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KEY TERMS AND DEFINITIONS

Distraction Technique: A playful teaching strategy whereby the practitioner (play specialist) coaches a subject (child) to re-direct their attention away from the painful or fearful procedure.

Guided Imagery: A collaborative distraction technique which involves a therapeutic conversation between practitioner (play specialist) and subject (child), during which the subject's attention is directed away from a problematic situation towards a new focal point.

Messy Play: The non-directive exploration of materials and their properties through open-ended play with tactile substances, such as water, sand, clay, and food items.

Play Disposition: The inclination to play and be playful; used to describe a state of mind rather than an activity.

Play Preparation: A playful teaching strategy designed to help the subject (child) understand a novel or challenging experience with the aim of correcting misconceptions, facilitating information exchange, and increasing coping behavior.

Play Specialist: A professional play practitioner who holds a recognized qualification for working with children when they are sick or in receipt of healthcare services.

Playful Learning: A learning opportunity which engages the subject (child) in a playful interaction which they may or may not perceive as play.

Playful Teaching: A playful intervention which has a pre-determined outcome identified by the 'teacher' (play specialist), in the context of what is expected of, or needed by, the 'learner' (child).

Pure Play: Play which is intrinsically motivated, self-initiated, and developed by the player (child), with an unspecified outcome.

ENDNOTE

¹ The term 'play specialist' is used to describe the professional play practitioner who holds a recognized qualification for working with children when they are sick or in hospital. In the UK, these practitioners are known as Health Play Specialists (HPS). The job title 'Hospital Play Specialist' is used in Japan and Hong Kong, and in the USA, Canada, and UAE, 'Child Life Specialist' is the preferred job title.