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Supporting Children Experiencing a Pediatric-Sexual Assault Forensic Examination: Preparation for and Perceptions of the Role of the Child Life Specialist

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ABSTRACT

To help minimize negative outcomes, child life specialists can provide psychosocial care to patients undergoing a pediatric sexual assault forensic examination (P-SAFE). This exploratory study used a survey to examine child life specialists' perspectives on their preparation for and role in P-SAFEs. Participants reported their main duties with this population include procedure support, play, and building rapport. The benefits of having child life involved in P-SAFEs were noted as decreasing re-traumatization, increasing cooperation, increasing coping, and decreasing stress and anxiety. Participants reported that most child life services were provided in preparation for the exam and during the exam. The services utilized were preparation, play, and distraction to help patients cope. Results indicated child life specialists felt valued by the multidisciplinary team, especially for their role in procedure support. Lastly, child life specialists reported training for this role occurring most often through informal on the job training. In summary, child life specialists acknowledged the stressors associated with a P-SAFE and perceived their role as beneficial in minimizing such stressors. Health care facilities that provide P-SAFEs should further consider the benefits of child life services to these patients and advocate for their services during P-SAFEs.

Introduction

In the United States, it is estimated one out of every seven girls and one out of every 25 boys are victims of sexual abuse (Townsend & Rheingold, 2013). In 2016, 8.5% of the reported child abuse and neglect cases were instances of sexual abuse, totaling approximately 57,329 cases in the U.S. (U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2018). When child sexual abuse (CSA) is reported, steps are taken to review the report and determine if a pediatric sexual assault forensic examination (P-SAFE) is necessary (U.S Department of Justice Office on Violence Against Women, 2016). During a P-SAFE, the health care provider collects forensic evidence, such as clothing and swabs from the child's mouth and anogenital area. Additionally, the provider examines the patient's anogenital areas with a camera looking for injury (e.g., bruises, cuts) and swabs the anogenital area for sexually transmitted diseases (Lahoti et al., 2001). Some hospitals use the following criteria

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for determining whether to conduct a P-SAFE on a prepubescent patient: 1) the disclosure of the assault or a witness to the assault, 2) the assault happened within the past five days, and 3) the assault involved skin to skin contact with the patient's anogenital area (Children's Mercy Hospital, 2015).

The P-SAFE process can be one that causes anxiety, distress, or pain for pediatric patients (Berenson et al., 1998; Tener et al., 2012). During a P-SAFE, body parts that were recently abused are examined. Therefore, the patient may experience stress, anxiety, and possibly re-traumatization of the abuse (Berson et al., 1993). Berson and colleagues (1993) examined children's perceptions of the P-SAFE and found children see the exam as intrusive and have a negative view of the doctor afterwards. Additionally, children reported restraining during the exam was reminiscent of their previous sexual abuse (Berson et al., 1993). Since hospital staff are working with this vulnerable population, it is important to consider the best practices in making sure the P-SAFE does not re-traumatize the patient. In the U.S. Department of Justice Office on Violence Against Women (2016) protocol for P-SAFEs, the importance of the exam being child-centered, victim-centered, and trauma- informed during the care for CSA victims is emphasized. Examples of different victim-centered techniques include preparation and distraction, which have been shown to be beneficial in easing stress and anxiety and increasing coping in pediatric patients (U.S. Department of Justice Office on Violence Against Women, 2016).

There is some evidence that victim-centered techniques are effective in minimizing negative outcomes during anogenital exams. For example, Rheingold et al. (2013) studied the effectiveness of providing a psychoeducation video to children and their caregivers about the upcoming anogenital procedure. Results indicated the education session decreased stress during the exam for the families (Rheingold, Danielson, et al., 2013). Similarly, another study found preparation before the exam and providing a supportive atmosphere during the exam helped to decrease stress for the child (Gulla et al., 2007). Furthermore, children that are more aware of what the exam entails appear to be less anxious during the exam (Rheingold et al., 2013). Such findings emphasize the importance of preparing children for sexual abuse exams; when they are prepared, they exhibit less anxiety and stress.

In addition, distraction interventions have been identified to offer support for children during exams, such as P-SAFEs (Chambers et al., 2009; Sinha et al., 2006). Distraction is a type of nonpharmacological support provided to children during different treatments and examinations. Distraction focuses a patient's attention away from the distress of the procedure to a more neutral stimulus, such as toys (Chambers et al., 2009), music (Sinha et al., 2006), and tablets (Sinha et al., 2006); leading to a decrease in stress for the patient (Stevenson et al., 2005). Research indicates the use of interventions such as using a clown for distraction (Tener et al., 2012) and video eyeglasses (Berenson et al., 1998) are effective in decreasing children's anxiety and fear during sexual abuse examinations. Such findings suggest distraction can decrease fear, anxiety, and stress for pediatric patients undergoing P-SAFEs.

As members of the health care team, child life specialists specialize in providing psychosocial care to pediatric patients, such as preparation and distraction. The American Academy of Pediatrics Policy Statement on Child Life Services (2021) states child life specialists are an essential role in pediatric health care because they focus on the development and well-being of every child and provide services that minimize the harmful effects of hospitalization for pediatric patients and their families. Research suggests that child life specialists can help relieve anxiety and promote coping in a variety of settings and with diverse medical diagnoses (Brewer et al., 2006; Burns-Nader et al., 2017). Child life specialists are increasingly working with P-SAFE patients, either in emergency departments or outpatient clinics that specialize in P-SAFEs. Due to the vulnerability of this population, child life specialists have the potential to benefit P-SAFE patients by providing patient-centered education and distraction. According to the Association of Child Life Professionals' Value Statement, "Expansive research consistently demonstrates that Certified Child Life Specialists generate positive behavioral, psychological, and physiological outcomes through individualized interventions with pediatric patients" (Boles et al., 2020, p.2). Evidence finds that child life specialists provide pediatric patients with play-based, coping-centered techniques, such as education and distraction, which have been shown to improve pediatric patients' experiences by decreasing pain, anxiety, and distress (Boles et al., 2020).

Current Study

Children who are sexually abused undergo stressful and upsetting procedures as part of their care. Although child life specialists are often the health care professionals providing psychosocial support to CSA patients, current literature is limited about the role of the child life specialists in P-SAFEs. The purpose of this study was to address the gap in the literature by collecting information on the role of child life specialists during P-SAFEs and their preparation for providing care to this population. When examining the role of child life specialists, this study also looked at the stressors child life specialists perceive children to experience during a P-SAFE. Information on both the perceived stressors of children during a P-SAFE and the role of child life specialists during a P-SAFE allows for a reflection on whether the children's identified stressors are appropriately addressed and attended to in the role of the child life specialist. Specifically, the study examined the following research questions:

1. What are child life specialists' perspectives of the stressors they see children experience during a P-SAFE?
2. What are child life specialists' roles during a P-SAFE?
3. What are the stressors child life specialists experience working with P-SAFE patients?
4. What training do child life specialists have to work with P-SAFE patients?

Methods

Procedure

To gather current data, an online survey was developed for use with individuals working with the P-SAFE population as Certified Child Life Specialists. With Institutional Review Board approval, the survey was disseminated through the Association of Child Life Professionals (ACLP) Forum. The ACLP Forum is an online network only available to members of ACLP. It provides child life specialists, program coordinators, and students the opportunity to share information related to the child life profession. There are approximately 4,138 ACLP members who receive ACLP Forum posts. Study information, such as the purpose of the study, inclusion criteria, as well as a hyperlink to participate, was posted on the ACLP Forum. The post was replicated three times over the period of a month. To be eligible to participate, a person had to be at least 18 years old, a Certified Child Life Specialist, and have at least four months of experience working with the P-SAFE population in the United States. If a person was non-certified, non-English speaking, and not working in the United States, they were not eligible for participation. Those eligible and interested in participation used the hyperlink to access study materials. Participants provided electronic consent and then completed a survey on their demographics and experiences working with P-SAFEs.

Participants

A total of 24 child life specialists responded to the ACLP Forum posts and completed the online consent and survey. Of the 24 surveys submitted, three were excluded due to being less than 50% complete. Although it can appear the response rate for participation was weak, information on the exact number of child life specialists providing care for PSAFEs is unknown at this time.

Participants (n =21) ranged in age from 24 to 51 years (M = 31.29, SD = 6.9). All the participants were female, and most were Caucasian. Additionally, participants' work experience with this population ranged from nine months to 240 months (M = 54.9, SD = 49.90), with a majority working with the P-SAFE population in the Emergency Department and/or Abuse Clinic (n = 18, 85.6%). For additional demographic information, see Table 1.

Measures

Background questionnaire

The background questionnaire included demographic questions of the participants including age, ethnicity, and gender. Additional information, including the participants' history as a child life specialist, how long they have been a Certified Child Life Specialist, how long they have worked with P-SAFEs, years of schooling, and location in which they worked with P-SAFE cases, was also collected.

The Child Life Specialist's Perceived Role in Sexual Abuse Examinations Survey

This survey examined the roles and needs of child life specialists serving patients receiving P-SAFEs. This survey was created by two child life specialists, with each contributing specific knowledge and experience to the survey development. The primary author is a Certified Child Life Specialist (CCLS) with

Table 1. *Participant Demographic Information*

Variable		n	%
Age (M,SD)	31.29, 6.69		
Ethnicity (%)			
Caucasian		19	90.5
Middle Eastern		1	4.8
Biracial		1	4.8
Gender (%)			
Female		21	100
Male		0	0
Education (%)			
Bachelor's		12	57.1
Professional - Master's		9	42.9
Hospital Size (%)			
Small Children's Hospital		5	23.8
Medium Children's Hospital		13	16.9
Large Children's Hospital		2	9.5
Large Adult Hospital		1	4.8
Location Worked in with P-SAFE population			
ED		12	57.1
ED and Abuse/Clinic		4	19.0
Inpatient		2	9.5
ED and Other Units		2	9.5
Child Protection Program		1	4.8

two years' experience, including training and clinical work specific to the P-SAFE population. The second CCLS has over 15 years experience and is a preeminent scholar in the field. The survey questions were created based on their training in child life, experiences working with the P-SAFE population, as well as empirical based knowledge from the literature of the child life field. For example, one question on the survey asked, "What services do you use with this population?" The possible choices of preparation, distraction, play, comfort positions, procedure support, and coping were selected because previous studies indicate the benefits of child life providing such interventions (e.g., Burns-Nader et al., 2017; Diener et al., 2018; Fereday & Darbyshire, 2008; Gursky et al., 2010; Hall et al., 2018; Scott et al., 2016). After the creation of the survey, it was distributed to a third CCLS with expertise with the P-SAFE population for feedback and critique. The survey was finalized with consideration of the third child life specialist's input.

The survey consisted of 46 questions in three domains: (1) Exploring the child life specialist's role with sexual abuse populations, including (a) interventions with P-SAFE patients, (b) roles, and (c) responsibilities and job duties; (2) Specific stressors in sexual abuse populations; and (3) Training received at preservice and in-service specific to working with sexual abuse populations. Most questions collected information by asking participants to select from a list of potential answers (e.g., "When do you provide support to this population? Select all that apply"). Other questions, such as how valued the child life specialist felt as part of the multidisciplinary team, were asked using a Likert scale (e.g., strongly valued to strongly not valued and very well trained and prepared to not trained or prepared at all). Additionally, two qualitative questions were included: 1) "What are the most difficult aspects of working with this population?" and 2) "What are the most rewarding aspects of working with this population?" Very little is known about child life specialists' view of the difficult and rewarding parts of working with P-SAFE patients. Understanding the difficulties and rewards is important as compassion fatigue is related to the presence of such factors when providing care (Van Mol et al., 2015). Compassion fatigue is defined as caregivers' experience with distress due to an ongoing relationship with demanding individuals (Van Mol et al., 2015). Therefore, the survey provided two qualitative questions to allow for an open-ended discussion about the variables child life specialists experience while providing care to P-SAFE patients.

Data Analysis

Statistical Package for the Social Sciences (SPSS) version 24 was used to analyze the descriptive data. For the two qualitative questions, the first two authors coded and extracted themes from the two questions using a constant comparative methodology (Glasser, 1965). Individually, the two authors reviewed the responses for the two questions. Each author selected short descriptors that they felt summarized the meaning of the response, with some responses having multiple descriptors identified. Then, they grouped the descriptors into broader categories. For example, "abuse story" and "hearing the child" were grouped into "feelings surrounding child's abuse story." Next, the two authors met to compare and discuss the identified categories, address questions, and determine a finalized coding scheme. The first two authors then coded the two questions with the chosen coding scheme. Answers were coded with the potential to identify multiple codes in a participant's response. After this round of coding, inter-rater reliability was determined, and any differences were resolved. The two questions were then coded for reliability a second time by a graduate research assistant. Inter-rater reliability was very high between the first two authors

(86% for question one and 93% for question two), as well as between the first author and the graduate research assistant (86% for question one and 86% for question two) and the second author and the graduate research assistant (93% for question one and 86% for question two). Analyses included identifying all codes and the frequency of codes.

Results

What are child life specialists' perspectives of the stressors they see children experience during a P-SAFE?

To address this question, participants were asked to select the stressors that they perceive this population experiences. Child life specialists perceived re-traumatization (n = 17, 81%) and lack of information/understanding (n = 11, 52.4%) as the two greatest stressors experienced by children in this population. Similar results were found when asked their perception of the most common stress points. Participants listed the exam itself (n = 16, 76.2%) and the pre-procedure events (n = 14, 66.7%) as the most common stress points. See Figure 1 for more information on perceived stressors.

What are child life specialists' roles in the P-SAFE population?

To determine the role of child life specialists in the P-SAFE population, the survey gathered information on job duties and responsibilities, when child life specialists provided support, and the types of preparation, distraction, and play used. Additionally, participants identified how they feel their role is beneficial, how they advocate for the patient, and how they perceive the multidisciplinary team views them. First, the participants reported numerous job duties and responsibilities with the P-SAFE population. As seen in Table 2, when asked to select their required job duties, the duties selected the most were procedure support, play, building rapport with patients, charting, assessment, education, and supporting co-workers. When asked to list their top five duties with consideration of time and importance of duty, there was no clear top duty; six participants (28.6%) selected assessment as their top duty, seven (33.3%) selected procedure support as their second duty of importance, and five (23.8%) selected rapport as their third top duty. See Table 3 for additional results.

Table 2. *Child Life Specialist Job Duties and Responsibilities During P-SAFE*

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

Participants were also asked to identify when they provided support to P-SAFE patients. The participants surveyed provided support to patients during preparation for the exam (n = 21, 100%), during the exam (n = 21, 100%), post exam (n = 20, 95.2%), prior to the exam (n = 19, 90.5%), and during interviews with other medical staff (n = 17, 81%). Some provided support at other times as seen in Table 4.

Participants reported providing support through play, preparation, and distraction. All the participants provided play and preparation to P-SAFE patients. For distraction, of the 21 participants, only one said they did not provide distraction to the population. The most noted ways of providing preparation were as follows: infor-

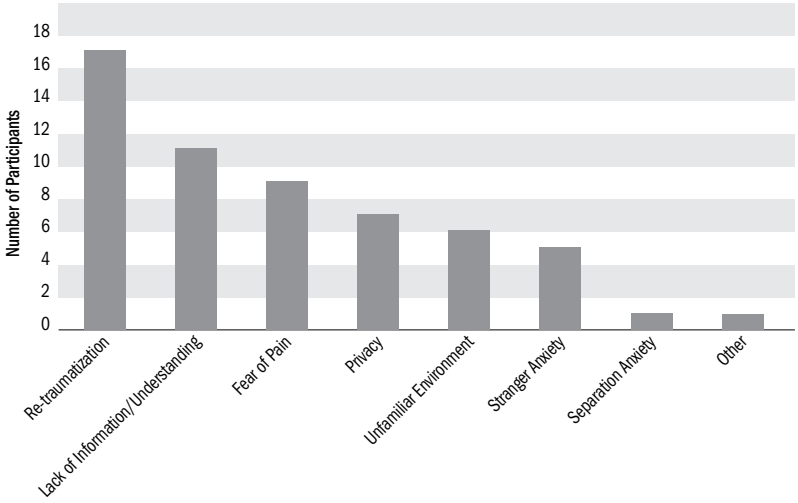

Figure 1. *Child Life Specialists' Perspective of the Stressors Experienced by Children During P-SAFE*

Table 3. *Top Duties of Importance and Time for Child Life Specialists during P-SAFEs*

Duty	1st-Duty	2nd Duty	3rd Duty	4th Duty	5th Duty
Procedure support	2	7	3	2	2
Education	2	3		2	
Rapprt	3	2	5	1	1
Preparation	3	2	1	1	
Coping				1	
Follow-up					
Child life dep. roles					1
Charting					1
Support to siblings					1
Support to caregivers					1
Support to co-workers					1

mation to the patient (*n* = 21, 100%), information to the adult caregiver (*n* = 19, 90.5%), familiarization with equipment (*n* = 19, 90.5%), comfort position (*n* = 18, 85.7%), and the use of medical teaching dolls (*n* = 12, 57.1%). The most noted distraction techniques utilized were conversation (*n* = 20, 95.2%), the iPad (*n* = 18, 85.7%), breathing exercises (*n* = 18, 85.7%), relaxation exercises (*n* = 17, 81%), and music (*n* = 17, 81). Play was primarily used to normalize the hospital environment (*n* = 20, 95.2%) and to build rapport (*n* = 20, 95.2%). A slight majority (*n* = 11, 52.4%) of the participants chose medical play as a form of play used during P-SAFEs.

The child life specialists reported their role to be beneficial in several ways, such as, minimized re-traumatization (*n* = 21, 100%), increased procedure cooperation (*n* = 21, 100%), increased coping (*n* = 20, 95.2%), decreased anxiety and stress (*n* = 20, 95.2%), and increased return to baseline by the child after the procedure (*n* = 18, 85.7%). See Figure 2. The participants reported that the interventions used most frequently to help minimize re-traumatization were respecting the privacy of the patient (*n* = 21, 100%), using a less-threatening position (*n* = 18, 85.7%), slowing down the examination (*n* = 18, 85.7%), advocating for the presence of a caregiver (*n* = 15, 71.4%), and stopping the exam because of re-traumatization (*n* = 10, 47.6%). See Figure 3. Of the 21 participants, 10 had experience advocating for stopping an exam. There were mixed results on the question that examined if the child life specialist was comfortable advocating for an exam to stop: 10 were very comfortable (47.6%), four were somewhat comfortable (19%), two were neutral (9.5%), and four were somewhat uncomfortable (19%).

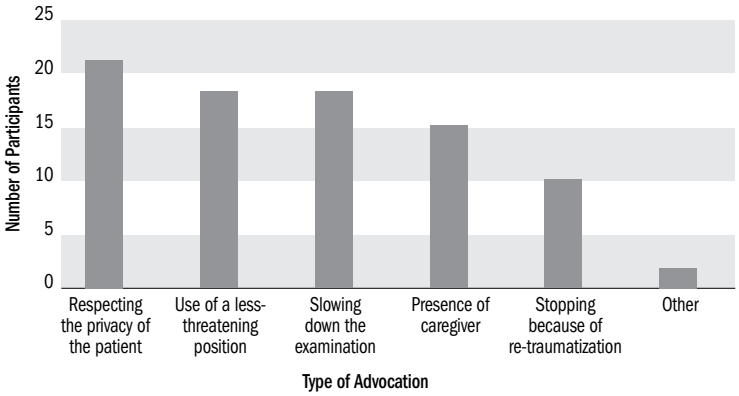

Figure 2. *Methods Child Life Specialists Use to Advocate for Patients During P-SAFE*

Table 4. *When Child Life Specialists Provide Support for P-SAFEs*

	N	%
During preparation	21	100
During the exam	21	100
Post exam	20	95.2
Prior to exam in patient room	19	90.5
During interviews	17	81
During vital signs	10	47.6
While in waiting room	6	28.6
During admission	5	23.8
During check-in	4	19
During support groups	1	4.8

In relation to the multidisciplinary staff, all the participants felt valued (*n* = 11, 52.4%) or strongly valued (*n* = 10, 47.6%). They also felt that the multidisciplinary team's perceptions of them was primarily as a procedure supporter (*n* = 10, 47.6%), educator (*n* = 5, 23.8%), and facilitator of coping (*n* = 4, 19%).

What are the stressors child life specialists experience working with the P-SAFE population?

The participants were asked two qualitative questions about the stressors of working with this population: 1) "What are the most difficult aspects of working with this population?" and 2) "What are the most rewarding aspects of working with this population?" Fourteen (66.67%) of the 21 participants responded to these questions. Ten of the 14 (71.4%) responded that hearing the children's stories was the most difficult part of working with this popula-

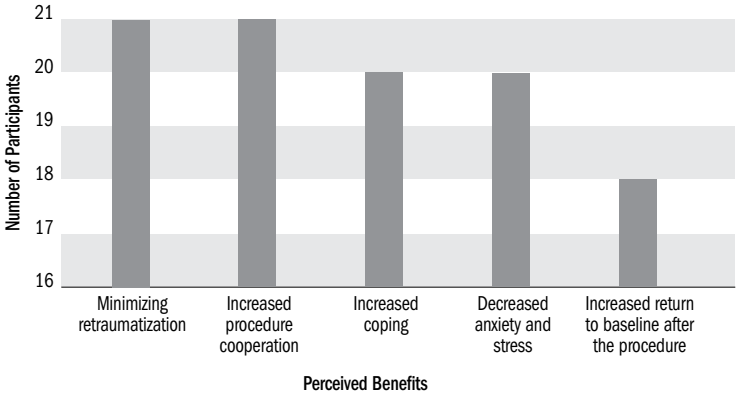

Figure 3. *Perceived Benefits of Child Life Services During a P-SAFE*

tion. One participant stated that "some of the stories can be heartbreaking and seeing how traumatized the patients can be is difficult." Another participant said, "hearing the stories of why children came in, and trying not to carry that home with me" was a difficult part. One participant stated that it is hard especially if they do not have a "supportive team" or another child life specialist who works with this population. Other difficult parts of working with this population included concern about patient re-traumatization (n = 2, 14.3%), patient anxiety (i.e., fear, stress, tears, vocalizations; n = 2, 14.3%), and patient traumatization from the abuse (n = 2, 14.3%). In addition, two (14.3%) participants brought up the point that it is hard to balance the length of time involved with these cases with other duties and responsibilities.

When asked about the rewarding parts of working with this population, five (35.7%) of the 14 participant's responses were related to feeling helpful, and five (35.7%) responses were about helping patients cope with the P-SAFE. Other responses included promoting overall coping with the abuse (n = 2, 14.3%), contributing to successful collection of forensic evidence (n = 2, 14.3%), and decreasing re-traumatization (n = 1, 7.1%). One participant (7.1%) also described being a part of a team caring for the P-SAFE patient: "Working with a team of people who are dedicated to helping victims of sexual abuse/assault cope and move forward on a journey of healing."

Participants were also asked to rate their frequency of self-care practices. Of the 21 participants, 19 responded to this question. It was found that 15 (71.5%) practiced self-care often, somewhat often, or very often. Whereas four (19.1%) did not practice it or practiced it not often.

What training do child life specialists have to work with this population?

To gain information on the question of what training do child life specialist have to work with this population, participants were asked how prepared they felt, trainings that prepared them for this role, trainings they lacked, and trainings that are important to seek for continued education. A majority, 15 of 20, responded they were at least trained and prepared adequately (71.4%), whereas four (19%) felt somewhat trained and prepared and one (4.8%) felt not trained or prepared at all. Most of the participants felt the training that best prepared them for this role was informal on the job training from other health care professionals (n = 19, 90.5), and the second most noted preparation was self-taught methods (n = 11, 52.4%). When asked about the training they lacked or needed more of, many stated the need for formal workshops for professional development units (n = 13, 61.9%) and information through ACLP's resources (n = 8, 42.9%). The participants also stated it is important to continue visiting various trainings and resources as part of this job. The question asked to select all that apply; the trainings noted included information on recent research related to this topic (n = 16, 76.2%), workshops (n = 13, 61.9%), information through the ACLP resources (n = 12, 57.1%), and informal on the job training from other health care professionals (n = 11, 2.4%).

Discussion

The role of the child life specialist on a team that conducts P-SAFEs is evolving. Child life specialists are trained to provide psychosocial care and support to children, adolescents, and their families during traumatic and stressful hospital experiences. This study examined child life specialists' perspectives regarding their role in P-SAFEs as well as the perceived benefits and difficulties working with that patient population. Findings identified that child life specialists view themselves as being beneficial to patients and the health care team during P-SAFEs by minimizing re-traumatization, increasing cooperation, increasing coping, and decreasing stress and anxiety. Participants note the common duties they provide are procedure support, play, and building rapport with patients. These duties most often occur during preparation for the exam and during the exam itself. Participants also

reported experiencing both difficulties and rewards when providing services during P-SAFEs. Results provide insight into the training that child life specialists receive for this role, including training that is needed, and training that they lacked.

Roles and Responsibilities of the Child Life Specialist During P-SAFEs

Findings suggest child life specialists have many duties during P-SAFEs such as procedure support, play, rapport building, charting, assessment, and education. Assessment, procedure support, and rapport building were consistently among the most important duties as part of child life specialists' role in P-SAFEs. The U.S. Department of Justice Office on Violence Against Women Protocol (2016) emphasizes the importance of the exam being child-centered, victim-centered, and trauma-informed. The importance of preparing patients through information sharing and offering distraction interventions during the examination are noted as essential parts of the P-SAFE process (U.S. Department of Justice Office on Violence Against Women Protocol, 2016). In the present study, all the child life specialists reported providing preparation for the examination, and all but one provided distraction during the examination. The present study found that child life specialists who work with this population recognize the need for preparation and distraction and provide interventions that allow information to be given and ease stressors. Thus, their work aligns with the national protocol.

Three important components of a child life specialist's work are preparation, play, and procedure support (Boles et al., 2020). A child life specialist provides information to the child and family and explains different aspects of the procedure, hospitalization, or experience to them (Romito et al., 2021). Preparation by a child life specialist has been found to be related to decreased pain and anxiety during procedures (Boles et al., 2020; Brewer et al., 2006; Gursky et al., 2010; Li & Lopez, 2008), an increase in understanding (Boles et al., 2020; Li & Lopez, 2008), and an increase in satisfaction from the patient and parent (Gursky et al., 2010; LeBlanc et al., 2014; Li & Lopez, 2008). When utilizing preparation interventions with the patients undergoing P-SAFEs, all the child life specialists in the current study stated giving information to the child and caregivers was the most important part of the intervention. Previous studies found that information given to the child and caregiver about the P-SAFE was beneficial in decreasing stress and increasing cooperation (Gulla et al., 2007; Rheingold et al., 2013).

In the current study, most of the child life specialists provided distraction using conversations, iPads, breathing exercises, relaxation exercises, and music. These techniques are used to help focus children's attention away from the stress-inducing exam to a more neutral stimulus (Burns-Nader et al., 2016). With other populations of pediatric patients, distraction techniques, such as iPads and breathing techniques, have been found to be beneficial during health care experiences (Boles et al., 2020; Burns-Nader et al., 2017; Hylan et al., 2015).

Child life specialists' use of play in the hospital is a main facet of their role, as it is beneficial in promoting development and decreasing anxiety in children during health care experiences (Boles et al., 2020). Play has been found to help decrease the amount of pain experienced and decrease negative physiological responses to medical procedures (Cassell, 1965; Kaminski et al., 2010; Moore et al., 2015). In this study, the child life specialists primarily used play to normalize the environment and build rapport. Play has been shown to be important for establishing a therapeutic relationship between an adult health care provider and the child (Boles et al., 2020; Burns-Nader & Hernandez-Reif, 2016). Interestingly, when rating their duties of importance, the child life specialists stated that building rapport was one of their top duties.

Play is a critical component to the role of the child life specialist; however, in this study, it was only ranked as the third, fourth, or fifth duty of importance. Participants perceived it as less important compared to providing assessment, procedure support, and rapport building to this population. For child life specialists, play is often described as unstructured time with materials that is child-led and has no extrinsic goal (Burns-Nader & Hernandez-Reif, 2016). Such a type of play requires materials, time, and space. Some of these variables may be difficult to control during a P-SAFE. For example, time can vary from patient to patient. Some patients may have more time while a parent meets with social work, and another may have a short period of time during such a meeting.

Stress Points of a P-SAFE for Patients

Participants reported that they perceived pre-procedure and the exam itself as the two biggest stress

points of a P-SAFE for patients. Additional findings suggest that they address these stress points in their role. The participants described that P-SAFE child life interventions are implemented most often during preparation for the exam and during the exam itself. As previously noted, patients experiencing a P-SAFE view it as being reminiscent of their trauma from the recent abuse (Berson et al., 1993). It is important to note that preparation for the exam and the exam itself are the points when the possibility of re-traumatization may increase (Berson et al., 1993). Therefore, it is appropriate for child life specialists to view these as the most important times to provide services, as they are the times children are displaying the potential for the most distress.

Benefits of Including Child Life Specialists in PSAFEs

The child life specialists in this study viewed their role as beneficial. Although these findings are self-reported by the child life specialists who participated in this study, the authors appreciate that child life specialists have a strong background in child development an understand the typical stressors that children encounter during health care experiences. The foundational knowledge of the child life specialist layered with understanding the potential stressors of the health care experience creates opportunities for the child life specialist to meet the unique needs of each patient (Lookabaugh & Ballard, 2018). In the current study, child life specialists thought their role helped to minimize re-traumatization, increase coping and cooperation, and lower anxiety and stress. Although previous studies have not examined the benefits of a child life specialist's support during a P-SAFE, previous studies have shown the presence of child life specialists minimize children and family's anxiety (Bartik & Torunner, 2017), promote coping (Brown et al., 2015), and promote procedure compliance (Tyson et al., 2014) during a variety of procedures, such as medical imaging, burn treatments, surgery, and laceration repairs (Boles et al., 2020).

Child life specialists provide interventions during the moments of a procedure they assess as being the greatest stressors; in the current study, this was viewed as prior to the exam and during the exam to prevent re-traumatization. In their role, child life specialists reported advocating for the prevention of re-traumatization by respecting the patient's privacy, using less threatening positions, slowing down the examination, advocating for the inclusion of the caregiver, and stopping the exam, if necessary. Although child life specialists recognized their role in advocating for the exam to stop, only half had experience in stopping an exam, and only a few felt comfortable with advocating for stopping an exam. As an advocate for children and families, the role of requesting an exam to end when the child is experiencing re-traumatization is an important one for child life specialist to consider.

Multidisciplinary Team's Value of Child Life Specialist's Role

The child life specialists reported feeling valued by the multidisciplinary team. This value of the child life specialist's role has developed over time. Historically, child life specialists were not seen as part of the health care team (Gaynard, 1985). However, a later study found that the multidisciplinary team reported child life specialists to be important for the psychosocial well-being of pediatric patients (Cole et al., 2001). This current study adds to this evidence that child life specialists hold positive attitudes towards their role.

Difficulties and Rewards

Working as a member of the health care team that provides support to victims of abuse or trauma can be an emotionally taxing job (Baird & Jenkins, 2003; Bride, 2007; Meadors & Lamson, 2008). The child life specialists in the current study listed hearing the children's abuse stories as the most difficult part of working with this population. They felt the most rewarding part of working with P-SAFEs was being helpful during a difficult time. Previous studies have examined compassion fatigue and its prevalence in health care professionals that work with higher-stress populations (Van Mol et al., 2015). Maslach et al., (2001) found that burnout can lead to numerous negative outcomes, such as poorer job performance and mental health concerns. It is important for health care professionals to engage in self-care, as self-care is recommended to be a solution to burnout and compassion fatigue (Newell & MacNeil, 2010). Self-care is important to assist the child life specialist in processing the stories presented with each patient.

Some participants in this study reported they do not engage in self-care. This finding is concerning, as there is ample research on secondary trauma and compassion fatigue that frame the importance of self-care for health care professionals (Baird & Jenkins, 2003; Bride, 2007; Meadors & Lamson, 2008; Newell &

MacNeil, 2010; Van Mol et al., 2015). It is important for a child life specialist working with this population to have the resources and knowledge of the value of self-care. However, much of the literature does not focus on health care workers such as nurses, social workers, and child life specialists that work with P-SAFEs. Additionally, there is not much information available on the rewards of working with this population.

Training

Most child life specialists in this study were trained to work with the P-SAFE population primarily through informal job training and self-taught methods and felt they lacked formal workshops and professional resources. When looking at the training that other professionals receive with this population, there is a stark difference in the specific training required. Pediatric Sexual Assault Forensic Nurse Examiners are required to go through a sexual assault nurse examiner education program with contact hours and examination beyond what is required of a basic nursing degree (Commission for Forensic Nursing Certification, 2019). Unless the child life specialist was trained to provide P-SAFEs during their internships, most of the training comes from other child life staff on the job. While on-the-job training is important, preservice curriculum and simulations that provide real world experiences may prove valuable to provide the emerging child life specialist with a sense of competence prior to being on the job.

Limitations

There are limitations to this study. For one, the sample size is small. Additionally, the participants were all female and majority were White; therefore, there are limitations for the generalizability of the findings. Furthermore, of the 21 respondents, a few did not answer all the questions or left some questions partially answered. Due to the quantitative nature of the study and the desire to offer a shorter survey, free response questions were limited. Based on the responses, some of the data collected were not able to be explained further, which could have helped clarify the results. Finally, this study used self-reported measures by child life specialists to examine their perceived value regarding their role in P-SAFEs. Therefore, the ability to draw conclusions from the findings is limited.

Implications for Practice

This is the first study designed to look at the role of child life specialists with the P-SAFE population. The current study found child life specialists view their services to patients undergoing P-SAFEs as decreasing re-traumatization, increasing cooperation during the examination, increasing coping, and decreasing stress and anxiety. As health care professionals learn more about the impact of trauma on children and families and include trauma-informed practice in their roles, the evidence will continue to support the inclusion of the child life specialist as a member of the P-SAFE team.

In this study, participants indicated they feel valued by the medical team, especially for their role in procedure support. Based on previous research, the benefits of child life services in other areas and the findings of this study, child life specialists can provide positive interventions with these patients; therefore, more hospitals that complete P-SAFEs should consider including child life specialists as part of the team. Furthermore, child life specialists should prepare and advocate for the ability to provide services during P-SAFEs.

As noted by the participants in this study, more training is necessary. To best align with other professionals who work within the P-SAFE team, child life specialists should have opportunities to develop knowledge and skills both at the preservice and in-service levels. In the current study, a lack of consensus in the identification of the most important duties of a child life specialist during a P-SAFE suggests additional evidence is needed to identify the essential duties of a child life specialist in fostering positive outcomes in P-SAFE patients. Such evidence could then inform a more standard training for child life students and clinicians. Preservice preparation may include specific training with trauma-informed simulations that offer insights for real-world situations that impact children and families. In addition to preservice preparation, professional development conference sessions, webinars, and certificate programs are needed to offer continuing education for the child life professional.

Implications for Future Research

This study offers an initial view of the role of the child life specialists as part of the P-SAFE team. More research is needed to fully understand the complexity of the child life professional's role and how they can best serve this population. For example, future research is needed to examine the benefits of distraction provided by child life specialists to patients during P-SAFEs. Additional information is needed to further

examine the child life specialist's role in advocating for the patient during the P-SAFE, and the stressors in advocating for the stopping of a P-SAFE to prevent re-traumatization of the patient. Future research is needed to examine other health care professionals, such as doctors, nurse examiners, social workers, and the patient and family about their views of the child life specialist's role in P-SAFEs.

Conclusion

With increased understanding in trauma-informed care and how to engage with and provide interventions for children and families who have experienced trauma, the role of the child life specialist continues to evolve in many areas of clinical practice. This study examined the evolving role of the child life professional in the P-SAFE population. With growing opportunities to move the child life profession to a more research-centered place, this study adds to the current literature and provides implications for the training of and roles of child life specialists in P-SAFEs and recommendations for future research.

References

Alcock, D., Goodman, J., Feldman, W., McGrath, P., Park, M., & Cappelli, M. (1985). Environment and waiting behaviors in emergency waiting areas. *Children's Health Care*, *13*(4), 174–180.

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency volunteer and paid staff. *Violence and Victims*, *18*, 71-86.

Bartik, K., & Toruner, E. (2017). Effectiveness of a preoperative preparation program on children's emotional states and parental anxiety. *Journal of Peri-Anesthesia Nursing*, *24*(12), 1217-1223.

Berenson, A. B., Wiemann, C. M., & Rickert, V. I. (1998). Use of video eyeglasses to decrease anxiety among children undergoing genital examinations. *American Journal of Obstetrics and Gynecology*, *178*(6), 1341-1345. https://doi.org/10.1016/S0002-9378(98)70341-2.

Berson, N. L., Herman-Giddens, M. E., & Frothingham, T. E. (1993). Children's perceptions of genital examinations during sexual abuse evaluations. *Child Welfare*, *72*(1), 41-49.

Boles, J., Fraser, C., Bennett, K., Jones, M., Dunbar, J., Woodburn, A., Gill, M. A., Duplechain, A., Munn, E. K., Hoskins, K. (2020). *The Value of Certified Child Life Specialists: Direct and Downstream Optimization of Pediatric Patient and Family Outcomes*. https://www.childlife.org/docs/default-source/the-child-life-profession/value-of-cclss-executive-summary.pdf?sfvrsn=61238d4d_2.

Brewer, S., Gleditsch, S. L., Syblik, D., Tietjens, M. E., & Vacik, H. W. (2006). Pediatric anxiety: Child life intervention in day surgery. *Journal of Pediatric Nursing*, *21*(1), 13-22. https://doi.org/10.1016/j.pedn.2005.06.004.

Bride, B. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work*, *25*(1), 63-70.

Brown, N., David, M., Cuttle, L., Kimble, R., Rodger, S., & Higashi, H. (2015). Cost-effectiveness of a nonpharmacological intervention in pediatric burn care. *Value in Health*, 18-631-637.

Burns-Nader, S., Atencio, S., & Chavez, M. (2016). Computer tablet distraction in children receiving an injection. *Pain Medicine*, *17*, 590-595. https://doi.org/10.1111/pme.12877.

Burns-Nader, S. & Hernandez-Reif, M. (2016). Facilitating play for hospitalized children through child life services. *Children's Health Care*, *45*(1), 1-21. https://doi.org/10.1080/02739615.2014.948161.

Burns-Nader, S., Joe, L., & Pinion, K. (2017). Computer tablet distraction reduces pain and anxiety in pediatric burn patients undergoing hydrotherapy: A randomized trial. *Burns*, *43*(6), 1203-1211, https://doi.org/ 10.1016/j.burns.2017.02.015.

Cassell, S. (1965). Effect of brief puppet therapy upon the emotional responses of children undergoing cardiac catheterization. *Journal of Consulting Psychology*, *29*(1), 1-8. https://doi.org/10.1037/h0021670

Chambers, C., Taddio, A., Uman, L., McCurtry, C., & HELPinKIDS Team. (2009). Psychological interventions for reducing pain and distress during routine childhood immunizations: A systemic review. *Clinical Therapy*, *31* (Supple 2), S77-S103.

Children's Mercy Hospital. (2015). *Acute Sexual Assault Algorithm*. Children's Mercy Hospital.

Cole, W., Diener, M., Wright, C., & Gaynard, L. (2001). Health care professionals' perceptions of child life specialists. *Children's Health Care*, *30*(1), 1–15.

Commission for Forensic Nursing Certification. (2019). *Commission for forensic nursing certification*. https://www.fornsicnursing.org.

Diener, M., Lofgren, A., Isabella, R., Magana, S., Choi, C., & Gourley, C. (2018). Children's distress during intravenous placement: The role of child life specialists. *Children's Health Care*, *48*(1), 1-17. https://doi.org/10.1080/02739615.2018.1492410

Fereday, J., & Darbyshire, P. (2008). Making the wait easier: Evaluating the role of supervised play in a surgical admission area. *Neonatal, Pediatric, and Child Health Nursing*, *11*(1), 4-9.

Gaynard, L. L. (1985). *Child life specialists as perceived by health care specialists* (Doctoral dissertation, University of Pennsylvania). ProQuest Dissertations and Theses database. (UMI No. AAI8523416).

Glasser, B. G. (1965). The constant comparative method of qualitative analysis. *Social Problems*, *12*, 436-445.

Gulla, K., Fenheim, G. E., Myhre, A. K., & Lydersen, S. (2007). Non-abused preschool children's perception of an anogenital examination. *Child Abuse & Neglect*, *31*(8), 885- 894. https://doi.org/10.1016/j.chiabu.2007.03.017.

Gursky, B., Kestler, L. P., & Lewis, M. (2010). Psychosocial intervention on procedure-related distress in children being treated for laceration repair. *Journal of Developmental*

and Behavioral Pediatrics, *31*(3), 217-222. https://doi.org/10.1097/DBP.0b013e3181d5a33f.

Hall, J., Patel, D., Thomas, J., Richards, C., Rogers, P., & Pruitt, C. (2018). Certified Child Life Specialists lessen emotional distress of children undergoing laceration repair in the emergency department. *Pediatric Emergency Care*, *34*(9), 603-606.

Hyland, E. J., D'Cruz, R., Harvey, J. G., Moir, J., Parkinson, C., & Holland, A. J. A. (2015). An assessment of early child life therapy pain and anxiety management: A prospective randomized controlled trial. *Burns*, *41*(8), 1642-1652. https://doi.org/10.1016/j.burns.2015.05.017

Kaminski, M., Pellino, T., & Wish, J. (2010). Play and pets: The physical and emotional impact of child-life and pet therapy on hospitalized children. *Children's Health Care*, *31*(4), 321-335. https://doi.org/10.1207/S15326888CHC314_5.

Lahoti, SL., McCain, N., Girardet, R., McNeese, M., & Cheung, K. (2001). Evaluating the child for sexual abuse. *American Family Physician*, *63*(5), 883-92.

LeBlanc, C. K., Naugler, K., Morrison, K., Parker, J. A., & Chambers, C. T. (2014). Parent perceptions and satisfaction with inpatient child life specialist interventions and the role of child temperament. *Children's Health Care*, *43*(3), 253-272. https://doi.org/10.1080/02739615.2013.845732.

Li, H. C. W. & Lopez, V. (2008). Effectiveness and appropriateness of therapeutic play intervention in preparing children for surgery: A randomized controlled trial study. *Journal for Specialists in Pediatric Nursing*, *13*(2), 63-73. https://doi.org/10.1111/j.1744-6155.2008.00138.x.

Lookabaugh, S. & Ballard, S. (2018). The scope and future direction of child life. *Journal of Child and Family Studies*, *27*(6), 1-11. https://doi.org/10.1007/s10826-018-1031-6.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, *52*, 397-422.

Meadors, P., & Lamson, A. (2008). Compassion fatigue and secondary traumatization: Provider self-care on intensive care units for children. *Journal of Pediatric Health Care*, *22*(1), 24-34.

Moore, E., Bennett, K., Dietrich, M. S., & Wells, N.(2015). The effect of directed medical play on young children's pain and distress during burn wound care. *Journal of Pediatric Health Care*, *29*(3), 265-273. https://doi.org/10.1016/j.pedhc.2014.12.006

Newell, J. M. & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health*, *6*(2), 57-68.

Rheingold, A. A., Davidson, T. M., Resnick, H., Self-Brown, S., & Danielson, C. K. (2013). The relationship between knowledge and child and caregiver distress during the medical examination for child sexual abuse. *Journal of Child Sexual Abuse*, *22*(5), 552-571. https://doi.org/10.1080/10538712.2013.800937.

Rheingold, A., Danielson, C., Davidson, T., Self-Brown, S., & Resnick, H. (2013). Video intervention for child and caregiver distress related to the child sexual abuse medical examination: A randomized controlled pilot study. *Journal of Child and Family Studies*, *22*(3), 386-397. https://doi.org/10.1007/s10826-012-9591-3.

Romito, B., Jewell, J., Jackson, M., AAP Committee on Hospital Care, & Association of Child Life Professionals. (2021). Child life Services. *Pediatrics*, *147*(1). https://doi.org/10.1542/peds.2020-040261

Scott, M., Todd, K., Oakley, H., Bradley, J., Rotondo, R., Morris, C., Klein, S., Mendenhall, N., Indelicato, D. (2016). Reducing anesthesia and health care costs through utilization of child life specialists in pediatric radiation oncology. *International Journal of Radiation Oncology*, *96*(2), 401-405.

Sinha, M., Christopher, N. C., Fenn, R., & Reeves, L. (2006). Evaluation of nonpharmacologic methods of pain and anxiety management for laceration repair in the pediatric emergency department. *Pediatrics*, *117*(4),1162-1168. https://doi.org/10.1542/peds/2005-1100.

Stevenson, M., Bivins, C., O'Brien, K., & Gonzalez del Rey, J. A. (2005). Child life intervention during angiocatheter insertion in the pediatric emergency department. *Pediatric Emergency Care*, *21*(11), 712-718. https://doi.org/10.1097/01.pec.000186423.84764.5a.

Tener, D., Lang-Franco, N., Ofir, S., & Lev-Wiesel, R. (2012). The use of medical clowns as a psychological distress buffer during anogenital examination of sexually abused children. *Journal of Loss and Trauma*, *17*(1), 12-22. https://doi.org/10.1080/15325024.2011.578025.

Townsend, C., & Rheingold, A. (2013). *Estimating a child sexual abuse prevalence rate for practitioners: A review of child sexual abuse prevalence studies*. https://www.D2L.org.

Tyson, M. E., Bohl, D. D., & Blickman, J. G. (2014). A randomized controlled trial: Child life services in pediatric imaging. *Pediatric Radiology*, *44*(11), 1426-1432.

U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). *Child Maltreatment 2016*. https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf.

U.S. Department of Justice Office on Violence against Women (2016). *A National Protocol for Sexual Abuse Medical Forensic Examinations Pediatric*. https://www.justice.gov/ovw/file/846856/download.

Van Mol, M. M., Kompanje, E. J., Benoit, D. D., Bakker, J., & Nijkamp, M. D. (2015). The prevalence of compassion fatigue and burnout among healthcare professionals in intensive care units: A systematic review. *PLOS ONE*, *10*(8), e0136955.