HOSPITALIZED SCHOOL-AGE CHILDREN: PSYCHOSOCIAL ISSUES
AND USE OF A LIVE, CLOSED-CIRCUIT TELEVISION PROGRAM

THESIS

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By

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This descriptive study utilized semi-structured interviews and observations to examine the experiences of hospitalized school-age children, and explore the potential of a live, closed-circuit television program as a psychosocial intervention. Among findings, Phase I data from 16 subjects indicates a) concern with painful medical procedures, particularly intravenous (IV) injections, b) a desire for more information, especially concerning medical equipment, c) a variety of responses to social issues among subjects, d) the importance of activities, and e) the central role of the hospital playroom. Phase II data indicates that live, closed-circuit television can provide ambulatory and room-bound children opportunities for making choices, social interaction, participation, and information on their environment. Conclusions and implications are included.
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CHAPTER I

INTRODUCTION

Statement of the Problem

What is the experience of school-age hospitalized children, and can a live closed-circuit television program help meet some of their age-specific psychosocial needs?

Purpose of the Study

The purpose of this study was to describe the experiences of school-age hospitalized children from a developmental perspective and to explore the psychosocial potential of closed-circuit television with these children. Phase I was designed to examine the special needs and concerns of school-age hospitalized children, and what activities they believe are helpful. Phase II examined the use of a live television program to provide children with opportunities for social interaction, information on the hospital environment, and opportunities for mastery.

Specifically, the study used 25 children between the ages of 7 and 11 years of age, all inpatients at a large pediatric hospital at the time of the study. Interviews, observations and reviews of documents were utilized to extract data concerning the experience of this group of hospitalized school-age children and the process and effectiveness of implementing a live closed-circuit television program to help meet their psychosocial needs.

Research Questions

Phase I of the study addressed the following research questions:

1. What experiences or activities will these hospitalized school-age children report as being positive and helpful?
2. What aspects of their experience cause great concern for these hospitalized school-age children?

3. What is the social experience of these school-age children in the hospital?

4. Will these hospitalized school-age children report a desire for information concerning the people, places, and things at the hospital?

5. What experiences will these hospitalized school-age children report as making them feel good or important?

Phase II of the study examined the following research questions:

6. Can a live closed-circuit television program provide opportunities for social interaction and peer modeling?

7. Can a live closed-circuit television program provide opportunities for participation, making choices, and self-worth?

8. Can a live closed-circuit television program be an effective tool for providing information about the hospital environment?

Background of the Study

Since studies in the 1950s began to document detrimental psychological and social effects of hospitalization, researchers have sought to learn which children are most vulnerable and what potential dangers exist. Others have concentrated on developing therapeutic programs and activities to lessen the stress, anxiety, and social isolation caused by hospitalization.

Toward these goals, many have worked within a developmental framework. Developmental theory attempts to describe changes in human needs, abilities, and perception over time. Jean Piaget and Erik Erikson, two of the most important figures in developmental work, describe these changes as a series of stages, each with its own set of characteristics. The most influential work of Piaget describes the cognitive development of
children from what he terms the sensory-motor period (birth to age 2) to the stage of formal operations (adolescence). Each stage brings new cognitive abilities and new challenges. Erikson's focus was on the life span of social development, each age group with its unique needs and characteristics.

Application of this developmental approach to hospitalization has led to a better understanding of how children experience hospitalization. Age differences have been found in perceptions of illness and reactions to hospitalization (Banks, 1990; Bibace, 1980; Brewster, 1982; Mabe 1991). In addition to providing a framework for understanding hospitalized children, awareness of age-related differences allows targeting a particular age-group of children when designing a therapeutic program or activity. Quantitative and observational data have shown that age-appropriate activities, such as supervised play for pre-schoolers and peer support for teens, help minimize negative psychosocial effects of hospitalization. What works for one age-group may not be as successful for another.

For these reasons, health-care professionals should take developmental differences into account when children are involved (Banks, 1990; Bibace, 1980; Bloome, 1987; Murray, 1979; Yoos, 1988; Hurley, 88; Brewster, 1982). By understanding age-specific abilities, concerns, or feelings, one can best assess and develop programs to meet the psychosocial needs of hospitalized children.

While a good deal of research has dealt with young children's reactions to hospitalization, less attention has been paid to school-age patients. This may be due, in part, to their high resiliency and the assumption that this age group can and will voice their concerns. Although school-age hospitalized children have been shown to be less adversely affected than younger children, programs that will provide opportunities for developmental growth and psychosocial assistance are needed. While personal, individualized care is the preferred form of care, a program that seems to have great potential as an effective, cost-efficient and popular intervention for these children is closed-circuit television.
The power and potential of television in children's lives, concern over extreme amounts of viewing by hospitalized children, and increasing affordability of equipment have led to increased use of closed-circuit television programming in children's hospitals. In these institutions, videotaped or live broadcasting is sent to rooms on the hospital's own station, allowing staff to show live or videotaped programs for entertainment or therapeutic reasons.

Since the first such programming was telecast in Minneapolis in 1978 (Johnson, 1981), a large number of hospitals have invested in the equipment, and several published articles attest to the benefits and success of this capability. Live programming is reported to have particular appeal and potential as a therapeutic tool. Interactive programs allow the audience to participate either at the telecast site or via telephone from their rooms. Health-care workers producing such programs report that segments such as interviews with patients and staff, call-in game shows, and educational programs are popular with hospitalized children. Closed-circuit television, especially interactive, live programming, has great appeal in the hospital, and may be utilized to meet some unfulfilled needs of hospitalized children.

Need for the Study

There is a need for descriptive studies of what children experience during hospitalization. Broome (1987) writes that assumptions are made about these children, supported by little "empirical data obtained from children themselves about their concerns and fears".

A 1992 Association for the Care of Children's Health Research Committee concluded that descriptive studies are needed when considering developmental issues, or how participants understand what is happening to them (Association for the Care of Children's Health [ACCH], 1992). They call for descriptive methodologies, and simple basic
research questions, as opposed to "rigorous evaluation studies" that call for randomization of subjects to treatment conditions (p. 122). Others have cited a need for descriptive and qualitative studies to help define the hospital experience from the patient's own perspective, rather than that of the experimenter or child's caregiver (Pass, 1987; Lambert, 1984).

Few studies have examined the school-age population exclusively (McLowry, 1990). Needs of these children may be overlooked because of their assumed ability to verbalize concerns (May, 1983). Information on age-specific reactions to hospitalization is necessary to plan developmentally appropriate interventions and to help assess how individual children are coping.

Documentation of the effectiveness of different psychosocial programs is needed as well. Research is needed to help determine which interventions and activities work, and this documentation is necessary to procure resources in the competitive health-care market (Skalko, 1984).

Finally, hospital staff utilizing audio-visual media agree that more work is needed to support its effective use in the hospital (Crocker, 1988). The current study both gives information on what activities children feel are helpful and assesses the potential of a live closed-circuit television program.

Assumptions

The researcher assumes that children are able to report their experiences in interviews. It is also assumed that those things children report as enjoying in the hospital are beneficial to the child. Finally, the study assumes that school-age children can learn through both active participation and watching television.
Delimitations

Potential participants, ages 7-11, were all inpatients at the hospital with no known developmental delay. No attempt was made to control for diagnosis and previous hospital experience.

This was an exploratory study. The interviews were designed by the researcher based on theory rather than previous data. Future research in this same setting could help confirm the findings.

Limitations

Because data was collected primarily through interviews and observations, subject and researcher bias are considerations. The children could have been trying to provide the correct answers. Their responses also may have been affected by preconceptions about the hospital experience. Although precautions were taken to avoid researcher bias, the possibility cannot be eliminated in a study of this type.

Finally, because of the descriptive nature of this study, generalizability of the data is a limitation. The participants in this study are all inpatients at the same hospital. Also, only children referred by the child life staff were included in the study. These referrals were made not only on the child’s availability, but on the appropriateness of participating due to medical or emotional reasons. A child, for example, recovering from a particularly uncomfortable procedure may have been excluded from the list. Therefore, this group of subjects may not be representative of the whole population. Conclusions should be treated as tentative explanations in this particular setting. The study would need to be reproduced with school-age children in a number of different hospital settings before generalizations could be made. The purpose of the television program was to contribute to an understanding of its potential as a psychosocial intervention. It is not intended to provide an ideal program model.
Definition of Terms

For this study, these terms will be defined as follows:

A school-age child is a boy or girl who's age ranges from 7 to 11, with no known developmental disability.

Closed-circuit television is an in-house system for televising video tapes and live television programming.

Developmentally appropriate means consistent with the level of cognitive, physical, and emotional ability and taking into consideration characteristic beliefs or concerns of an age-group of children.

An interactive television program is a program in which the viewer can participate by use of telephone or other method.

An intervention is an activity or program provided to meet a specific goal or goals. These may be directed to external or environmental factors, or to influencing the child and family's perceptions of the stressful experience (Francis, 1990).

Potential participant refers to any child who was asked to participate in the current study. These were all children between 7-11 years of age, inpatients at the hospital, and referred by the child life staff.

Research Design

The qualitative research approach was selected for several reasons. The goal was to gather information from the child's perspective rather than experimenter perspective. Qualitative methodology allows the experimenter to enter the subject's world through observations and interviews.

In hospital research, controlling for variance in diagnosis and previous hospital experience is extremely difficult. The validity of qualitative methodology does not rely on similarities between subjects.
Research has found individual differences in coping styles of hospitalized children. Qualitative research allows for these individual differences. The qualitative approach also allows the researcher to gather more detailed information than quantitative methodology.

Procedure

Data consisted of transcripts of interviews, field notes, and analysis of videotapes of the television programs in order to triangulate the data. Triangulation refers to the use of multiple data techniques, allowing the researcher to understand better and cross-validate findings (Bernheimer, 1986).

The data collection took place in two parts: Phase I, designed to gather information on the experience of school-age hospitalized children, and Phase II, implementation of a series of four live, closed-circuit television programs. Phase I data collection included audio taped interviews and observations. Open-ended structured interviews were the primary research tool for this study. They were designed and conducted by the researcher. Questions focused on what the subject liked and disliked about the hospital, and opportunities for peer interaction, learning about the hospital, and mastery. Field notes were written and audio recorded by the researcher during data collection visits to the hospital. Observations included the researcher's descriptions and perceptions of events, ideas and questions. Responses to each question and relevant field notes are presented in tables and narrative form in Chapter 4.

The second phase involved the implementation of a series of closed-circuit television programs. The entire patient population was welcome to participate in the program either in person or via television and telephone. Nine participants were interviewed following the program.

Data collection in this phase included a second structured interview, observations, and analysis of program video tapes. The open-ended structured interview was designed by the
researcher to gather information on the program's effectiveness in meeting its social, informative and mastery goals. Because the researcher hosted the show, this interview was administered by an assistant to guard against bias. As in Phase I, written and recorded field-notes were taken. Video tapes of the four programs were analyzed to construct a detailed outline of events occurring on the program. This allowed collection of data such as how many calls were received, who called, what types of participation took place, and what questions were asked. The researcher then combined the data obtained through interviews, observations, and analysis of the video tapes into the narrative form presented in Chapter 4.
CHAPTER II

REVIEW OF RELATED LITERATURE

The review of literature examines the psychosocial impact of hospitalization on children, and what programs or "interventions" have been successful with these children. Developmental theory and its application in research is described. Literature on the hospitalized school-age population is presented, particularly concerning three often-cited needs of these children: a) social interaction, b) information, and c) opportunities for mastery. Finally, the use of audio-visual media and closed-circuit television with hospitalized children is examined.

Psychosocial Issues in Hospitalization

According to the 1981 National Center for Health Statistics, approximately 6% of all children under 18 years of age are hospitalized at least once during a given year (Ack, 1983). Of those hospitalized, the average number of days in the hospital is 5.8 days. According to another source, one third of children in the United States will be hospitalized at least once prior to adulthood (Visintainer & Wolfer, 1975). As Ack points out hospitalization is an experience that a great many children will face at some point.

Authors have long expressed concern over the emotional effects of such experiences. In a 1936 article, Beverly (1936) argued that even brief hospitalization can interfere with normal emotional development. In the 1950s, a number of research studies supported reports of adverse reactions to hospitalization (see Vernon, 1965; Thompson, 1985 for review). Among reactions to hospitalization were apathy (Jessner, 1952), aggression (Jenson, 1955), panic and screaming (Prugh, 1953), and regression (Chapman, 1956).
Since these early studies, research has continued to find short- and long-term effects of hospitalization. For example, Riffee (1981) found lower self-esteem in a group of hospitalized children than a control group. In a study of long-term effects of hospitalization, Douglas (1975) followed-up on more than 1,000 children after their release from the hospital. He found problems in a number of areas, including reading difficulties and behavioral problems.

In addition to emotional and behavioral problems, research has shown that children often have misconceptions regarding hospitalization that may lead to stress (see Peters, 1978 for review). For example, Brewster (1982) conducted interviews with hospitalized children to gain information on their concepts of illness. All 5- and 6-year-old children in the study reported that medical procedures were done as punishment.

These and other studies are largely responsible for changes in hospital procedures over the past 20 years (Peterson, 1988). Child-centered wards, encouragement of visitation and rooming-in, and a variety of psychosocial interventions and programs have become common in children's health care.

Simple changes in policy have been effective in improving reactions to hospitalization. For example, an inservice to nurses describing the concerns of hospitalized children resulted in a reduction of the patient's primary concerns (May, 1983).

Much work has attempted to develop and implement activities, experiences and programs to meet psychosocial needs of hospitalized children. In an early program directed toward parents, an experimental group of caregivers was provided information and emotional support during the child's hospitalization. These children had less severe reactions compared with a control group of hospitalized children on physiological measures and observational reports of staff and parents (Skipper, 1968).

Participation in special activities has also been effective. Books and films have been helpful in preparing children for surgery (Peterson, 1988). Case studies attest to the value
of creative arts in helping children cope with body-image issues (Cameron, 1984). Among activities that appear to be helpful but lack empirical evidence are making autobiographical scrapbooks (Romero, 1986), use of puppets (Ramsey, 1988), and play (Fosson, 1990).

In 1975, a study was designed to test the effectiveness of systematic psychological preparation and supportive care during the hospital stay. This intervention consisted of information about upcoming events, information on how to respond, previews of procedures through play techniques, and ongoing support. Children in this treatment group were less upset, more cooperative, and had more optimum pulse rates before and after painful procedures, among findings (Wolfer, 1975).

Designed specifically to meet the psychosocial and developmental needs of hospitalized children, a "child life" program has been shown to have a positive impact on these children. Child life departments are found at a number of North American and Canadian pediatric and general hospitals. In 1988, Children's Health Care published results of an ambitious research project to test the effectiveness of such a program (Wolfer, 1988). For 8 months, control group data was collected on a number of measures. A child life program was then implemented and tested during a 16-month period. This program provided a variety of therapeutic experiences, including social and therapeutic play, preparation for medical procedures, special entertainment, and individual care based on assessment. Children in the experimental group scored significantly higher in the following areas: (a) emotional distress during procedures, (b) coping effectiveness during procedures, (c) pulse before and after procedures, (d) overall coping-adjustment rating, (e) understanding of reason for hospitalization, (f) understanding of procedures, (g) surgical recovery (e.g., number of days, number of analgesics), (h) post-hospital adjustment (scale), (i) degree of parents participation, (j) parental self-reports of tension or anxiety, and (k) post-hospital recovery parental ratings.
While numerous studies have documented detrimental effects of hospitalization on children, at least some of these problems can be minimized through a variety of experiences, activities and programs within the hospital.

Developmental Issues and Hospitalization

Many health-care workers cite a need to consider developmental issues when seeking to understand or care for children in the hospital. Understanding normative (usual) development enables one to assess an individual child (Francis, 1988). In addition, studies have found developmentally-specific reactions to and perceptions of the hospital experience. This knowledge can be used to best design programs for specific age-groups of children.

Work of Jean Piaget (1896-1980) is at the heart of developmental theory. He identified four cognitive stages of children. These stages are a part of a continuous process, each building upon, then graduating to another. While there may be some individual differences in the rate individual children pass through these stages, all children follow identical paths. It may be helpful to review each stage according to Piaget:

**Sensory-motor (0-2 years).** Child begins to recognize the permanency of objects outside his own perception.

**Preoperational (2-7 years).** Symbolic functioning appears. Child is able to represent one thing with another. Not yet able to think logically, consider another's viewpoint or follow an action backward mentally from effect to cause.

**Concrete operations (7-11 years).** Child is capable of concrete logical thinking (thinking dealing with physical objects). Now has reversibility of thought, and able to think about things that are not physically present, based on images of past experiences. Child is now able to differentiate between self and others, consider another viewpoint.
**Formal operations (11-15 years).** Child is able to think abstractly, beyond concrete reality.

The work of Piaget has been the basis for studies of children's concepts of illness. Based on his interviews with children, Bibace (1980) identified six developmentally ordered categories of explanation of illness. These are consistent with Piaget's major stages of cognitive development. **Prelogical explanations** include explanations of phenomenism (e.g., "the sun gives you colds") and contagion (e.g., "someone gets close and you get a cold"). **Concrete explanations** include contamination (e.g., "you get it when you go outside") and internalization (e.g., "you get a cold in you"). **Formal explanations** include physiological explanations (e.g., "your sinus gets filled up with mucus") and psychophysiologic (e.g., "worrying too much can hurt your heart"). Bibace concludes that more effective health care and health education can result from understanding developmental differences.

Similar findings of age-specific concepts of illness were reported by Brewster (1982). Three conceptual stages were identified through interviews with hospitalized children. As in Bibace's study, these stages are said to coincide with Piaget's stages of cognitive development. Brewster concludes that medical staff must understand and address this cognitive sequence. This call for health-care workers to take cognitive and psychological developmental differences into account is repeated by others studying concepts of illness (Banks, 1990; Bloome, 1989).

Also found to vary between age groups is children's perception of pain. Interviewing children from first through eighth grades, Hurley (1988) found a correspondence between Piagetian stages and children's perception of pain. Among findings, preoperational children often thought in magical and egocentric terms, often holding someone or something accountable for pain (e.g., "the sun made it hurt"). Concrete-operational children related very physically to pain, often with fear of bodily harm or destruction.
Hurley reports adolescent views toward pain as similar to adults, though somewhat immature because of a lack of life experience. Hurley concludes that nurses must be aware of the developmental stages and behaviors. Misunderstanding, he says, can result in frustration, increased anxiety, and impaired learning.

Studies such as these show the importance of using a developmental approach when working with hospitalized children. Unfortunately, health-care staff do not always do so (Perrin, 1983).

School-Age Children and Hospitalization

School-age children, in the Piagetian stage of concrete operations, are now able to focus simultaneously on several dimensions of a situation, are sensitive to transformations, and can reverse direction of their thinking. They can clearly differentiate between themselves and others and have developed the ability to distinguish internal and external phenomenon. They can begin to appreciate cause and effect relationships.

Therefore, they now can distinguish between the cause of the illness and the outcome of the illness. Until this time they are only able to explain things in immediate terms (e.g., "a heart attack is falling on your back"). Now they can understand that doing something can cause something. The cause of illness is most often viewed as a person, object or action external to the child that is harmful to the body (Yoos, 1988). Along with their cognitive advances comes an increased awareness of body function and subsequent fear of bodily harm and body destruction (Hurley, 1988).

There is evidence that school-age children are not as susceptible to negative effects of hospital as younger children. McCowry (1990) found no significant change in behavior of school-age children following hospitalization. A study by Saylor (1987) looked at the effect of medical procedures and illness events on reactions to hospitalization. Scores on anxiety scales, as well as parental ratings of children, suggested "that the hospitalized
children were experiencing no greater distress than that noted for children in the general population" (p. 167). Younger children did not fare so well. In a partial replication, Mabe (1991) again found no greater levels of depression or anxiety among hospitalized school-age children than those in the general public.

Although a body of research attests to the resiliency of school-age children, several authors cite concerns these children may be misunderstood and overlooked. Mabe (1991) suggests that denial may be taking place in school-age children's self reports of anxiety and depression. Peters (1978) writes that school-age children are particularly vulnerable to misunderstanding due to over-estimation of their capabilities by hospital staff. Other authors agree that it may be taken for granted that school-age children can and will verbalize needs (May, 1983; Lambert, 1984).

School-age children often have misconceptions about illness which can lead to psychological stress. A belief that they are being punished is common, as are feelings of rejection, insecurity, and hostility (Peters 1978).

The hospitalized school-age group may be at risk for lowered self-esteem. Riffee (1980) found changes in self-esteem among hospitalized school-age children. The drop was caused in large part by changes in the peer/social subscale within the self-esteem test. This finding raises questions about potential peer contacts in the hospital.

Social and peer issues are considered extremely important in normative psychosocial development of school-age children. According to Piagetian theory, these children have gained the ability to consider a viewpoint other than their own. For Erikson, social issues are central ones for the school-age child.

So, while the school-age group appears more resilient to hospitalization than younger children on some measures, including anxiety and long-term behavior after hospitalization, they appear to have age-specific perceptions, needs, and concerns. The health-care
community needs to address both normative (Green, 1983), and special needs stemming from developmental characteristics.

In literature addressing needs of hospitalized school-age children from a developmental perspective, many authors cite one or more of the following: (a) opportunities for peer socialization, (b) information about their illness and the hospital environment, and (c) support to increase mastery. While these needs are not unique to school-age children, they are considered especially important for these children, based on developmental theory and research. However, a limited amount of research has examined hospitalized children specifically, and even less utilizes methodology that gathers data from the child's perspective rather than from that of the experimenter, caregiver, or staff (Broome, 1987; McLowry 1990).

Peer socialization

Peer interactions and friendships play a fundamental role in the development of children, contributing to social and problem-solving skills. As children enter the school years, their relationships move from egocentric interactions to more mature relationships (Furman, 1982). Through these interactions, positive self-concept is developed, leading to self-esteem (Winkelstein, 1989).

Peer contact is disrupted in the hospital (May, 1983; Lambert 1984). For school-age children, socialization is an important issue, and this change could have developmental and psychosocial consequences. School-age children often fear being different than their peers, and isolation and body changes occurring in the hospital may have a particularly debilitating effect on these children (Romero, 1986; Green, 1983).

Research by Riffee (1981) supports these comments. In this study, children hospitalized for surgery and non-surgery patients, ages 9 through 12 years, were administered a self-esteem inventory on the day of admission and again one month later. This measure (Coopersmith Self-Esteem Inventory [SEI]) contains four subscale measures.
Scores of the surgery group dropped significantly lower than non-surgery and non-hospitalized children. In addition, on the subscale dealing with peer group acceptance and interaction, the surgical group dropped more than non-surgical and non-hospitalized children. Combined scores of the two hospitalized groups dropped more than the control group of non-hospitalized children.

To protect against this type of reaction, Riffee suggests alternate forms of play, activities, education and competition in the hospital to prevent isolation. Others call for hospital staff to promote the child's contact with existing friends (Winkelstein, 1989), to promote new peer relationships in the hospital (Chadwich, 1978), and to promote group interaction (Winkelstein, 1989).

Information

Information concerning the equipment, personnel and procedures in the hospital is often cited as a need of hospitalized school-age children. Wilson (1989) writes that clear depictions of things encountered at the hospital are needed by these children.

Children in the Piagetian stage of concrete-operational thinking (7-11 years) are able to focus on several dimensions of a situation at once. They can logically follow an event back to its cause. They are receptive to health teaching and strive to learn process.

A new cognitive awareness of body function leads to a desire to learn more, but can also lead to new fears. School-age children often have a fear of anesthesia (Ack, 1983), death and disfigurement (Wilson, 1989).

Allowing these children to explain and clarify their perceptions may be helpful (Clough, 1979). They should be encouraged to ask questions, and staff should help them sort out misinformation (Yoos, 1988). Factual information on the purpose and process involved in particular procedures may decrease anxiety (Broome, 1987). Information on reacting and dealing with medical experiences may also be helpful. Because school-age children's chief
modes of learning are psychomotor and visual, participation and use of models, drawings, or diagrams may be most effective.

In a 1968 study, one group of school-age patients received tutoring about the illness while another group engaged in group psychosocial-therapeutic meetings. Less anxiety and increased knowledge of their illness were found in both groups when compared to a control group receiving no treatment.

However, some authors have expressed concerns about presenting information to hospitalized children. Brewster (1982) argues that what we call misconceptions may be defense mechanisms. No child, in his opinion, should be forced onto a higher level of comprehension. He questions the assumption that medical staff need to correct the child's "distorted ideas" unless one is confident the child is prepared for the alternative. More research is needed into the importance and role of information in children's hospitalization.

**Mastery**

Often cited as needs of hospitalized school-age children are opportunities for mastery of the hospital experience. Francis (1990) describes mastery as positive coping with stress and as the ability for positive adaptation to changes in the environment. Experiences that support positive adaptive patterns lead to mastery. Referring to an early study by Visotosky (1961) of polio patients, Francis writes that among effective coping patterns may be: (a) keeping distress within manageable limits, (b) generating encouragement and hope, (c) maintaining or restoring a sense of personal worth, (d) maintaining or restoring relations with significant others, (e) enhancing prospects for physical recovery, and (f) enhancing prospects for favorable situations after physical recovery.

Opportunities for self-expression and control over the environment may help children adapt to hospitalization and maintain a sense of worth. Cheifetz (1976) considers power a developmental need for all children. To experience having an impact on the world, making
a difference is important for the child. Children, he writes, must develop the ability to make independent decisions, to be assertive and feel capable of creating.

Because chances for self-expression may be limited in the hospital (May, 1983), healthcare-workers should provide such opportunities (Romero, 1986; Green, 1983). Expressing feelings may help maintain a sense of personal worth, and keep distress manageable, facilitating adaptation to the hospital environment. Self-expression may also help combat a loss of control (Goldstein, 1982).

School-age children are reported to have a need to maintain control (Lambert, 1984). Increases in cognitive development bring a sense of personal control. This need to play an active role in the environment may be particularly important for school-age hospitalized children who have been forced to give up much control (Bibace, 1980). Developing skills (Romero, 1986), making choices, and taking part in the hospital experience (Hurley, 1988; May, 1983) may help foster self control. According to Erikson (1964), school-related achievement is essential for children to maintain self-esteem. Hospitalized children need similar opportunities.

Because of the strong need for control, limit setting, rules and regulations are important for school-age children (Ack, 1983). Green (1983) writes that these children may be less anxious when they understand what is expected of them in the hospital.

Audio-Visual Media and the Hospitalized Child

There is evidence that television viewing can have detrimental effects on children. However, there is also evidence that when used correctly, television programming can be a successful therapeutic tool.

Crocker (1989) writes that television may be harmful and detrimental to the total concept of good health, especially in the hospital. In contrast, others believe that because children
are accustomed to television, its presence in the hospital provides an important normalizing link for children (Elsner, 1989).

A 1981 survey at a large children's hospital indicated that despite an active psychosocial program, patients were watching a great deal of commercial television, most of which was directed at an adult audience (Guttentag, 1981). Another study found that hospitalized school-aged and adolescent children spent 50.6% of their daytime hours watching television (Bordeaux, 1986). The majority of programs viewed were adult-oriented dramas or soap operas.

Guttentag (1989) points out that commercial television may alleviate boredom and help fight anxiety, but may have a negative side as well. He writes, "unfortunately, the same features that make television a mixed blessing in the home may be magnified in the hospital environment, where the audience is much more captive, emotionally aroused, and often viewing in isolation from others" (p. 7).

As audio-visual equipment has become less expensive and more accessible, health educators and workers have begun to explore its power and potential. A survey of children's hospitals conducted between 1983 and 1985 found that almost all hospitals used some form of alternative media, including film, video games, videotape, records and audiotapes (Gaffney, 1988). This study also found a consensus among pediatric professionals that there is a need for an alternative to commercial television in the hospital.

But audio-visual media use in the hospital need not be a mere diversion from commercial television. Film and video tape has been used to prepare patients for procedures (see Peterson, 1988 for review). Pinto (1989) showed pre-surgical children a video tape depicting a model successfully coping with a medical procedure. Those viewing the video exhibited less arousal (as measured by amount of sweating [Palmer Sweat Index]), less self-reported anxiety prior to the operation, and better ratings on observed
anxiety than those children in the nonviewing control group. This type of study demonstrates the potential benefits of media use in hospitals.

Closed-Circuit Television in the Hospital

An increasingly popular use of media is closed-circuit television. Such programs can either telecast video taped material throughout the hospital, or produce in-house live programming.

A 1983 study examined the effects of implementing such a program (Guttentag, 1983). Programs picked or produced specifically for hospitalized children were telecast on the closed-circuit station for three months. A survey done before and after the station was instituted found an overall increase in television viewing, but a decrease in viewing of commercial television. Children in the 8-11 age-group watched the most television, an average 5.5 hours per day. Of patients total television viewing time, 60% was devoted to the closed-circuit station.

In a staff questionnaire at that hospital, 98% thought the closed-circuit station had a positive effect on the patients, and many workers offered case histories to illustrate their point. Asked the best thing about the hospital, 45% of patients named the television station.

In a more recent study, medical staff using closed-circuit television seemed to agree that it can have therapeutic value, has potential as a tool to communicate with children, to educate, entertain, and relax children and families (Gaffney, 1988). Some are quick to point out that the goal of increasing media use in the hospital is not to replace people, but to provide alternatives (Andrews, 1989; Crocker, 1988). Some consider closed-circuit programming a cost-efficient way to benefit special groups of patients. Programs have been designed for adolescent children and for specific cultural groups (Harris, 1989).
In her book describing possible uses of closed-circuit television with children in the hospital, Gaffney (1988) reports on a number and variety of programs and activities. The author reports that a group media project was successful in facilitating socialization among patients. She also reports that media projects programs resulted in increased awareness of children's feelings, attitudes, and abilities by hospital staff, and at times, provided meaningful information about a child.

Possibly the most popular and beneficial use of closed-circuit television is live programming. In one study, viewing of the in-house station was found to peak during a live program (Guttentag, 1983). Eighty percent of patients watching television were watching the hospital's live program, including 93% of the targeted school-age audience. The personal aspects of the program, such as interviewing patients and showing their possessions, were most popular. Case studies indicate that this program was a valuable tool to reach children, educate, entertain, and boost morale.

Andrews (1989) asserts that live telecast can approximate the excitement of the actual event as the viewer becomes a participant. In addition to involving children in activities, she continues, live television may also be used (a) to prepare children for procedures, (b) as a social network for room-bound patients, (c) as a forum for children to share their hospital experiences, (d) to provide educational opportunities, and (e) for diversionary activities.

Methodology

**Qualitative Research**

Qualitative research has a long tradition in fields of anthropology and sociology and is often used in educational research. While there are a variety of approaches to conducting such research, the general approach is one in which the researcher enters into the setting to explore and construct an understanding of that situation. The following characteristics,
adapted from Borg (1989), describe qualitative research methodology and how it differs from quantitative research.

Qualitative research is carried out in a natural versus controlled environment. The goal is to gain a holistic understanding rather than study a particular aspect of the situation. Humans are the primary data-gathering instrument, most often through observation, interviews and the use of informants.

Qualitative methodology is used. Techniques include structured or unstructured interviews and field notes. While quantitative researchers are primarily concerned with reliability, the ability to reproduce findings, qualitative researchers mainly seek to insure the validity of their findings. One method of doing so is triangulation, the use of more than one method, such as interviews and observations, allowing the researcher to cross check and validate findings (Bernheimer, 1986).

Purposive rather than random sampling is used in qualitative research. This approach allows inclusion of those that may be missed by random sampling or rejected as "outliers" in quantitative research. Qualitative research makes it possible to consider and uncover "multiple realities" relevant to the research question.

The focus of qualitative research is on hypothesis generating versus hypothesis testing. Instead of testing preconceived hypotheses, the researcher studies the data inductively to reveal unanticipated outcomes. Rather than starting out with predetermined notions and proving them true or false, the qualitative researcher begins with tentative assumptions, attempting to develop understanding and draw generalizations as data is gathered. Thus, the theory is grounded in the data.

Subjects play a role in interpreting outcomes. Borg writes "quantitative researchers with behaviorist orientations often overlook the fact that much can be learned from human subjects simply by asking for their perceptions" (p. 386).
Intuitive insights are utilized. Rather than using observable, quantifiable data, the investigator enters the setting and attempts to suspend preconceptions in order to discover the perspective of the subjects. For this reason, the design of the study may shift as the research progresses, according to the evolving insight of the researcher.

The qualitative researcher may present individual case studies. These in-depth descriptions of individual cases can help the researcher gain insight into the larger question while allowing the reader to better understand and judge the researchers conclusions. Ellen (1984) writes that case studies may help one develop general theory because the researcher can appreciate and explore the "interconnections among the actors and events" first hand (p. 240). She maintains that rather than attempting to find a typical case, the researcher will be better served to select a "telling" case, which can "serve to make previously obscure theoretical relationships suddenly apparent" (p. 239).

Use of Qualitative Methodology in Health Care Research

Bernheimer (1986) writes that although quantitative research has been the predominant scientific methodology for much of this century, it cannot provide all the answers in children's health research. "In addition," she writes, "it may not allow them to ask the most relevant questions" (p. 224). Pass (1987) stresses that quantitative methods "do not provide health care professionals with data about children's views of their personal experiences" (p. 214). They too often depend on measures from the point of the researcher, parents or staff. She asserts that previous quantitative studies have provided valuable insight, but may be biased. "Qualitative methodology", she writes, "allows the investigator and the consumer of that research to enter the world of the child and gain some understanding of the child's view of a health care situation in which that child is the protagonist." (Pass, 1987, pp. 214-215).

Research has found individual differences in coping styles between hospitalized children (Caty, 1984; Field, 1988). Whereas quantitative research is designed to get rid of outliers,
qualitative research allows the researcher to explore such "multiple realities" (Borg, 1989). In addition, there are ethical issues regarding doing studies using control and treatment groups in health-care research (ACCH, 1992; Rae, 1986).

Summary of Literature Review

Hospitalization can have a detrimental effect on children. High anxiety levels, lowered self-esteem, and behavioral problems have been shown to result from hospitalization. However, a variety of interventions and programs have been shown effective in improving reactions to hospitalization. Some researchers have examined the general population, while others have targeted particular age-groups.

Age-related differences in concepts of illness, and reactions to hospitalization have been shown. These findings suggest that interventions should be based on developmental differences of children.

As television has become a central and important aspect of children's lives, some have taken advantage of its strong appeal and convenience to provide psychosocial support. There is an increasing interest in creating alternative television options to children in hospitals. Concern about the quality and quantity of commercial television viewing by children is magnified in the hospital, where children may be more vulnerable than the general population.

Through closed-circuit television, health-care workers have been able to provide alternatives that capitalize on the power of the medium to enrich the lives of hospitalized children. Many pediatric and general hospitals have closed-circuit systems already in place, and a small but growing body of literature attests to the potential benefits of in-house programming.
As with other interventions, it is best to target a particular age group when designing a closed-circuit television program. School-age children are a loyal television audience at home and in the hospital. Theory and research suggests that among their needs are a) opportunities for peer socialization, b) information about the hospital environment, and c) opportunities for mastery.

**Opportunities for peer socialization**

Having opportunities for peer socialization is a normative developmental need for school-age children, but may be especially important for those in a hospital. Talking with peers may provide assurance that other children are experiencing the same things and provide opportunities to learn how others cope.

**Information about the hospital environment**

School-age children have developed the ability to think and reason logically. Learning about the people, things and events in the hospital may help ease hospital-related anxiety and stress. An intervention designed to meet these needs should both minimize negative effects of hospitalization and provide a positive, enriching experience.

**Opportunities for mastery**

Participating in the environment and maintaining a sense of control is important for school-age children. Self-expression, using and developing skills, and participation may help maintain self-esteem and self-image. Providing such opportunities may help the child cope more successfully with the hospital experience.

Qualitative methodology seems to be an appropriate method of gathering data on the experience of hospitalized school-age children and the use of closed-circuit television with this population. This approach respects individual coping styles and allows the researcher to gather data from the child's perspective, thus providing more in-depth understanding than quantitative methodology would allow.
CHAPTER III

PROCEDURES

The role of the researcher was that of observer-as-participant. In Phase I, hospitalized school-age children were interviewed concerning their experience in the hospital. Content analysis was used to extract themes and patterns. Field notes were also recorded during these visits. In Phase II, a series of four live closed-circuit television programs were produced. Data from interviews, field notes, and reviews of the programs provide data on the process and effectiveness of the program as a psychosocial intervention.

Location

The study took place at Children’s Medical Center of Dallas, a large pediatric hospital near downtown Dallas. The hospital is a 6-story, 225-bed acute care pediatric hospital that serves inpatients and outpatients from birth to 18 years of age and “provides a full spectrum of medical care ... ranging from primary to tertiary” (Children’s Medical Center Mission Statement, 1991). It is the primary pediatric teaching facility for the University of Texas Southwestern Medical School. Information concerning the number or percentage of school-age children within the total patient population was not available, except that this number fluctuated daily.

The researcher worked in conjunction with the Child Life/Child Development Department, who provided assistance and media equipment. The staff of 22 child life specialists work to provide emotional, cognitive, and developmental support to patients.

Patients at the hospital are grouped according to diagnosis. The Child Life Department runs six playrooms throughout the hospital, each equipped with an assortment of toys, games, and activities. Child life specialists supervise playroom activities daily. Schedules
of supervised play hours are posted at each playroom and vary per unit from 2 to 6 hours per day, Monday through Friday. Children may visit with an adult at anytime. Playrooms typically include computers, stuffed animals, fish tanks, games, toys and pinball machines. A locked activity closet contains art supplies and a majority of the smaller games and toys used during supervised hours, which may be checked out by patients. Other popular locations in the hospital are the gift shop, an outdoor playscape, and a large model train display at the main entrance.

Television at the Hospital

Each room contains a color television mounted high on the wall facing the bed. The remote control is connected to the bed. The hospital receives 10 locally broadcast channels, and has 12 cable channels.

A closed-circuit system at Children’s Medical Center was installed about 5 years ago as part of a package bringing in several cable and local stations (T. Sutton, personal communication, March 17, 1993). An Audio-Visual Department of two staff members operate the five-channel system. Three channels are available for live programming broadcast from within the hospital. One of these channels is reserved for educational programming for staff, and another channel is reserved for the pastoral care staff members, who broadcast daily chapel services. The third channel with live-broadcast capability is reserved for the Child Life Department.

In addition, two channels are available for broadcasting taped programs. One is used daily to broadcast taped educational programming for staff. The other channel is used to show taped productions such as educational videos for families and delay broadcasts of special programs at the hospital. A final channel is designated for a bulletin board.

Installation of the system was paid out of the capital budget of the hospital, and donations funded additional child life equipment. Child life programs are produced with a
portable system consisting of a video camera and low-power transmitter on a cart. The unit plugs into any cable outlet throughout the hospital. A feature called "visit vision" feature allows visitors to communicate with isolated patients via telephone and video cameras.

The primary responsibility of the Audio-Visual Department is to provide instructional support to staff. They document and broadcast events such as lectures and workshops, and make and distribute copies of video tapes. At times the audio-visual and child life staff members work together to produce taped, edited programs featuring the patients. Special events are sometimes broadcast live by the child life staff. However, the present study was the first program of its type at this hospital.

Subjects

Subjects were a total of 25 boys and girls ages 7 to 11 years who are inpatients at Children's Medical Center of Dallas at the time of the study. No subjects had been diagnosed as developmentally delayed. Sixteen of the subjects participated in Phase I, and nine participated in Phase II. Appendix A presents subjects by age and gender.

Potential participants were all 7- through 11-year-old patients referred by the child life staff. Referrals were made on the basis of each child's age, availability, and appropriateness. An effort was made to approach and give all such subjects the opportunity to participate, but in some instances participation was not deemed appropriate due to medical status. For both Phase I and Phase II, on each of seven data-collection visits, all patients meeting this protocol were eligible to participate. No subject participated in both phases.

Consent

The study was submitted to and approved by the institutional review boards of the University of North Texas, Children's Medical Center of Dallas, and the University of Texas Southwestern Medical Center At Dallas.
All subjects signed an assent form designed by the researcher (see Appendix B). The reading level of this form is at grade level 2.6, as computed by the Fry Readability Graph. A guardian of each child signed a consent form consisting of: a) two pages required by the Institutional Review Board, describing subject rights, b) a page describing the purpose of the study, and c) the signature page (see Appendix C).

For each of the scheduled data collection dates, the Child Life staff compiled a list of all potential subjects. The researcher went to the subject's room, introduced himself to the child, and explained that he was working with the Child Life Department. The study and consent form were described briefly. After prospective subjects gave oral willingness to participate, they were given the assent form. Guardians were given the consent form. One copy of each signed consent and assent form was put in each participant's medical record, and another copy was given to the participant.

In two instances the researcher was unable to contact the guardian. In one of these cases the researcher left a note with the consent form, and in the other a child life specialist obtained guardian consent.

Instrumentation

Primary instruments in the study were two separate interview forms designed by the author. These instruments were used with the children by the author and a trained interviewer (Appendices D and E). All subjects were interviewed individually, 24 in their rooms and 1 in the playroom. Interviews were audio recorded with a small portable cassette recorder.

The instrument for Phase I included 13 questions, which were asked in the same order each time by the interviewer. Five of these questions were general questions about being in the hospital. Other questions were more specifically designed to examine their perspective on the importance of and opportunities for peer socialization, information about the hospital, and activities for self-esteem and mastery (See Appendix F)
The instrument for Phase II included eight questions. Four of these questions were general questions to gather information concerning the child's opinion of the show. Other questions were designed to gather information on the interactive, informative and personal aspects of the program.

Conducting a pilot study was not feasible due to the complexity and difficulty of obtaining patient consent. While designing the interviews, the researcher asked non-hospitalized school-age children similarly worded questions to check for appropriate wording. For example, rather than asking "What is it like to talk with other children here at the hospital?", the researcher asked several children "What was it like to talk with other children at school?". Through this process, wording was checked until the researcher was satisfied with question clarity and accuracy.

While a pilot study of the instruments would have been optimal, this approach was deemed acceptable for the following reasons: a) wording seemed appropriate based on pre-testing the questions with non-hospitalized children; b) the semi-structured nature of the interviews would allow the interviewer to reword questions if needed; and c) the qualitative nature of the research did not demand identical wording of questions to each subject.

**Procedure**

In Phase I, the researcher made seven trips to the hospital during a 15-day period to gather data. In Phase II, the researcher made seven trips to the hospital. Four of these visits included production of a television program, the other visits were for preparation and gathering subjects.

In each of the scheduled collection dates, the child life staff assembled a list of available children meeting the protocol. Any child on that list was considered a potential participant. The researcher attempted to visit each child on the list, explain the study, and ask for willingness to participate. Care was taken to clarify the voluntary nature of the study.
After receiving oral and written permission from children, parents or guardians were asked to sign the consent forms. It was rare to find the patient and child together on the first trip to the room. Usually, multiple visits were required before the interviews were administered.

In several cases, potential subjects were lost because the parents or child could not be contacted. Other children were released before they were able to participate. A few children were included on the list of potential subjects, but were not visited because of their emotional and/or physical state.

In Phase I, the researcher administered the structured interview upon receiving the signed consent and assent forms. A small cassette recorder was placed near the subject. The researcher explained the reasons for recording the interview and allowed the subject to help decide where to place the recorder. Questions were asked in the same order each time, but were occasionally re-asked or reworded without changing original meaning.

The interviewer often gave a reflective response following the child's answer. For example, subjects were asked "What is the hardest thing to get used to?". If a child answered "getting stuck", the interviewer might respond with "getting stuck is hard to get used to". This was done a) to stimulate possible further comments; and b) to assist in transcribing the interview.

In Phase II, the researcher was given a list of potential participants by the child life staff either one or two days before the program. All of these subjects were approached and invited to participate in the program. They were also told that the program was part of a research project. Participation in the program was not dependent on participation in the study.

All children who were contacted were given options to how they could participate. The options differed according to the child's ambulatory condition. Those able to leave their room could join the "studio audience" in the playroom or view from their room, while
those unable to attend could participate from their room. All children were given the opportunity to show a personal item (i.e., artwork, gift from a friend). Several children were given the opportunity to choose jokes out of a book provided by the researcher. Table 1 presents some of the options made available to participants.

**Table 1**

**Participant Options**

<table>
<thead>
<tr>
<th>Children joining the studio audience</th>
<th>Children watching from room</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Take personal item to be shown</td>
<td>a) Send personal item to be shown</td>
</tr>
<tr>
<td>b) Be seen on the show or not</td>
<td>b) Pick joke to be read on show</td>
</tr>
<tr>
<td>c) Read a joke on show</td>
<td>c) Play &quot;stump the juggler&quot; by phone</td>
</tr>
<tr>
<td>d) Pick a joke to be read</td>
<td>d) Call to ask guests questions</td>
</tr>
<tr>
<td>e) Play &quot;stump the juggler&quot;</td>
<td>e) Participate in games by phone</td>
</tr>
<tr>
<td>f) Ask guests questions</td>
<td></td>
</tr>
<tr>
<td>g) Participate in games at the show</td>
<td></td>
</tr>
</tbody>
</table>

Some children were given the consent and assent forms on the initial visit. In other cases, the researcher waited until a later visit. In either case, the researcher returned before the program to discuss the child's participation in the show.

Thirty-minutes to one hour after the program, an assistant went to the subjects' rooms to administer interviews. As in Phase I, questions were asked in order, but the interviewer was permitted to expound on them when appropriate. Again, a reflective response was usually made by the interviewer following each answer.

Throughout the study, field notes were written and recorded on audio tape. Notes included anything considered noteworthy by the researcher, including observations,
perceptions or questions. These notes were transcribed chronologically onto a computer diskette as a single document. In a second document these notes were compressed and categorized on an on-going basis. The researcher viewed video tapes and transcribed events taking place on each program. A transcription example is presented in Appendix G.

Periodically, the notes were sorted, compressed and categorized. This is an important process in qualitative research, in which the researcher uses intuition, looks for trends and formulates ideas as the research progresses.

Implementation of the Television Program

While the general goals and process of doing the show were planned before the research commenced, information from Phase I guided several aspects of the program. For example, providing information on the things in the hospital became a more central objective due to Phase I findings. Also, the researcher originally planned to visit patient rooms with a child life staff member to explain the television program. It became apparent in Phase I that this would not be possible for time and logistics reasons.

The researcher arrived at the playroom approximately 45 minutes before each program began, setting up props and moving chairs. Approximately 15 minutes before the show, the camera was focused on a sign reading "You Make the Call will start at 6:30" and the visual-only signal was turned on. This was done so children tuning in the station early would not see "dead air" and change the channel.

A staff member asked studio audience members to sign release forms when they entered the door. This was not related to the research, but was required by the public relations department for any children who would be shown on camera.

The researcher was the host for each program. Before the show began, the researcher/host thanked the studio audience for coming. The applause signs and other
props were then explained. When the host gave the signal, the camera person turned on the audio signal, sending both picture and sound to television viewers.

Each show began with a theme song written and sung by the host. Next, the host greeted viewers, and told them where the show was being broadcast, what would happen during the program, and how to call the playroom. A sign with the phone number was in view of the camera through most of the program. Periodically the host would encourage the viewers to call and participate.

The four programs did not follow identical outlines, but all included segments designed: a) to provide information, b) provide interaction, and c) to provide opportunities for mastery. Appendix H lists and describes each segment of the program. Program goals and opportunities designed to meet each are presented in Table 2.

Table 2

**Program Goals and Opportunities Designed to Meet Them**

<table>
<thead>
<tr>
<th>Peer interaction</th>
<th>Information</th>
<th>Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coming to the playroom</td>
<td>Staff interviews</td>
<td>Joke telling</td>
</tr>
<tr>
<td>Participating during show</td>
<td>Introduction of juggling items</td>
<td>Personal items</td>
</tr>
<tr>
<td>Participating via telephone</td>
<td>Hospital Bingo</td>
<td>Stumping the juggler</td>
</tr>
<tr>
<td>Singing songs together</td>
<td>What/Where is it game</td>
<td>Singing together</td>
</tr>
<tr>
<td>Gathering after show</td>
<td></td>
<td>Asking questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group responses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Volunteering</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of applause signs</td>
</tr>
</tbody>
</table>
Changes and additions were made as the series of shows progressed. For example, in the second show the host began to congratulate audience participation in this way: When Tony called from their room, the host would say "Who made the call?", followed by an enthusiastic audience response of "Tony made the call!" This response was used whenever possible, for those telling jokes or stumping the juggler.

During the program an attempt was made to give options whenever possible. For example, children could tell their jokes from their seat or come to the "stage" where the host sat. Throughout the program, the host attempted to encourage effort rather than the product, saying for example, "yes, it looks like Yogi Bear", rather than "no, it's not Yogi Bear".

Analysis of Data

Audio tapes were transcribed and saved on computer disk. Each transcription was saved as a separate document. Comments by parents or staff were noted but were not transcribed in full. Analysis of answers was performed by the researcher from these transcriptions. Audio tapes were referred to in cases requiring clarification.

For each subject, comments were broken down into "units". The units for this study were themes. Themes may be one sentence, a series of sentences, or a portion of a sentence. Complex sentences were broken down into shorter thematic units (Weber, 1990). For example, the sentence, "From the nurses and when I have to go to dialysis" was edited to two units: From the nurses (+) when I have to go to dialysis. This document was saved in a separate file.

Responses that were provoked by a parent's comment were not included. Consider, for example:

Interviewer: "Where do you learn about the things in the hospital?"
Participant: "Nowhere."
Parent: "James took you around the surgery room."
Participant: "Oh, yeah, the surgery room."

Because the guardian prompted the "surgery" response, only the "nowhere" response would be considered a unit.

After all transcripts were broken into units, a document for each question was produced, containing all response units to that question. Responses to each question were then classified using a coding system of categories suggested by previous research and literature. Revision of the coding rules was made as needed until satisfactory reliability was achieved. The goal was to create accurate categories for the largest number of units, but in accordance with the goal of qualitative analysis to allow for "multiple realities", some categories contained only one or two units.

Categories for each question were derived according to the following requirements set forth by Holsti (1969): a) categories must reflect the purposes of the research, b) All themes must fit into a category; c) No single theme may fit into more than one category, d) categories must be independent, and e) categories must be conceptually similar.

Analysis was done according to the procedure set forth by Weber (1990):

a) define the recording units - units were defined as themes.

b) define the categories - for each question, categories were defined based on previous research and literature

c) test coding on sample of text - text of 10 sample interviews (five from each phase) were coded by the researcher and a judge to check for ambiguities or need for revision.

d) access accuracy or reliability - percent agreement between the two judges was determined.

e) revise the coding rules - when needed.

f) return to step 3 - cycle was continued until judges achieved sufficient reliability.

g) code all the text - rules were applied to text.
Reliability

Inter-coder reliability and stability were examined. Five Phase I and Phase II interviews were selected at random. They contained a total of 66 units, and 34 units, respectively. The five randomly-picked Phase I interviews, for example, contained a total of 66 different thematic answers on the 12 interview questions. The independent coder placed each unit into one of the possible categories for that question. Percent intercoder reliability was figured by dividing the number of researcher/coder matches by the total number of units.

Categorization of units by the judge was compared to that of the researcher. Analysis showed 94% agreement between researcher and coder on Phase I and 91% agreement on Phase II. These findings indicate high inter-coder reliability.

Stability, or the extent to which classifications remain accurate over time by the same coder, was assessed by repeating coding of samples. One month after all text was coded, the investigator randomly picked five interviews in each phase for repeat coding. Ninety-nine percent of Phase I units and 100% of Phase II units were placed in identical categories as the original analysis, indicating high stability of categories across time.

In accordance with qualitative methodology, observation data was categorized, combined, and condensed into its final form. Interview results, observation notes, and other data were organized as pertaining to Phase I, Phase II or both. The researcher then sought to break them down further into categories for presentation. Items were combined, some omitted, and the outline of Chapter 4 emerged. Some data was deemed more appropriate for the Appendix section than in the text.
CHAPTER IV

PRESENTATION OF DATA AND DISCUSSION

Organization of data yielded five topic headings: a) general participation in the study, b) Phase I findings concerning the hospital experience of subjects, c) Phase II findings concerning the implementation of and effectiveness of the television program, d) television viewing among subjects, and e) a case study.

General Participation in the Study

Of 21 potential participants approached in Phase I, 16 agreed to participate and three declined. One mother did not want to participate, and in one case the child was willing to participate but the researcher could not contact the parent.

These figures attest to the high overall level of participation, but do not fully document the range of reactions to the researcher. Some children were quite eager to talk with the researcher while others were more passive or reluctant to do so. One potential 8-year-old subject said he did not want to participate. At his mother's suggestion, the researcher returned the next day, to be told with a smile and a proud voice "I don't like it here, it's boring, and I don't want to talk with you about it". The researcher noted that this child, in his refusal to participate, was able to display a sort of mastery of the situation. He was in charge of his decision to say no and seemed to enjoy asserting this right.

Other patients did not appear to be coping as well. One potential participant agreed to the interview but began to cry when the researcher explained the consent form to her mother. In another case, a guardian said "she's not happy about being here and really doesn't want to talk about it."
The demeanor of subjects during interviews varied as well. Some were very comfortable, while others looked to their parent before or during responses. One of the most comfortable participants was a boy whose mother was a nurse. He was eager to begin the interview even though his parents were not present. In the interview he indicated that he knew all he needed to know about the hospital, and that the hospital was "fun". In contrast, as one 7-year-old subject began to answer interview questions, her mother moved across the room to answer the phone. The subject became much quieter, and did not respond to several questions, sometimes looking toward the mother in an uncomfortable manner.

Guardians, as well, were generally receptive with some exceptions. In several interviews a guardian prompted the subject, or added comments. On the other hand, after describing the purpose of the study to one parent, the interviewer was told "I am really not interested". There was insufficient data to look for trends in responding between children and their guardians. 

The researchers primary time to approach and interview potential participants was from 4:00 p.m. to 8:00 p.m. This seemed to be the best time to find potential participants and their guardians together in the room. Some guardians were present during daytime hours, and others came in late evening or were not contacted by the researcher.

Phase I Findings

The Hospital Experience

Responses to each interview question are presented in Table 3. The table presents the number of response units in each category as well as examples of each category. Subjects may have had more than one response, or no response to a given question.

Analysis of the interviews revealed that the children especially enjoyed the playroom, personal relationships with peers and staff, and activities at the hospital. Many reported
difficulty coping with painful medical procedures. Confinement and social issues were bothersome for some as well.

Thirty-three total responses were given to the question "What things have you enjoyed here in the hospital. Eleven of the sixteen subjects (69%) named the playroom as something they had enjoyed. Asked what they liked about the playroom, ten subjects named activities, such as painting and playing games. Four children specifically mentioned the pinball machine. For two subjects, the social aspects of the playroom were most enjoyable.

Personal relations with peers and staff members was often mentioned as something the children enjoyed. Responses included "meeting new people" and "the kindness of all the nurses and doctors and child life people". Eight children named specific activities as the thing they enjoyed, such as pinball or drawing. Three children said they enjoyed getting things.

Asked the hardest thing to get used to, most subjects cited medical procedures. Children found it especially bothersome getting poked with needles, particularly during intravenous (IV) injections. Treatments, surgeries, and medicine were also mentioned. Confinement was the theme of two answers; "staying here" said one child. Making friends was most difficult for one subject, and getting used to the food for another.

Responding to the question, "What is the first thing you would change about the hospital?", seven answers concerned medical procedures. Of these, children said they would take away the pain. Three specifically would take away the pain related to IVs. Two subjects would have fewer treatments.

Other children would change something about the environment. For example, one subject said she would make the rooms bigger, and another wanted to put in a swimming pool. Other answers concern confinement (i.e., "getting out of this thing") and getting well.
At the end of the interview, children were asked "What else would you like to say about being in the hospital?". Eight of the responses were categorized as being positive responses, and three were rated as negative. Half of the positive responses included statements about social relations with staff members, such as "I like all the nurses and doctors, they're very kind". Three subjects described the hospital as "fun" in their response. Negative responses included "I don't want to come back" and "I wish I weren't hooked up to the IV so I could look around more". One subject gave the thoughtful response "Well, you need to sometimes".

Table 3

Responses to Phase I Interviews: The General Hospital Experience

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Playroom</td>
<td>&quot;Going to the playroom&quot;</td>
</tr>
<tr>
<td>8</td>
<td>Personal relations w/peers, staff</td>
<td>&quot;I've enjoyed meeting new people&quot;</td>
</tr>
<tr>
<td>8</td>
<td>Activities</td>
<td>&quot;Playing games&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Getting things</td>
<td>&quot;Getting all the gifts&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Food</td>
<td>&quot;The food&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Train</td>
<td>&quot;The train&quot;</td>
</tr>
</tbody>
</table>
**QUESTION:** What is the hardest thing to get used to?

(17 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>sub-category (number)</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Medical procedures</td>
<td></td>
<td>&quot;All the blood work that has to be done&quot;</td>
</tr>
<tr>
<td></td>
<td>Needles, IV's, being poked</td>
<td>(8)</td>
<td>&quot;When they poke me&quot;</td>
</tr>
<tr>
<td></td>
<td>Treatments</td>
<td>(3)</td>
<td>&quot;Doing all this breathing stuff&quot;</td>
</tr>
<tr>
<td></td>
<td>Surgery</td>
<td>(2)</td>
<td>&quot;The surgeries&quot;</td>
</tr>
<tr>
<td></td>
<td>Medicine</td>
<td>(1)</td>
<td>&quot;The medicine&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Confinement</td>
<td></td>
<td>&quot;Being connected to this machine&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Making friends</td>
<td></td>
<td>&quot;Making friends&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Food</td>
<td></td>
<td>&quot;The food&quot;</td>
</tr>
</tbody>
</table>

**QUESTION:** What is the first thing you would change about the hospital?

(17 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>sub-category (number)</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Medical procedures</td>
<td></td>
<td>&quot;Whenever you got stuck with the needle, you couldn't feel it at all&quot;</td>
</tr>
<tr>
<td></td>
<td>No pain</td>
<td>(5)</td>
<td>&quot;Treatments&quot;</td>
</tr>
<tr>
<td></td>
<td>Fewer treatments</td>
<td>(2)</td>
<td>&quot;Put a swimming pool in&quot;</td>
</tr>
<tr>
<td>5</td>
<td>Environmental changes</td>
<td>(5)</td>
<td>&quot;I would like to get out of this&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Confinement</td>
<td>(3)</td>
<td>&quot;My asthma got better&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Getting well</td>
<td>(1)</td>
<td></td>
</tr>
</tbody>
</table>
QUESTION: What else would you like to say about being in the hospital?

(11 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Positive things about experience</td>
<td>&quot;I think this is a pretty good hospital&quot;</td>
</tr>
<tr>
<td></td>
<td>Social relations w/ staff (4)</td>
<td>&quot;You get to know all the nurses and doctors&quot;</td>
</tr>
<tr>
<td></td>
<td>It's fun (2)</td>
<td>&quot;It's really very fun&quot;</td>
</tr>
<tr>
<td></td>
<td>Games (1)</td>
<td>&quot;I like playing the games&quot;</td>
</tr>
<tr>
<td></td>
<td>It will help (1)</td>
<td>&quot;Well, you need to sometimes&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Negative things about experience (3)</td>
<td>&quot;That I don't want to come back&quot;</td>
</tr>
</tbody>
</table>

Social Interaction

Interviews indicate the subjects had a variety and number of opportunities for social interaction. Interview results are presented in Table 4. The playroom played a primary role in the social experience of the children. Observations supported these findings. During supervised playroom hours children talked with each other, staff, and others. And it was not rare to see a child standing in the doorway in the evening, chatting with passer-bys or venturing down the hallway. Most children reported positive peer interactions in the hospital, but a small number had strong negative responses. A few instances of peer modeling were noted.

Asked where they had chances to talk with other children at the hospital, 10 of the 16 subjects named the playroom. Four children named specific places in the hospital other than the playroom, such as the elevator or "around". Three patients said they were able to talk with others in the patients room. Two subjects had strong negative answers, that there
was no place they could talk with other children. "I've got no friends here" said one subject.

The question "What is it like to talk with other kids your age here in the hospital was answered by all sixteen subjects. Eight subjects had a strong positive response, such as "fun" and "exciting". Four subjects had a slightly positive response such as "O.K.", or "all right". The remaining four subjects used negative terms to describe the experience, such as "different" and "weird".

Table 4
Responses to Phase I Interviews: Social Interaction

QUESTION: Where do you get to meet other kids your age?
(19 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Playroom</td>
<td>&quot;In the playroom&quot;</td>
</tr>
<tr>
<td>4</td>
<td>Other places in the hospital</td>
<td>&quot;In the triage for asthma&quot;</td>
</tr>
<tr>
<td>3</td>
<td>In rooms</td>
<td>&quot;Going to meet other kids in their rooms&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Strong negative answers</td>
<td>&quot;Nowhere&quot; (Mother: &quot;In the playroom&quot;)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;I know, but nobody knows me&quot;</td>
</tr>
</tbody>
</table>

QUESTION: What is it like to talk with kids your age here in the hospital?
(16 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Strong positive response</td>
<td>&quot;It's pretty exciting&quot;</td>
</tr>
<tr>
<td>4</td>
<td>Slight positive response</td>
<td>&quot;All right&quot;</td>
</tr>
<tr>
<td>4</td>
<td>Negative responses</td>
<td>&quot;Weird&quot;</td>
</tr>
</tbody>
</table>
Based on literature citing the need for children to learn from each other, the researcher included the question "Do you learn anything talking with other kids here?" The question was designed to explore the possibility that peer modeling, learning through the experience of others, was taking place among subjects. Five children responded "no" to the question, and three said "sometimes" or "maybe", but did not elaborate. Two children answered affirmatively. One reported learning "what's wrong with them" and the other said "that they have problems."

Though this question was rather unproductive at uncovering instances of social modeling, some examples were noted elsewhere in interviews. One child reported a desire for information on "how they get kids to calm down during IVs". A 9-year-old subject said "When I was nervous about something that had to be done, I asked if I could talk to another kid that had it done, and that maybe it would help".

Information

Interview results regarding information are presented in Table 5. Eleven of fifteen subjects (73%) responded that they would like to know more about the people, places and things in the hospital. Four subjects (27%) did not want to know more.
Asked "What things would you like to know more about", seven of ten subjects (70%) said they would like to know more about the machines. Three of these subjects specifically mentioned the IV pole, which consists of a line, mobile stand, and control box. Other subjects desired information on why procedures were done, how the staff got kids to calm down during IVs, why procedures are done, and where things are in the hospital.

Asked where they learned about the hospital, children gave a variety of answers, making categorization a difficult process. The researcher categorized responses as to the situation in which the event occurred. Five subjects reported learning during or just before procedures, for example "watching them do it", "when I have to go to dialysis", and "when they come and give me medicine". One subject mentioned a tour. One subject learned by listening to nurses talk to his mother. Six subjects named the source of the information but did not explain the situation in which it occurred, and three subjects could not name any place. Among subjects naming specific sources of information, nurses were named four times, and a child life specialist, doctor and parent were named one time each.

Table 5
Responses to Phase I Interviews: Information

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Like to know more</td>
<td>&quot;I'd like to know more&quot;</td>
</tr>
<tr>
<td>4</td>
<td>Know enough</td>
<td>&quot;Yes, I do know a lot&quot;</td>
</tr>
</tbody>
</table>
QUESTION: What would you like to know more about?

(10 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>sub-category (number)</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Machines</td>
<td></td>
<td>&quot;I would like to know more about the machines than I do right now&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specifically about IV (3)</td>
<td>&quot;Different things like the IV. How it works&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Why procedures are done</td>
<td></td>
<td>&quot;How come they have to poke you&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Coping</td>
<td></td>
<td>&quot;How they get kids to calm down when they’re getting ready to do that IV&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Where things are in hospital</td>
<td></td>
<td>&quot;Where's the gift shop&quot;</td>
</tr>
</tbody>
</table>

QUESTION: Where do you learn about the hospital?

(16 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>During procedures</td>
<td>&quot;Watching them do it&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Tour</td>
<td>&quot;Showed me around&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Overheard nurse talking</td>
<td>&quot;I heard the nurse talk to my mom&quot;</td>
</tr>
<tr>
<td>6</td>
<td>Situation unknown (subject named source instead)</td>
<td>&quot;From the nurses&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Nowhere, don't know</td>
<td>&quot;Nowhere&quot;</td>
</tr>
</tbody>
</table>

Mastery

The question "What things have made you feel good or important in hospital?" was intended to uncover experiences leading to self-worth and mastery. There was a wide variety of answers to this question (See Table 7). Four children named activities, such as
"learned to play games". Three responses concerned receiving special care. Participation in one's own care, for example, by helping with the blood pressure cuff, was named by three subjects. Other answers included decorating their door, getting presents, having visitors and talking with new people. Five subjects either did not respond or could not think of anything.

Table 6

Responses to Phase I Interviews: Mastery

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Activities</td>
<td>&quot;Learned how to play games&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Receiving care</td>
<td>&quot;I get special care from people&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Participating in own care</td>
<td>&quot;Taking off the blood pressure&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Personalization</td>
<td>&quot;Decorate my door&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Getting things</td>
<td>&quot;Presents&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Visitors</td>
<td>&quot;Having family members that come in&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Talking with new people</td>
<td>&quot;Talking to people I haven't met before&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Sharing</td>
<td>&quot;Sharing my things&quot;</td>
</tr>
<tr>
<td>5</td>
<td>Negative response</td>
<td>&quot;Nothing, really&quot;</td>
</tr>
</tbody>
</table>

Considering the amount and variety of opportunities given patients at the hospital, the researcher was somewhat surprised that five subjects did not give a response to this question. One subject, for example, answered that "nothing" had made her feel good or important. Her mother then interjected that the girl had been on a television commercial and
in a parade while at the hospital. The subject acknowledged these events, but did not elaborate.

Phase II Findings

General information on program

The four programs were broadcast from a playroom in the hospital. All children and families in the hospital were welcome to come to the show. Flyers were distributed by the child life staff on the day of the program, inviting patients to watch the program or come be part of the studio audience (See Appendix F).

Approximately 8 to 15 children attended each program. The audience consisted primarily of patients, but siblings played a significant role in several of the programs. Relatives and guardians were present also, as well as staff members and hospital volunteers. The total number of people in the room during shows ranged from 15 to 25 people. Some children brought wheelchairs and IV poles. Some children entered or left during the program. One participant read a joke to the studio audience at the show, then returned to her room to watch and participate by phone.

The entertainment aspects of the show seemed especially helpful in drawing interest when describing the program to potential participants. For example, Terri, a 8-year-old patient, was very quiet on the researcher’s initial visit to discuss the show. She showed almost no interest until juggling was mentioned, when she looked up and acknowledged she wanted to go. Terri attended the program, and sat quietly with the other children. Following the program, she told the host “next time I’m going to stump you!”. In her interview, Terri said that her favorite parts of the program were "when the kids stumped the juggler" and "the jokes". She said the show was "pretty fun", and said it was "O.K." to see and talk with the other children at the show. Given the literature stressing the importance of social interaction to hospitalized school-age children, the ability of
entertainment aspects of the program to attract this child to a social situation attests to the value of special events at the hospital.

Originally the researcher had considered having only school-age children in the studio audience. The researcher was concerned that having younger children in the room might make it more difficult to target school-age children. After discussion with staff it was decided that the program should be open to everyone.

Participants in the studio audience ranged from toddlers to adolescents, but the majority were school-age children. This could be due in part to the program's appeal to that age-group and to the focus of the researcher in recruiting that age group.

The mixture of ages was successful and revealing. The room was arranged to allow children to play rather than watch the program. In one instance, a toddler sat playing only yards from the host, totally uninterested in the goings-on. In another program, as a guest explained the X-ray machine, a pre-schooler left the audience to go play with toys across the room. These instances support the idea that activities should allow for age-difference, but that it is possible to have successful mixed-age activities.

Television viewers included those unable to leave their room, and children who decided to watch from their room rather than come to the playroom. It is difficult to estimate how many children watched the program from their rooms. The first show received a total of 3 calls from viewers wanting to participate, and the remaining shows received 6 calls each (not including a few calls to get Bingo cards and report bad transmission). Children often called several times during the show. There is reason to think there were children watching who did not call. Two children who called to get Bingo cards at the end of show #3 had not called until that point. Also, when there were transmission problems, calls came in from children who had not participated to that point.
The results were promising, supporting Guttentag's (1983) finding that a live, hospital produced program can compete with professional prime-time broadcasting. Children approached by the interviewer regularly participated in or viewed the program if possible.

Interviews revealed that children especially enjoyed the juggling, jokes, and songs in the programs. They enjoyed the participatory nature of the show as well as the entertainment aspects of the show. Responses to general questions regarding the program are presented in Table 7.

Table 7
Responses to Phase 2 Interviews: General Questions About Program

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>sub-category (number)</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Juggling</td>
<td></td>
<td>&quot;When the kids stumped the juggler&quot;</td>
</tr>
<tr>
<td>4</td>
<td>Jokes</td>
<td>Hearing jokes (3)</td>
<td>&quot;When he told the jokes&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Telling a joke (1)</td>
<td>&quot;I liked when I did a joke&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Songs</td>
<td>Listening to songs (1)</td>
<td>&quot;His songs&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Singing a song (1)</td>
<td>&quot;I liked when we sung the song about the IV&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Others participated</td>
<td></td>
<td>&quot;He had people on the phone&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Made audience laugh</td>
<td></td>
<td>&quot;He made us laugh&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Sound effects machine</td>
<td></td>
<td>&quot;I liked that instrument that made the clapping noise&quot;</td>
</tr>
</tbody>
</table>
QUESTION: Is there anything else you would like to say about the show?

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Positive statements about the show</td>
<td>&quot;I loved the show&quot;</td>
</tr>
<tr>
<td>4</td>
<td>No comments</td>
<td></td>
</tr>
</tbody>
</table>

QUESTION: How could we change the show?

(10 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Make it longer</td>
<td>&quot;You can change the show, like longer&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Have a puppet show</td>
<td>&quot;We could make a play on there, a puppet show&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Stomp the jugglers toe when he misses</td>
<td>&quot;You could stomp his toe&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Change the song</td>
<td>&quot;The song&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Different signs</td>
<td>&quot;The signs. You could go, like 'wow’&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Audience participation</td>
<td>&quot;Let everyone in the audience that wants to do something can do something in the show&quot;</td>
</tr>
</tbody>
</table>

Social Interaction During Program

The program was able to offer several opportunities for participation by the studio audience. Post-show interviews indicate that the children enjoyed the social and participatory aspects of the program.

Although they were free to explore the playroom at any time, audience members usually sat as a group during the program. On several occasions young children left the audience to play with toys in the playroom. Guardians were present at each show, some sitting with their child, others sitting behind the audience. The children seemed quiet comfortable in the
environment, not surprising considering the popularity and frequency of playroom visits for this population. Before the show began, the host thanked the studio audience for coming and explained what would happen during the show. To promote the idea of the audience as a group, the host said the goal was to work together to make a show for the people watching from their rooms.

During one program, a group of four participants came up to sing a song with the host. In interviews, one said "I liked the part where we were standing there singing", and the other said it was "O.K..

After each program the host thanked the studio audience for attending. While many children left immediately, others remained to come up and look at the items on the host's desk or juggle.

There is no evidence that the program succeeded at promoting peer modeling. Originally, the researcher hoped to stimulate discussions among patients during the program. This did not materialize due in part to the presence of children without signed release to be seen or heard on camera. Future programs could address this topic.

One primary goal of the program was to allow children the opportunity to participate from their rooms. Throughout the program, the host would encourage those watching to call. A sign with the playroom phone number was visible throughout most of the program.

Callers often made more than one call during a program, either to play a game or say hello. In one show, for example, a subject called twice; once to try to stump the juggler and once to relay a joke through the host.

In post-show interviews, subjects were asked "What was it like to hear and talk with other children at the show?". Four subjects had strong positive reactions such as "fun" and "nice", and three had slight positive responses such as "all right". There were no negative responses (See Table 8).
Table 8
Responses to Phase 2 Interviews: Social Aspects of Program

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Positive response</td>
<td>&quot;Fun&quot;</td>
</tr>
<tr>
<td>3</td>
<td>Slightly positive response</td>
<td>&quot;O.K.&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Misunderstood question</td>
<td>&quot;It was easy&quot;</td>
</tr>
</tbody>
</table>

QUESTION: What was it like to hear and talk with other children at the show?
(8 total responses)

Informative Aspects of The Program

Following Phase I results indicating a desire for more information about the machines, providing such information through special segments became a primary objective of the program. Post-show interviews indicate that the subjects enjoyed these segments of the program, it is not clear to what degree the segments increased knowledge or was beneficial.

Special guests and games were used to provide information on the people, places and things in the hospital. An advanced nurse practitioner (ANP) came to the show twice, discussing the IV one week and the pulse oxymeter another. An X-ray technician was a special guest as well. The guests talked with the host, and used real equipment and volunteers to discuss and demonstrate the parts and functions of machines. Children were encouraged to ask questions. In addition, items used for the "stump the juggler" segment twice included medical items such as a surgical glove, mask, and an IV board. The nurse introduced and briefly described each item.

Information on the places in the hospital was presented through special guests and games. Child life specialists talked with the host about the playroom, outdoor playscape,
In one segment, the host used photographs of special places in the hospital, covering portions of the picture and challenging the audience to guess "Where is it?" During one program, the audience played hospital Bingo, an adaptation of the original game that uses medical items rather than numbers.

In post-show interviews, subjects were asked "Did you learn anything from the show that will help you?" Six subjects responded that they had learned something from the program, while three said they had not learned anything. Three children reported learning about the machines and another reported learning about the playroom. One child said she learned jokes, and another reported learning about juggling. Responses to interview questions regarding informative aspects of the program are presented in Table 9.

**Table 9**

**Responses to Phase 2 Interviews: Informative aspects of Program**

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>About machines (3)</td>
<td>&quot;I learned about that machine they had&quot;</td>
</tr>
<tr>
<td></td>
<td>About the playroom (1)</td>
<td>&quot;I learned what was the playroom for&quot;</td>
</tr>
<tr>
<td></td>
<td>About juggling (1)</td>
<td>&quot;I can learn how to juggle&quot;</td>
</tr>
<tr>
<td></td>
<td>Jokes (1)</td>
<td>&quot;Jokes&quot;</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>&quot;No&quot;</td>
</tr>
</tbody>
</table>
QUESTION: What was it like to hear about the machines?

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>No response</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Strong positive response</td>
<td>&quot;It was fun&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Missed segment</td>
<td>&quot;We didn't see that part&quot;</td>
</tr>
</tbody>
</table>

Mastery Through Participation in the Program

The show was designed to provide opportunities for mastery and self-worth through making choices, participation, displaying personal items, and learning and using skills. Interviews and observation indicate the show was successful in promoting participation. In post-show interviews, seven of the nine children interviewed could name something they did at the show. Three children named more than one form of participation, for example, singing and helping the guest as a volunteer. Table 10 presents results of interview questions concerning participation in the program.

Table 10
Responses to Phase 2 Interviews: Participation in Program

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Yes</td>
<td>&quot;Yes&quot;</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>&quot;No&quot;</td>
</tr>
</tbody>
</table>
QUESTION: What did you do at the show?

(10 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Told a joke</td>
<td>&quot;I joked&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Stumped the juggler</td>
<td>&quot;I tricked the juggler&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Volunteered to help guest</td>
<td>&quot;I let the lady tell the kids about my machine&quot;</td>
</tr>
<tr>
<td>2</td>
<td>Sang</td>
<td>&quot;I sung&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Magic trick</td>
<td>&quot;A magic trick&quot;</td>
</tr>
</tbody>
</table>

QUESTION: What was that like, being on the show?

(7 total responses)

<table>
<thead>
<tr>
<th>number</th>
<th>category</th>
<th>example</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Strong positive response</td>
<td>&quot;It was fun&quot;</td>
</tr>
<tr>
<td>1</td>
<td>Slight positive response</td>
<td>&quot;It was O.K.&quot;</td>
</tr>
</tbody>
</table>

Asked what it was like to be a part of the show, six subjects gave strong positive responses such as "it was fun", and "I liked it". One subject had a slightly positive response, saying "it was all right". There were no negative responses. Several of the children's responses reflected appreciation of the participatory nature of the program. Asked what they liked about the show, answers included "I liked when we sung the song about the IV", "He had people on the phone", "He made us laugh", and "That he picked some people out of the audience. One subject had this suggestion "Let everyone in the audience that wants to do something can do something in the show"
The "Stump the Juggler" segment, in which children tried to choose items the host could not juggle, was quite popular. A total of nine children played this game during the shows, four of them calling from their rooms. Two children played the game in more than one show. Asked what they liked about the show, seven of the nine children interviewed named the juggling. It was clear from the audience reactions during these segments that they enjoyed the "drops" more than the "catches". That is, they seemed to enjoy outsmarting the juggler more than watching the event itself. One subject said "I liked when he juggled and he couldn't do it", and another said "I liked when the kids stumped the juggler". Asked how it made her feel to stump the juggler, one girl said "I was like ... yippee!" One subject said he learned about juggling on the show.

During "Joke Breaks", the host told jokes and encouraged the audience to do the same. This was a surprisingly popular segment. Eleven children told jokes from the studio audience during the shows, and one child told a joke over the phone. In post-show interviews, three subjects named jokes as something they enjoyed about the program. One subject specified that she enjoyed "when I did a joke". Another subject said she had learned jokes from watching the show.

Some children had the opportunity to participate by being a volunteer for the special guests. A total of four children helped the guest demonstrate and explain the medical equipment.

The power of television may give it unique potential to promote self-worth. In the current program, children were given the opportunity to display personal items. Several participants did so. In one show, the host showed artwork of three different patients, and a gift belonging to another. One boy who decided to watch from his room gave the host a remote control car to demonstrate on-camera.

A type of host/audience response was initiated in the second program to increase the self-worth aspect of the program. When someone stumped the juggler, the host would
give an enthusiastic "who stumped the juggler?" The audience would respond "Tony stumped the juggler!"

A child life specialist observed the following: A young boy named John was viewing the program from his room. He called to ask the host and audience to say hello to him. The host did so, and then said "Who made the call?", whereupon the audience responded "John made the call!". In his room, John was very excited, yelling his own name and copying the host's sweeping pointing gestures and throwing his hands in the air. John called back two more times during the program to have the host say hello.

The program was also able to provide opportunities for familiarization. Familiarization is the idea that providing experiences with medical items can help patients become more comfortable with them. Child life specialists often encourage children to handle and play with medical items for this purpose. The program attempted to do so with interviews and entertainment.

For example, following the demonstration of how the IV machine works, the director of the child life staff talked about how some children personalized their IV pole by decorating it, or even giving it a name. Next, the host sang a light-hearted song called "The IV Pole Stroll" ("What's got five wheels and loves to roll? I'm talkin' about an IV pole"). During that program, one participant volunteered to let the nurse use her IV pole for a demonstration, and later joined in singing the IV song with the host and four other children at the end of the program. She told the interviewer afterwards "I liked where we sang about the IV". Another week, a technician not only gave information about the function and parts of the X-ray machine, but used it to display such items as cartoon characters and sports heroes.
Television Viewing Among Subjects

Observations support Guttentag's (1983) findings and concerns regarding the central role of television among hospitalized children. It was rare to enter a patient room with the television turned off. Because the interviews were audio recorded, it was often necessary to turn down the television volume. The researcher noted that children were very familiar with how to adjust the volume, and were glad to do so at the suggestion.

One episode highlighted the importance of considering television and hospitalized children. On one particular visit, the researcher began visiting rooms around 4:00 p.m. to recruit interview participants. In two of the four rooms entered, the child and a parent were watching the Oprah talk show. The topic of the program that day was teen-age girls who had been abducted.

As the researcher entered one of these rooms, the patient lay in the bed watching the program while her mother sat next to the bed, talking on the telephone. The talk-show host was discussing a case where the young ladies were murdered after their abduction. The researcher left the room, gesturing that he would come back. Re-entering the room when the mother was off the phone, the researcher was asked to return after the program ended at 5:00 p.m. The mother said she had been waiting all day to see it and had been interrupted by the phone call. Meanwhile, the 7-year-old subject watched the program, obviously intended for a different audience. For the researcher, this event brought to life literature citing concerns about daytime television and the potentially vulnerable hospitalized child.

Case Study

Lori, an 8-year-old female, participated in three of the television programs. In addition to being administered the structured interview following the first program, she was interviewed by the researcher after the final show. Her involvement and comments provide insight into both her hospital experience and participation in the television program.
According to her child life specialist, Lori has been in and out of the hospital over the last nine months. In her early visits, Lori was not active, and did not talk much. She seldom made choices given the opportunity. She has since become very active in the playroom, choosing what she does there. She often comes to the playroom early, waiting for the supervised time to begin. She interacts well with other children. Lori is sometimes reserved with adults, but when she "warms up to you" she is quite conversive. Her somewhat rare, chronic liver problem, requires periodic stays varying in length from a few days to weeks at a time.

Her mother told the researcher that Lori is "the type of child that wants to know ahead of time what you're going to do ... a detail of the procedure, a rundown." Her child life specialist also reported that Lori actively seeks information, especially concerning medical procedures.

During the researcher's first visit to her room, Lori slept while her mother sat in a chair next to the bed. The researcher and the mother went into the hall where the researcher explained the study and the program. She said she would talk with Lori about it. The mother said she would be leaving soon but the father would be coming later that evening. She thought Lori might be interested in participating. The researcher left the consent and assent forms.

When the researcher returned a couple hours later, Lori was awake, watching television with her father. She acknowledged that her mother had mentioned the program. The researcher told her about the show, explaining that she could come to or watch from the room, that there would be music and juggling, and that she could bring or send an item to be shown to the audience.

Lori was not very talkative, but said she would like to attend. Given the option to choose a joke for the show Lori said "I have a joke book". The researcher gave her the choice to read the joke herself, or pick out jokes for the host to read on the show. Consent
and assent forms were explained and signed. The researcher said he would come back the next afternoon before the show to see what she had decided to do.

The researcher returned the next day, several hours before the program. Lori had decided to pick some jokes for the host to read, and would be coming to the playroom to be part of the audience. The researcher marked the jokes she pointed out, and took the jokebook.

Lori and her father arrived just before the show was ready to begin. They sat on the outskirts of the group of around 15 people, about 25 feet from the host. She was connected to an IV pole that she had decorated with leys and a fish.

Lori participated in several ways during the program. During an interview, the nurse said that there were three situations able to set off the IV alarm, and described each. Lori corrected her, asking "what about air in the line?" Lori asked another question during an interview with another staff member.

Discussing how one might personalize the IV pole, that same guest pointed out that Lori had decorated hers. The camera person was not able to turn the camera to show her, because she was sitting among children who had not signed the release form. The host and guest described Lori's IV pole to the viewing audience.

When the host asked "Who would like to try to stump the juggler?", Lori raised her hand. The host asked if she would like to choose items from her chair, or come up front. She preferred to select the items from her seat. When host dropped the items, the crowd clapped with amusement.

Later, in the "joke break" segment, the host thanked Lori for use of the joke book. He read the joke she had picked: "What is black and white and red all over? A dalmatian with the measles."

Toward the end of the program, a staff member in the audience suggested that the participants who had signed the release forms come up to sing with the host. Lori, two
other patients and a sibling came to the front and joined the host singing the song about the IV pole.

After the show, Lori came up to the host's table. She was very interested in juggling the bean bags. She threw and caught them, and the host talked with her about juggling.

Thirty minutes or so after the program, the host saw Lori and her father standing outside the elevator. Her father said Lori had just commented that she knew the trick to "stumping the juggler". Lori smiled, saying she would be ready next time.

The structured interview after the show provided insight both into Lori's reaction to the show and her hospital experience in general. It was clear that she was very concerned with medical procedures, particularly the IV. The interview suggests that Lori has a desire to know about medical procedures and medication. She also made several references to her home and school during the interview.

In addition, the interview indicated that Lori enjoyed the program, and wanted to participate again. She did not verbalize that she had learned anything from the show, and had no response when asked what it was like to hear about the IV. This is interesting considering her participation in the show and apparent desire for information. The following interview excerpts are in chronological order:

Lori: What's this for (referring to tape recorder)?
Interviewer: This is for Rusty (the researcher) to listen to later.
Lori: Oh.
Interviewer: He's working on a school project.
Lori: He goes to school?
Interviewer: Yes.
Lori: He took a day off?
Interviewer: Yea, right now we don't have class. We start classes a little bit later. What were some of the things you liked about the show?
Lori: The juggling.

Interviewer: The juggling? You liked the juggling.

Father: Did you like the singing and the guitar playing?"

Lori: Well, it was kind of western.

Interviewer: Did you do something during the show?

Lori: I sang.

Interviewer: You sang, at the end.

Interviewer: What was it like singing on the show?

Father: Did you enjoy it?

Interviewer: What was it like?

Lori: O.K..

Interviewer: Did you learn anything from the show that will help you?

Lori: (no response)

Interviewer: No, what was it like to learn about the IV machine?

Lori: (no response)

Interviewer: Not much to say about the IV machine?

Lori: No.

Father: We didn’t know about the amount of air in it, that every time it beeps that the nurse needs to look at it.

Lori: Even when it’s on battery.

Interviewer: Even when it’s on battery.

Lori: I mean when it says help battery.

Interviewer: Oh, help battery.

Lori: You need to plug it in.

Interviewer: It sounds like you really know about this IV machine.

Lori: It’s gonna hurt when they take it out.
Interviewer: It hurts when it comes out?
Lori: No, it’s going to hurt even worse than the hand ones. Because they don’t put me to sleep when they take it out. It hurts even worse than the hand one.
Interviewer: So the one in the chest hurts more than the one in the hand.
Lori: Yea, last time I was here I had two of them.
Interviewer: You had two of them.
Lori: Yea, one on this side and this one fell and they put one in this side. Then I had to have another one on this side. And when I went to have surgery I told them that it was just going to hurt to put it in anyway.
Interviewer: It sounds like you don’t like having the IV.
Lori: I don’t mind if it’s in my hand but I do mind if its right here (points to chest).
Interviewer: Oh.
Lori: It hurts too much when you have to change dressing, and it hurts too much when you have to take it out.
Interviewer: So it seems a little bit better when it’s in the hand, is that right?
Lori: I don’t have good veins in my hand, I have good veins up here.
Interviewer: Good veins up here.
Lori: I have one put there but in surgery they were going to put an IV on, but when I woke up they took this one out.
Interviewer: Oh, it was a little different than what you expected. I have a couple more questions.
Lori: And they put ... (names drug) in this thing up here.
Interviewer: Oh really.
Lori: And they put Benedril, ... (names drug) makes me sleepy, and because I’ll have it right here, it will make it sting up there. Then it runs down and I feel sleepy, because of the Benadryl.
Interviewer: The Benadryl makes you sleepy and the other one stings?
Lori: Well, I'm off ... (names drug) so I don't get it anymore.
Interviewer: Oh, I see. Is there anything else you would like to say about the show?
Lori: It was fun.
Interviewer: It was fun, anything else you would like to tell us?
Lori: Come back again sometime.
Interviewer: Thank you very much, Lori.
Lori: Didn't they say he was going to be here again next week?
Interviewer: He is planning to come back again, I'm not sure when.
Lori: I'm supposed to be out of the hospital by then, but I could come visit.
Interviewer: Yea, you could do that, we'd have to let you know when the show is.
Lori: We could give you the number at our house.
Interviewer: You could find out by calling the child life office.
Lori: I don't know that number.
Father: We can find out.
Lori: We're all the way from Grand Prairie, all the way to here in Dallas.
Interviewer: Oh, is that a long way?
Father: About 15 miles.
Interviewer: Sounds like you want to come to see the next show.
Father: Would it be next Thursday evening?
Interviewer: I'm not sure, I would have to find out from Rusty.
Lori: I'll be in school, maybe.
Interviewer: I think they will do the show in the evening.
Lori: Past three?
Interviewer: Yes.
Lori: I’ll be out by then. Cause he picks me up when he gets out at 4:30 p.m. and I get home before 6:00 p.m.. Because that’s what time if your parents haven’t picked you up at daycare, you have to go the Elementary building, the first and second grade building, over where Ms. Gray’s office is.

Interviewer: Oh, and you wait for your parents to pick you up.

Lori: Yep. Only if your parents haven’t picked you up by 6:00 p.m..

Interviewer: Oh, and you have to go to a different spot.

Lori: And I’ve done that before.

Interviewer: O.K., thank you for answering all our questions.

The following week, Lori was back at the hospital the day of the show. The researcher went to her room, asked if she wanted to participate again. She said yes. The researcher asked if Lori wanted to use her joke book again. She said she wanted the host to pick the jokes this time.

During the second program, the host thanked her for use of the book and told two jokes from it. Toward the end of the program, Lori chose to tell the following joke from her seat: "What is the difference between a cat and a frog? A cat only dies once but a frog croaks every night." The host said "Who made the joke?" and the audience replied with "Lori made the joke!"

During the interview with the nurse, Lori asked a question concerning the use of a piece of medical equipment. She asked if the pulse oxymeter was used with asthma patients.

Following the show, Lori and several other children came up to the host’s table to throw and catch beanbags. She appeared intent on juggling.

Lori was not at the hospital for the third show, but in week four, she had returned. Lori sat near the front. She volunteered to pick three of the medical items to try and "stump the juggler". Rather than choose from her chair, Lori came to the table. The host introduced her as being the only person to be at three of the four shows. Noticing that after selecting
three items she had returned one and replaced it, the host said "It looks like you have a way to pick those". Lori replied "By how heavy they are." The host tried, and failed at juggling the items. As the audience clapped and laughed, Lori said "You get two tries", referring to the rule set in previous weeks. Following the second failure of the host to juggle the items, he said "Who stumped the juggler?" whereupon the audience replied "Lori stumped the juggler!".

During this program Lori was one of two volunteers assisting the special guest explain X-ray equipment. She also told the cat and frog joke from her seat during a "joke-break".

The host had tentatively arranged to juggle with a patient to conclude the program. When the patient decided not to, the host asked for another volunteer. Lori volunteered, and did a short juggling trick with the host. Approximately one hour after the program, Lori and two other show participants came to the host's table to play with the sound effects machine and throw the bean bags some more.

An hour after the program, the researcher asked Lori and her parents if they would be willing to answer some questions. They agreed. The interviewer had two goals in mind: To get Lori's perspective after participating in three programs, and to get her reaction to hearing about the machines on the shows.

The interview indicated that Lori enjoyed the participatory and social aspects of the program. Most interesting were her comments on medical procedures and hearing about the machines. She stressed the discomfort of procedures, and had a mixed response to hearing about the IV procedure, saying "I don't want to know about it" but that it was "O.K." to hear about things in the hospital. She said it was not scary "as long as they're not doing it for real".

**Interviewer:** Why don't you tell me anything about the shows you have been to, what you liked, what you did.

**Lori:** Stumped the juggler
Interviewer: Yes, you sure did!

Interviewer: Let’s see, what were some other things you did.

Lori: Juggled.

Interviewer: Yes, and one time you told a joke.

Lori: Told a joke.

Interviewer: From the show we did tonight, what was your favorite part?

Lori: The juggling.

Interviewer: The juggling, why do you think you like that so much?

Lori: You can try to stump you.

Interviewer: If we did the show again, what things do you think we should do again?

Lori: Get some different kinds of things.

Interviewer: Get some different things to juggle? O.K. What was it like to be with other kids in the room, what did you think about that?

Lori: Fun.

Interviewer: It was fun? Did you learn anything about any of the stuff in the hospital from the show?

Lori: I don’t want to know.

Interviewer: You don’t want to know. Really. Well, then what was that like to hear us talk about it? Was that O.K. or would you rather we didn’t do that?

Lori: O.K..

Interviewer: O.K. Because that’s the kind of thing I’m wondering, if you like it when they talk about the machines or if you don’t like it.

Mother: Does it help you to be less scared when you know what’s going on, with like the X-ray?

Lori: I’m not scared when it was the X-rays ...
Father: If we could find her tape, she has a children's tape, you could maybe learn a song and sing it with everyone. One of the songs on the tape is "Doctor, Doctor I know you want to help but sometimes it hurts". It's a cute song, it's a rap song.

Lori: Well it's kind of like a rap song.

Father: And it talks about all the different kinds of "ologies", and all the different things the doctor uses, and radiology and that kind of stuff.

Interviewer: Yeah, that would be neat. If we did that everyone could sing along.

Lori (singing): Doctor, doctor I know you want to help but sometimes it hurts.

Interviewer: Well, yeah, that's true isn't it.

Father and Subject: Yes.

Interviewer (to mother): Are there any suggestions you have, or anything you liked about the show?

Mother: I think getting people from the departments, of all the tests and things the children have to go through, I think that's very helpful to let the kids understand the process its going through.

Interviewer: That's what I wanted to do, but I wondered if it would be scary if I did that.

Lori: Well, as long as they’re not doing it for real.

Interviewer: Right.

Mother: Well, speaking from our experience, of having Lori in the hospital several times, she's the type of child that wants to know ahead of time what you’re going to do, give me a detail of the procedure, a run down. So that's the reason that I think it's helpful. You may get a kid come in that hasn’t had the test done yet, and they don't know what to expect. And maybe sometimes the parents themselves don’t, and they don’t know how to put it into words, so that's helpful to the children.

Interviewer: Good. That was one of the goals, to talk with the people, talk a little about the places, and about the things here, and have fun at the same time. Sure was fun.
These interviews and observations indicate that Lori desires information about medical events. Her comments suggest that she has great concern over painful procedures, and is not entirely comfortable hearing about some of them.

It is clear that she enjoyed participating in the television program. She chose to tell jokes, ask questions, and sing. Being able to outsmart the juggler gave her great satisfaction. The program appears to have given Lori opportunities to participate with others, make choices, and use skills. It is not clear whether she learned anything from the program.
CHAPTER V

SUMMARY, CONCLUSIONS AND IMPLICATIONS

Summary and Conclusions

Data indicates a variety of responses among subjects regarding hospital experiences. Those approached were generally willing to participate and express themselves. In general, subjects have a number of opportunities for social interaction. Most report positive social experiences, but others have concerns about making friends. Most children report a desire for more information, especially concerning medical equipment. Activities and social relations are among things reported to make children feel good or important. Data indicate that the playroom is an important aspect of the hospital for these children.

Variety in responses

While a number of trends emerged, observations and interviews yielded a wide variety of responses among subjects. Most were willing, even eager to participate in the study, but others were non-receptive. Answering the open-ended question "Is there anything else you would like to say about being in the hospital", the majority of subjects gave positive responses, but a few had strong negative reactions. Responses varied from "It's fun" and "I like it here" to "I don't want to come back".

Subjects differed in their desire for information and social experiences at the hospital. The range of responses supports the conclusion of several authors (Caty, 1984; Field, 1988) that a variety of styles and levels of coping exist among hospitalized children. This suggests that while developmental issues should be considered in the hospital setting, individual differences must be taken into account. The findings also support the use of research methodology that allows for such differences.
Willingness to participate in study

Although care was taken to present participation as entirely voluntary, most children were quite willing to participate in the interviews and program. This would tend to support the contention that participation and self-expression are important for this group of school-age children. It may also reflect their trust in the staff, developmental factors, or desire to do "the right thing".

The general experience of hospitalization

The overall trend among subjects seemed to be one of enjoying the activities and social opportunities in the hospital, but dreading medical procedures. Subjects were particularly concerned with painful procedures, especially getting "sticks" and "pokes" during IV's. These results support findings of May (1983), who reported a preoccupation with pain among hospitalized school-age children. That study found that staff in-service education resulted in a decline in such negative responses.

The IV was often mentioned by subjects. They described it as something painful, confining, hard to get used to, and something they would change if they could. Several subjects desired more information about the IV and how it worked. One child wanted to know how the staff got kids to calm down during the IV procedure.

Confinement and making friends were problems for some subjects. Given the opportunity to express any feeling about the hospital, most had positive things to say, particularly regarding the staff and it's being a "fun" place. These findings may tentatively support the contention by several authors (Broome, 1987; McClowry, 1990; Saylor, 1987) and others that the school-age population is a very resilient group.

However, the study also suggests that there are psychosocial needs that should be addressed. For example, a high number of subjects desired more information, and one subject cited "making friends" as the most difficult thing to get used to in the hospital.
There was no mention of television in interviews about the subject's experience in the hospital. This was interesting, considering research findings and observations indicating the central role of television with hospitalized children.

Playroom is important

The study demonstrates the importance of the playroom for these children. Interviews indicate it is not only a place children enjoy, but is the primary sight of social interaction. Subjects also report the playroom as a place they have opportunities to feel good and important and to learn about the hospital. Observations support these findings. It was rare to find a child in his/her room during supervised play time unless there was a reason (i.e., getting a treatment, unable to leave room). There was also sporadic activity in the playrooms during evening hours. A variety and number of interactions between patients, staff, and visitors was noted in the playroom.

Activity and Participation

Interviews indicate the subjects enjoy activities and participation. These experiences often occur in the playroom. The subjects particularly enjoy the pinball machine. Using a developmental approach may help explain this phenomenon. Accomplishment and comparing oneself to others are important for the school-age child. While playing pinball one does both, working to gain points, trying to beat other scores. It is a skill the child can develop, a form of mastery. Consider the following excerpt from a subject indicating he enjoys developing skill at the game as well as comparing his results to others:

Interviewer: What things have you enjoyed here in the hospital?
Subject: Pinball machine. Of course, I haven’t tried anything else so I don’t know.
Interviewer: You’ve been practicing on the pinball machine, though?
Subject: Yep, good at it. Got a million and something points one time. That isn’t even the record. The record is like 15 trillion or something, big record.
Results indicate that subjects enjoy and desire active participation. The television program was able to provide such opportunities. Guests and viewers were able to participate through games, songs, jokes and volunteering for demonstrations.

Social Interaction

The data underscores the importance of social issues among school-age hospitalized children. Fifty percent (50%) of subjects cited personal relations with peers or staff as something they enjoyed about the hospital. Interview and observational data indicates a variety of opportunities for social interaction at the hospital. However, 25% of subjects had negative responses when asked about their peer relations in the hospital.

The data indicates a number of places children saw and talked with others, including the playroom, hallway, elevators, and in other patient's rooms.

The majority of children reported ample opportunities to meet others, and that these were positive experiences. But for some, the social aspect of hospitalization is difficult to deal with, as evidenced by one child who said "making friends" was the hardest thing to get used to at the hospital.

The study found few examples of peer modeling. This could be due to inadequacy of measures in the study, or it could be the case that social modeling, learning how others cope, is not as common in the hospital as developmental theory would predict.

Information in the Hospital

Subjects named a variety of locations and sources of information; during procedures, from tours, at the playroom, from nurses, child life specialists, doctors and parents. But there seems to be a general desire for more information, particularly concerning the machines.

The IV machine was most often mentioned. It is possible that this group of subjects had a higher than average experience with IVs. In any case, it is clear that the IV procedure and apparatus held considerable interest and concern for this group of children.
The television program provided a way to inform participants about the machines, people and places in the hospital. Subjects participated in these segments by asking questions and volunteering to assist in demonstrations. Some subjects reported learning from and enjoying the informative aspects of the program. Others were unresponsive to questions concerning information in the hospital and during the program. It is possible that the term "learn" used in interview questions relied on preconceived ideas by subjects. Future research could use alternate approaches to explore how children acquire information at the hospital.

Mastery

The concept of "mastery" is wide-ranging, referring to the ability to adapt and cope successfully to the situation. The question "What things have you done that have made you feel good or important?" sought to illicit from subjects the type of experience that can lead to such mastery.

Responses indicate that active participation, particularly in games and activities, were beneficial to subjects. Social interaction was helpful as well. Many of the experiences occurred in the playroom. Participation in their own health care was also reported to make children feel good or important.

Potential of Live, Closed-Circuit Television

The researcher was able to provide opportunities for participation and making choices through a live closed-circuit television program. Both mobile and non-ambulatory children participated, as did those choosing to remain in their room. Interviews indicate that children were not just passively entertained, but enjoyed the participatory and social aspects of the program. The program served as a tool to provide information and familiarization with the people, places and equipment at the hospital.

Results concerning the informative benefits of the program are somewhat inconclusive. Six subjects reported learning something from the program, three reported no learning.
Some subjects reported enjoying hearing about the machines, but a larger number had no response when asked their opinions on hearing about the machines. Coupled with Phase I results indicating a strong desire for such information, this seems to be a promising area of future research. Can this type of program increase knowledge and comfort levels? And, what happens if knowledge is given to children who do not want it?

In a review of literature on coping styles, Peterson and Mori (1988) conclude that while research gives no definitive answer, there is at least reason to be concerned about how repressor-type children will respond to information. No negative responses to information were noted in the present study, but a large number of subjects gave non-responses when asked their opinion about informative aspects of the program. The present study indicates further investigation is needed concerning hospitalized school-age children's desire for information, and the potential of a closed-circuit program in providing such information.

Children can provide guidance to health professionals

The subjects were generally willing to express their feelings, needs and concerns. This may be due in part to their level of comfort or trust at this particular hospital. While generalizability is limited, the findings suggest that given the opportunity, hospitalized school-age children can help guide health-care professionals to meet their psycho-social needs.

Implications

* Psychosocial needs differ among hospitalized school-age children. Health-care research and programs must respect such individual differences.
* Developmental theory can help in understanding and designing programs for hospitalized children.
* Hospitalized school-age children should be given a variety of opportunities to participate in activities.
The hospital playroom is not only a place where children have fun, but a place where developmental and coping needs are met. Health-care workers can ask children what they want to know and provide appropriate opportunities for information. Closed-circuit television can be used to familiarize children with the hospital environment, entertain, and provide opportunities for participation. Due to the primary role of the playroom as a place for mastery and socialization, one might expect differences between mobile and room-bound children. Future research could compare the hospital experience of these groups of school-aged patients. Future research could examine the ability of such a live, closed-circuit program to produce knowledge gains and increase comfort levels related to hospital machines. Further research is needed to understand what information school-aged children want, and how to provide this information. Future research could examine the potential of an on-going, consistent television program. Future research could consider alternative program formats and programs designed for age-groups other than school-age children.
APPENDIX A

SUBJECTS BY AGE AND GENDER
## APPENDIX A

### SUBJECTS BY AGE AND GENDER

<table>
<thead>
<tr>
<th>Phase I</th>
<th>Subject</th>
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APPENDIX B
ASSENT FORM
APPENDIX B

ASSENT FORM

I agree to be in this study. I understand that someone will ask me questions about being in the hospital, and will tape-record my answers. I can choose not to answer questions and can quit at any time.

I may be asked to help with a television show. The show will be seen on televisions in this hospital. I can choose whether people will see me and hear me on the show, and can quit at any time.

Name and Signature of Subject

Age

Date

Name and Signature of Witness

Signature of Person Obtaining Consent

Signature of Investigator

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APPENDIX C

CONSENT FORM
APPENDIX C

CONSENT FORM

THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS
SUBJECT CONSENT TO PARTICIPATE IN RESEARCH

TITLE OF STUDY: LIVE, INTERACTIVE, CLOSED-CIRCUIT TV PROGRAM

INVESTIGATOR: Russell D. Ravert
OFFICE PHONE#: (817) 565-2555
NIGHT/WEEKEND#: (817) 566-6467

You are being asked to participate in a research study. Persons who participate in research are entitled to certain rights. These rights include but are not limited to the subject's right to:

1. Be informed of the nature and purpose of the research;

2. Be given an explanation of the procedures to be followed;

3. Be given a disclosure of any benefits or risks reasonable to be expected;

4. Be given the opportunity to ask any questions concerning the research and the procedures involved;

5. Be instructed that the subject may withdraw consent to participate or discontinue participation at any time;

6. Be given a copy of the signed and dated consent form;

7. And be given the opportunity to decide to consent or not to consent to participate in research without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

IRB File # 1192 47300
Date Approved DEC 14 1992
TITLE OF STUDY: The Effectiveness of a Live, Interactive, Closed-Circuit Television Program in Meeting Self-Reported Needs of School-Age Hospitalized Children.

You have the right to privacy. All information that is obtained in connection with this study that can be identified with you will remain confidential within the limits of State Law. Information gained from this study that can be identified with you will be released only to the investigators. The results of this study may be published in scientific journals without identifying you by name.

In addition, the records of your participation in this study may be reviewed by members and staff of the Institutional Review Board, and you may be contacted by a representative of the Board for information about your experience with this study. If you wish, you may refuse to answer any questions the Board may ask of you. We also would like for you to understand that your record may be selected at random (as by drawing straws) for examination by the Board to insure that this research project is being conducted properly.

Every effort will be made to prevent any injury that could result from this research. Compensation for physical injuries incurred as a result of participating in the research is not available. Phone numbers where the investigators may be reached are listed in the heading of this form.

If you have any questions about the research or about your rights as a subject, we want you to ask us. If you have questions later, or if you wish to report a research-related incident, you may call the Chairman of the Institutional Review Board during office hours at 214-688-2258.

Participation in this research study is entirely voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time without affecting your status as a patient, or the medical care that you will receive. Under certain circumstances the study may be discontinued by the sponsor or the investigator.

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP
CONSENT FORM

I have asked you and your child to participate in my research study for fulfillment of my Master's Degree at the University of North Texas. The title of my study is "The effectiveness of a live closed-circuit television in meeting self-reported needs of school-age hospitalized children".

This study is designed to gather information from school-age children about their experience in the hospital. I hope to learn which aspects of the hospital school-age children like and dislike, and what activities can help them cope with the experience.

You will be asked a series of questions. You may choose not to answer any question if you wish. The interview will last approximately 10-15 minutes and will be tape-recorded. You may be asked to participate in a television program. If so, you will be given choices on how to take part. You may choose any, or none of the options, and may quit at any time.

There are no known risks if you decide to participate.

You are making a decision whether or not to participate in this study. You should not sign until you understand all the information presented in the previous pages and until all your questions about the research have been answered to your satisfaction. Your signature indicates that you have decided to participate having read (or been read) the information provided above.

Name and Signature of Subject Age Date

Name and Signature of Witness

Signature of Person Obtaining Consent Signature of Investigator

Signature of Legally Responsible Relationship to Subject Representative
APPENDIX D

STRUCTURED INTERVIEW - PHASE I
APPENDIX D

STRUCTURED INTERVIEW - PHASE I

What things have you enjoyed since you have been in the hospital?
Why did you enjoy that? What did you like about it?
What has been the hardest thing to get used to at the hospital?
What is the first thing you would change about being in the hospital?
Where you have chances to talk with other children your age?
What is it like to talk with other children your age in the hospital?
What things do you learn about when you talk with other children here?
Do you think you know enough about the people, places and things at the hospital, or would you like to know more?
Where have you learned about the people and things in the hospital?
What things would you like to know more of about the hospital?
What things have you done at the hospital that have made you feel good or important?
Is there anything else you would like to say about being in the hospital?
APPENDIX E

STRUCTURED INTERVIEW - PHASE II
APPENDIX E

STRUCTURED INTERVIEW - PHASE II

What were some things you liked about the show?
What was it like to hear and talk with other children on the show?
Did you take part in the show? How?
What was that like?
Did you learn anything from the show that will help you?
What would you change about the show?
Is there anything else you would like to say about the show?
APPENDIX F

RATIONALE OF PHASE I INTERVIEW
APPENDIX F

RATIONALE OF PHASE I INTERVIEW

Questions concerning the general hospital experience

What things have you enjoyed since you have been in the hospital?
What is the hardest thing to get used to about being in the hospital?
What is the first thing you would change about the hospital?
Is there anything else you would like to say about being in the hospital?

Questions concerning social interaction at the hospital

Where do you have chances to talk with other children your age?
What is it like to talk with other children your age in the hospital?
What things do you learn when you talk with other children here?

Questions concerning information about the hospital environment

Do you think you know enough about the people, places and things in the hospital or would you like to know more?
Where have you learned about the people, places and things in the hospital?
Where have you learned about the hospital?

Questions concerning opportunities for mastery

What have you done in the hospital that has made you feel good or important?
APPENDIX G

EXAMPLE OF PROGRAM TRANSCRIPTION
APPENDIX G

EXAMPLE OF PROGRAM TRANSCRIPTION

Show #4

Greetings, what we are going to do

Shot of audience

Someone calls - talks with assistant

Opening song - crowd clapping

Ask: "Anyone have a joke picked out yet?" - no

Introduce juggling items - Kim comes up

I ask: "What floor do you work on?"

Ask audience "How many of you have been to playroom today?"

Most raise hands

Ask: "What did you do?" Lori says "played"

Camera shows audience

Kim introduces juggling items from playroom (instrument, bubbles..)

? says "I pop them"

Kim asks "Where else do you get them?" someone says "craft cart"

Holds up letter t "What's this?"

Someone says "scramble"

She says "That's right, scramble or scrabble"

Phone rings - I go get it - climb over sofa

Boy is telling me "don't get on the furniture"

I ask how do people get to use these? She says ask CLS

Mike says "Justin called us to say hi"
Say "Glad you’re watching"
"Justin, if you're watching, want to stump juggler, you can call us again"
Explain "Justin made the call" response
Phone rings
"Who made the call?"
We say "Justin made the call!"
Lori comes up to pick juggling items
I say "before you start", introduce her
She picks three.
I say “ready”
Boy says “I’m ready”
I mess up
Lori reminds me I get three chances
APPENDIX H

PROMOTIONAL FLYER
Wednesday Night!

CMC television and the Child Life Department Present:

Live T.V.!

Watch "You Make The Call" on Channel 31

or

Come be part of the studio audience!

(Juggling, music, special guests and fun)

6:30
Wednesday, Feb. 10
5-East Playroom
APPENDIX I

DESCRIPTIONS OF PROGRAM SEGMENTS
APPENDIX I

DESCRIPTION OF PROGRAM SEGMENTS

"Stay Tuned" Sign

For approximately 10 minutes before each show, the camera was turned on and focused on a sign reading "Stay Tuned, You Make The Call will start at 6:30." This was done to prevent confusion arising if anyone tuned into dead air.

Opening song and greetings

A theme song began each program, in order to provide consistency. The host then greeted the studio and television audience, described the format, and explained how to participate by calling the playroom.

Special guests

Guests were staff members who answered questions about their role at the hospital and used visual aids and volunteers to discuss things at the hospital. Child life staff members discussed toys and games available in the playrooms, how to check out these items, and popular locations in the hospital. An advanced nurse practitioner (ANP) demonstrated and discussed the IV pole one week, and the pulse oxymeter another. She also introduced the medical equipment to be juggled as a way to familiarize and provide information on the objects. On another show, an X-ray technician used a portable machine and a variety of negatives in an informative and entertaining presentation.

Joke break

The host read jokes picked in advance by patients, and invited audience members to tell their own jokes.
Stump the Juggler

Displaying 7-8 items found in the hospital, the host challenged volunteers from the studio or television audience to select three he would be unable to juggle. Two types of items were used, toys from the playroom (i.e., deck of cards, chess piece, toy) and medical equipment (i.e., oxygen mask, syringe). In introducing the items, the guests were able to provide information and familiarization.

Songs

Two songs were written and performed by the host. "The IV Pole Stroll" and "My Friendly Oxymeter" were intended to personalize and familiarize. They also provided opportunities for audience participation. On one program the audience sang along using cue cards, and another night five audience members joined together on-camera to sing with the host.

What is it and What is it

Large photographs of items found in the hospital were partially covered. The host slowly uncovered portions of the picture, and asked the studio and television audience to guess "What is it?". This was intended to provide opportunities for participation and mastery, and to provide further information.

Thanks, Farewell

Each show ended with the host thanking the audience and singing the theme song.

Personal items

Prior to each program, the host visited patient rooms to ask how they wanted to participate. One option was to bring a personal item, such as a painting or stuffed animal, to the room.

Special Volunteers

One child did a magic trick, and another juggled with the host.
Hospital Bingo

Played like regular Bingo using hospital items rather than letters. This game is often used in pediatric hospitals and may be an effective way to provide information on the environment.
APPENDIX J

SUGGESTIONS FOR DESIGNING AND IMPLEMENTING
A LIVE CLOSED-CIRCUIT PROGRAM
APPENDIX J

SUGGESTIONS FOR DESIGNING AND IMPLEMENTING
A LIVE CLOSED-CIRCUIT PROGRAM

Designing the Program

Three steps are necessary to produce an effective and appealing program: to analyze the audience, set program goals, and develop strategies to meet those goals (Andrews, 1989). The following guidelines and suggestions compiled from Crocker (1989), Gaffney (1988), Wilson (1989) and Cameron (1984) may help when planning a live program:

* Target the audience. The age of the audience is of premier importance in designing a television program. Crocker (1989) points out that because of vast developmental differences between age groups, "there is no such thing as a mass child audience" (p. 218). Program goals, subject matter, language used and manner of presentation should be directed toward a target audience.

* Present gender roles, racial groups positively. Adults should be shown in caring, supportive roles.

* Present conflict in a way that a child can understand and demonstrate positive techniques for resolving the conflict.

* Separate fact from fantasy during the program.

* Present humor at a child's level (as opposed to adult sarcasm, ridicule).

* Use a pace that allows the child to absorb and contemplate the material presented.

* Present accurate content. Acknowledge emotions, without attempting to delete negative issues. For example, it is all right to be anxious about the hospital.

* Give children option whether to be on-camera. These children may be dealing with issues of altered body image. Being shown on the broadcast must be voluntary.
Implementing the Program

These tips by Elsner (1989) may help in implementing and hosting a live program:

* Introduce yourself.
* Look into the lens.
* Write each room-bound viewer's name on a cue card and hang it below the camera lens.
* Prepare the viewer for participation. Tell about the show, how to participate, and the length of the show. Be sure to allow time to formulate thoughts before putting a child on camera.
* Use appropriate language, genuine interest.
* Use engaging, open-ended questions.
* Use directive statements, ways for the children to respond. "Raise your hand if you have been to the playroom."
* Give viewers time to participate. It may take time to dial phone, or react to cues.
* Identify the voice of a caller, make them feel involved.
* Use dramatic techniques. Use facial expressions.
* Personalize the show. Remember special bits of information about the patients. Use nicknames, include family members.
* Close the program. Prepare the audience for the end of the show by allowing one last chance to call in or using theme music.

These additional tips from the author may help as well:

* Briefly discuss the show with the camera person in advance. Be courteous when moving around. Quick, unpredictable movements are hard to follow on-camera.
* Have water available for the host and guests.
* Talk with studio audience before the show begins. Explain the format, purpose, how they can participate.
* Keep notes during pre-show visits to patient rooms, such as their name, what floor they are on, and who else may have been in the room when you talked with them. Then transfer all into one central form to avoid fumbling while on-camera.

* Decide what you will do when the program ends. Children usually like to talk and look at show items. The host may want to visit television participant rooms to say hi or return personal items. The playroom might need to be re-arranged, and equipment put away.

* Use qualified personnel as guests in all hospital-related issues. For example, a nurse or doctor may help in discussions of medical procedures, while a child life specialist could help in discussing what it is like to be in the hospital.

* When giving children options regarding the show, remember that they will only be able to be on camera if their parent signs the release form (if this requirement applies).

* Bring adhesive note pads. They are helpful when gathering art pieces or other items from children, or marking which joke they pick out of the jokebook.

* Discuss your questions briefly with guests. Begin with simple, general questions such as "what do you like about working here", or "how did you become interested".

* Use a stand to display artwork or other items. This will help the camera person keep a steady picture.

* Discuss program ideas and goals with staff. Program objectives must match those of the hospital. The support and assistance of the staff is essential to the implementation and success of the program.

* Be well-prepared but flexible. In the fast-paced hospital environment, situations and priorities can change unexpectedly.

* Arrange seats so children can choose to be on-camera or not.

* Allow space for children to enter and exit easily.
APPENDIX K

LYRICS TO SONGS USED IN THE PROGRAM
APPENDIX K
LYRICS TO SONGS USED IN THE PROGRAM

Opening Theme Song (by Russell Ravert)
You make the call, we hope you'll make the call,
We'd really like to hear from you all, we hope you'll make the call.
This show is your show too, this show is your show too,
We'd really like to hear from you, this show is your show too.
So, (repeat first verse)

IV Pole Stroll (by Russell Ravert)
What's got five wheels, and loves to roll?
I'm talking about an IV pole,

CHORUS:
Do the IV pole stroll, do the IV pole stroll,
Do the IV pole stroll, everybody rock and roll.

Push it to the left, push it to the right,
this IV pole dance, man it's out of sight,

(CHORUS)
Beep, beep, beep goes the little blue box,
That's when this place really rocks

(CHORUS)
Everybody's dancing, down the hall,
with an IV pole, about seven feet tall,

(CHORUS)
BIBLIOGRAPHY


