CHILDREN'S USE OF TRANSITIONAL OBJECTS IN PEDIATRIC HEALTHCARE SETTINGS: POLICIES AND PRACTICES

By

Katelyn S. Leitner

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Director of Thesis: Dr. Sandra Lookabaugh

Major Department: Human Development and Family Science

Children experience medical interventions and hospitalizations every day. These settings are often characterized as strange and unfamiliar for children, may require some separations from established attachment figures, and have the potential to be extremely stressful. Many children turn to transitional objects such as soft stuffed animals or blankets to facilitate comfort in these environments, as these objects soothe and calm children when they are experiencing anxiety-like symptoms. Child life specialists work as a part of multidisciplinary healthcare teams, with a central role of identifying effective coping strategies for children who are experiencing stress. For many children, this coping mechanism may be the use of a transitional object. Currently, there is limited research examining children's use of transitional objects in healthcare settings or how child life specialists advocate for children's use of transitional objects in healthcare settings. The purpose of this study was to examine how child life specialists advocate for the use of transitional objects in pediatric healthcare settings. Using an exploratory design, the current study explored the current policies in medical settings that guide the use of transitional objects, as well as the practices of child life specialists when they encounter a child with a transitional object. Participants answered questions about how the policies at their setting are created,

questions about their level of knowledge about transitional objects, and situational questions regarding their practices with transitional objects. Responses from 24 participants were analyzed through descriptive statics and thematic analysis. Results of the study revealed that only five of the 24 participants reported that their setting did not have any policies guiding the use of transitional objects. The majority of participants (*n*= 14) reported that they felt mostly knowledgeable about transitional objects, the majority of participants (*n*= 21) also believed transitional objects to be extremely important in stressful settings. Overall, participants revealed that they were willing to advocate for children's need to have access to transitional objects in healthcare settings.

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Katelyn S. Leiter

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Katelyn S. Leitner

APPROVED BY:

DIRECTOR OF THESIS: _____
Sandra Lookabaugh, PhD

COMMITTEE MEMBER: _____
Natalia Sira, PhD

COMMITTEE MEMBER: _____
Mary Frances Drake Pate, PhD

CHAIR OF THE DEPARTMENT
OF HUMAN DEVELOPMENT
AND FAMILY SCIENCE:_____
Sharon Ballard, PhD

DEAN OF THE
GRADUATE SCHOOL: _____
Paul J. Gemperline, PhD

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

In 2009, there were 6.4 million overnight hospital stays for children 17 years and younger (Yu, Wier, & Elixhauser, 2011). This number accounts for almost 17% of all hospital stays that year (Yu et al., 2011). Children are hospitalized due to chronic conditions, trauma, and everyday illnesses or procedures. A child's hospital stay lasts on average 3.8 days, with 2.3% of children being discharged to another hospital or institution (i.e. rehab facility) (Yu et al., 2011). Hospitalization requires various degrees of separation from children's parents or caregivers, being placed in an unfamiliar, and potentially stressful environment. In addition to an unfamiliar setting, they are also surrounded with unfamiliar people such as physicians, physician's assistants, nurses, dieticians, social work, and child life specialist are constantly streaming in and out of rooms. These medical professionals are speaking in an unfamiliar medical language, poking and prodding the child, affecting the child's psychosocial attitudes (Kaddoura, Cormier, & Leduc, 2013). All of these factors lead to increased levels of stress and anxiety for a child who does not understand what is going on, especially if he/she has been placed in the environment suddenly.

It is estimated that about 60% of children in Western cultures are classified as object attached (Lehman, Arnold, & Reeves, 1995). These objects are typically soft in nature and are usually blankets, pillows, or soft toys. Object attached children use their objects as soothers or for comfort as they go to sleep or are experiencing distress. These child-object relationships are characterized as intense and persistent, and are developed as an extension of a secure attachment to the child's caregiver (Lehman et al., 1995). Therefore, the objects provide the child a semblance of the same soothing and comforting qualities as the presence of his/her secure attachment figure.

Nurses are often recognized as the foundation of care for hospitalized patients and their families throughout their healthcare experience (Kaddoura et al., 2013). Alongside nurses are child life specialist, who are working to ease many of the fears and anxieties of children and families in healthcare settings. Child life specialists are trained in combining developmental knowledge with their expertise in helping children/families overcome challenges related to healthcare, hospitalization, illness, and disability. They foster an environment that incorporates emotional support, encouraging understanding and cooperation by providing non-medical support, preparation for children in medical settings, and helping to identify healthy coping strategies meeting each individual child's needs (Kaddoura et al, 2013).

CHAPTER 2: Theoretical Review

The current study utilizes attachment theory based on the work of John Bowlby and Mary Ainsworth (Ainsworth, Bell, & Stanton, 1971; Bowlby, 1980; Bretherton, 1992) to explore the use of transitional objects in pediatric medical settings. In addition to attachment theory, Winnicott's theory (Winnicott, 1953), which established the transitional phenomena and defined transitional objects in regards to a "not-me possession" (Winnicott, 1953) is used to examine the objects in a pediatric medical setting. Both of these theories, attachment and transitional object, will be used to further examine children's use of transitional objects with regards to their hospitalization experience and to examine child life specialist's perspectives of children's use of transitional objects.

Attachment Theory

Attachment theory is established by the combined work of John Bowlby and Mary Ainsworth. Bowlby began his work in the 1930's by examining maternal loss and personality development. Ainsworth began her research by examining security theory. The two united in the 1950s to examine attachment, in both individual and joint research projects (Bretherton, 1992).

Bowlby. The foundation of attachment theory was first establish by John Bowlby and was rooted in ethology, and developmental psychology (Bowlby, 1980). Bowlby first recognized behaviors of distress in animals when they lose contact from their parent, in addition to other ways of maintaining close proximity. Bowlby also saw that animals clung to their caregiver and became the first behaviors Bowlby deemed attachment behaviors. Bowlby recognized these behaviors as instinctive and highly adaptive, protecting the baby animals from prey. Bowlby then saw the same patterns of behavior in humans and began to study the attachment relationship in humans, as well as different aspects of the relationship (Bowlby, 1982).

Bowlby revolutionized the way the child-mother relationship is thought of with regard to deprivation and separation (Bretherton, 1992). Bowlby identified the behaviors of crying, clinging, or desiring to be in the proximity of the caregiver as attachment behaviors (Bowlby, 1982). Attachment behaviors are part of humans' instinctive nature for survival and adaptation (Bowlby, 1973).

Bowlby's initial studies sought to define how family experiences in early life can effect emotional development of an individual, in particular to emotional attachment. Bowlby's research was grounded in interviews and observation studies (Bretherton, 1992). In Bowlby's early conclusions, there was a presence of psychoanalytical theory. Bowlby found that during a child's first years, he/she is developing the ability to self-regulate, during which, the mother acts as the child's ego and superego. Bowlby postulated, that for children to grow up with a healthy mental state, they require a warm, constant relationship with a mother-like figure that satisfies the child. After concluding the importance of establishing attachment, there needed to be a distinction made between attachment and dependency. Bowlby stated that attachment is not suggestive of a child's regression, but rather, attachment is a healthy function that continues into adulthood (Bretherton, 1992).

Bowlby identifies four phases that attachment is established within through behaviors of the child (Bowlby, 1973; Bowlby, 1982). The first phase, social gestures with limited selectivity, occurs from birth to three months. During this stage, the infant's selectivity is limited, responding to everyone in the same way through social smiles that occur for almost all interactions. Different behaviors such as smiling, babbling, crying, and holding on are elicited by the infant to help promote attachment to the caregiver. Smiling and babbling help promote a loving relationship that causes delight in the caregiver, while crying and holding on behaviors

assist in maintaining proximity to the caregiver. Phase two, focusing on familiar people, occurs between three to six months. During this stage, infants' social interactions become much more selective, only occurring for familiar people. Infants will typically identify two or three people that they prefer, with one in particular that they have developed the strongest attachment. This preferred individual is characterized by being the most alert in responding to the infant's signals and has engaged in the most pleasurable interactions with the infant. Phase three, intense attachment and active proximity-seeking, occurs from 6 months to three years (Bowlby, 1982). During this stage, infants are characterized to cry out when the caregiver leaves the room, displaying separation anxiety. Infants also begin displaying signs of fearing strangers. By the end of the infant's first year, a working model of the attachment figure should be established through day-to-day interactions. The fourth and last phase, partnership behaviors, occur during 3 years to the end of childhood. During this time, the child is only concerned with their own need to maintain a close proximity to their care giver. As the child ages, they begin to take more of a partner role in the relationship and are more willing to let the parent go for a period of time (Bowlby, 1973; Bowlby, 1982).

Separation anxiety that beings to occur in the third phase of attachment (one to three year olds), was a second term defined by Bowlby, as a follow up to attachment. Three phases of separation were identified; protest, despair, and denial or detachment (Bowlby, 1980; Bretherton, 1992). The stage of protest is characterized by crying and screaming for the attachment figure. Despair is characterized by the child becoming uncharacteristically quieter, less active, and appears to be in a visible state of mourning. Denial or detachment is characterized by the child becoming livelier and accepting the care of others. The child may also turn away from the caregiver when they return, as a protection against further disappointment (Bowlby, 1980).

Bowlby expresses that separation anxiety occurs when children encounter a situation that stimulates both escape and attachment behaviors when there is not an attachment figure present. Visible reactions of grief and mourning are displayed when a child's attachment behaviors are initiated, however, the attachment figure continuously makes themselves unavailable (Bretherton, 1992).

Bowlby identified a sensitive period that encompasses the child's ability to imprint. The child's relationship formed with the attachment figure is indicative of imprinting, and is motivated by the child's need for protection (Bretherton, 1992). Imprinting occurs through the child's signaling for distress by crying for the caregiver or smiling at the caregiver, showing love, and continues until an established preference for an individual is shown (Bowlby, 1982). This figure will then be utilized as a secure base, further defined by Ainsworth, being crawled after and wanted in close proximity (Bowlby, 1982; Bretherton, 1992). Bowlby notes that there are two distinct stimuli that create fear in children, one is the presence of clues to danger, and the other is the absence of the attachment figure (Bretherton, 1992).

Ainsworth. Bowlby's theory of attachment was empirically tested by Mary Ainsworth, who expanded and further established attachment theory expanding the theory to include the mother as a secure base (Ainsworth et al., 1971; Bretherton, 1992).

Ainsworth began her studies at the University of Toronto, where she was introduced to Blatz's security theory, and continued studies with Bowlby's research projects (Bretherton, 1992). After working under the direction of Bowlby, Ainsworth moved to Uganda and began her own observational studies of mother-child interactions and attachment. The Strange Situation was a laboratory experiment created by Ainsworth that examined infant's abilities to balance attachment and behaviors of exploration under different levels of stress (Ainsworth et al., 1971;

Ainsworth, Blehar, Waters, & Wall, 1978). The Strange Situation is a study that takes place in a laboratory setting and separate children of twelve months from their mother in three different stages or situations that each last about three minutes, twenty minutes total.

It is a series of eight episodes lasting approximately 3 minutes each: (and each becoming increasingly more stressful for the child)

1) Mother, child, and experimenter (lasts less than 1 minute).

2) Mother and child alone.

3) Stranger joins mother and child.

4) Mother leaves child and stranger alone.

5) Mother returns to child and stranger leaves.

6) Mother leaves; child left completely alone.

7) Stranger returns to child.

8) Mother returns to child and stranger leaves.

In the first situation, infants are introduced to a new environment and the mother remains present, observations are made about how the children explore the new setting while utilizing the mother as a base. The second stage introduces separation from the mother, the infants are left with a stranger and in a new environment. In the third and final stage, the infants are left alone in a new setting without the mother and stranger (Ainsworth et al., 1971; Ainsworth, et al., 1978). Ainsworth's study yielded that infants were much more prone to explore the surroundings with their mother present, than when a stranger was present, or with the mother absent (Ainsworth et al., 1971; Ainsworth et al., 1978; Bretherton, 1992). The reunion behaviors

displayed by the children, upon being united with their mother revealed a continuation of Bowlby's research into ambivalent and avoidant behaviors.

In the study of the Strange Situation, Ainsworth was able to refine Bowlby's definition of secure base and identify different patterns of attachment in attachment theory. There were three defined infant attachment styles identified: secure, insecure-avoidant, and insecure-ambivalent (Ainsworth et al., 1971; Ainsworth, et al., 1978; Bretherton, 1992). The three attachment styles were defined by the interaction between the mother and infant (Bretherton, 1992). In securely attached pairs, the infant cried very little and felt free to explore their surroundings with the mother present, utilizing the mother as a secure-base. When the mother did leave the room, the infant's exploratory play ended and the infant sometimes displayed visible signs of distress and upon the mother's return they actively greeted the mother (Ainsworth et al., 1971; Ainsworth et al., 1978). Ainsworth believed that this pattern of attachment was the healthiest. Infants who were categorized as insecure-avoidant attached would enter the new setting and explore their surroundings, paying very little attention to the mother. The infant did not check in with the mother, and when the mother left the room, the infant did not become visibly upset. Upon the mothers return, the infant did not seek proximity and tried to avoid her. These infants could appear as overly independent. Insecure-ambivalent infants are categorized as being overly clingy and extremely preoccupied with knowing the mothers whereabouts. The infant showed visible signs of distress when the mother left, when the mother returned the infant would switch between being happy to see the mother and angrily pushing the mother away (Ainsworth et al., 1971; Ainsworth et al., 1978). Ainsworth noted that many of the attachment categorizations correlated with the mother's sensitivity to the infant, this also correlated with the infant's security (Bretherton, 1992). Later, Main and Solomon (1990) identified a fourth attachment style to be

added to Ainsworth's contributions. This fourth attachment style is identified as disorganized/disoriented and is intended for the infants in the Strange Situation study that did not fit into the categories of securely attached, insecure-avoidant, or insecure-ambivalent (Main & Solomon, 1990). Disorganized/disoriented infants are characterized by the ways they reacted when their mother re-entered the room. The infant wants to approach the mother, however, the infant shows signs and facial expressions that communicated the infant was afraid to do so, the infant was at a loss of how to act. This fourth attachment style introduces possibilities of how physical abuse fits into attachment styles (Main & Solomon, 1990).

Ainsworth further identified characteristic infant-mother interactions that occur during the infants first three months, and separate studies were conducted to further study each interaction (Ainsworth et al., 1978; Bretherton, 1992). The interactions were feeding interactions, mother-infant face to face scenarios, infant greetings, the balance between attachment and explorations, infant obedience, bodily contact between mother and infant, and affectionate contact. Ainsworth concluded from a study that mother's levels of responsiveness was directly related to the infant's ability to achieve and develop confidence in their abilities. The level of responsiveness from the mother leads to the building infant's confidence level, and in belief that the infant has control over what happens to them from their signals (Ainsworth et al., 1978; Bretherton, 1992).

The different attachment types as defined by Bowlby and further established by Ainsworth remain relevant today, as do their definitions of secure base and descriptions of separation. Empirical literature supports understanding that the security of the child's attachment to their primary care giver is necessary to create a full understanding of the development of the child within the family (Donate-Bartfield & Passman, 2004). The attachment

relationship between the child and caregiver directly effects the type of relationships that are formed with other family members. Avoidant behavior/attachment is characterized by avoiding contact with the parent or attachment figure and when they are reunited, they do not greet the parent. Children are managing the conflict of this relationship and able to control their interactions by not having an interaction with the attachment figure at all. Therefore, the security of the child's attachment to parents or other caregivers have important effects on the child's day-to-day habits (Donate-Bartfield & Passman, 2004).

Transitional Phenomena/Object

In 1953, Donald Winnicott presented his idea of the transitional object and how they play a role in children's development. Children's abilities to attach themselves to objects displays a phase of ego development, and later assist in the child develops a sense of self (Litt, 1986). Winnicott focused on defining the transition from an infant's first in-mouth activities, such as thumb sucking, and relying on a teddy or other soft toy for comfort (Winnicott, 1953). Transitional phenomena was established through Winnicott's observation of objects that gain importance to the child by examining a personal pattern that children develop with objects that are not contained within themselves. Winnicott states that when a child connects a common experience with an auto-erotic experience, for example, using a piece of cloth or blanket and sucking on it or sucking on a thumb and babbling, is indicative of transitional phenomena. Transitional phenomena is also visible through a child's use of objects that are not part of their body, but are also not completely recognized to be part of the external reality. The phenomena is seen through children's use of these objects when going to sleep, and as a defense against anxiety, or depression. The use of the object displays the phenomena Winnicott speaks of, the object used is what he terms the transitional object. The soft object used by the child in the

transitional phenomena and woven into their daily pattern is what Winnicott defines as a transitional object. Winnicott suggested that the pattern of transitional phenomena begins to emerge between 6 and 12 months of age. This object is valued by the child and taken most places that the child goes. In addition to traveling with the child, it can also not be washed. Many times washing the object can break continuity in the experience and can destroy the meaning of the object for the child. Winnicott (1953) notes there is no observable difference when considering gender in the choice of transitional objects.

An important quality in the relationship between the child and object, is that the object never changes unless done so by the child. The objects holds so much symbolic value for the child that it becomes the child's reality. Even while children may not be able to cognitively understand symbolism yet, the object is able to show the beginnings of symbolism. Winnicott (1953) also bases the relationship off of ideas set forth in Freud's psychoanalytic theory. Winnicott (1953) observed that most objects began as oral stimulation with sucking on a corner of a blanket or thumb. Winnicott conceptualizes that children are able to establish attachment to transition objects due to the child's experience in their nursing relationship (Litt, 1986). A satisfactory nursing relationship is necessary for children to transfer those soothing properties to another object for self-soothing, however, nursing is not a necessary pre-requisite for stabling a child's use of transitional objects (Litt, 1986). Transitional objects continue to be used as a defense mechanism, to protect and soothe the child when facing anxieties or depression (Winnicott, 1953).

CHAPTER 3: Review of Literature

Based on the theories of attachment presented by Bowlby and Ainsworth (Ainsworth et al., 1971; Bowlby, 1973; Ainsworth et al., 1978; Bowlby, 1980; Bretherton, 1992), as well as the criteria of transitional objects as established by Winnicott (1953), one can hypothesize the importance of the child's relationship with a transitional object. In understanding the transitional phenomena and the transitional objects utilized by children, it is important to examine previous empirical research on transitional objects. Examination of how transitional objects are defined, perceptions and attitudes about transitional objects, and the benefits transitional objects can offer children in a variety of settings is needed.

What Are Transitional Objects

Transitional objects are often defined to be a special inanimate object that is used for the purpose of soothing and providing comfort (Free & Goodrich, 1985; Lehman et al., 1995; Triebenbacher, 1996; Passman et al., 2000; Steier & Lehman, 2000; Donate-Bartfield & Passman, 2004; Fortuna et al., 2014). Examples of common transitional objects are soft pieces of cloth, blankets, stuffed animals, or pillows (Free & Goodrich, 1985; Wolf & Lozoff, 1988; Lehman et al., 1995; Steier & Lehman, 2000; Donate-Bartfield & Passman, 2004; Fortuna et al., 2014). The most common action is for children to rub, or stroke, or hug the object; or want the object in close proximity but not touching them (Triebenbacher, 1996). Children's ability to establish attachment to a transitional object can also be seen as establishing a protective factor (Fortuna et al., 2014). The object's presence is able to provide the child with a sense of emotional protection, as seen through the soothing qualities for the child (Lehman et al., 1995; Ybarr, et al., 2000; Fortuna et al., 2014). The transitional object has special qualities that are present in the relationship with the child, as specifically described by Winnicott (1953):

1) The infant assumes rights over the object, and we agree to this assumption. Nevertheless, some abrogation of omnipotence is a feature from the start.

2) The object is affectionately cuddled, as well as excitedly loved and mutilated.

3) It must never change, unless changed by the infant.

4) It must survive instinctual loving, and also hating, and, if it be a feature, pure aggression.

5) Yet it must seem to the infant to give warmth, or to move, or to have texture, or to do something that seems to show it has vitality or reality of its own.

6) It comes from without from our point of view, but not so from the point of view of the baby. Neither does it come from within; it is not a hallucination.

7) Its fate is to be gradually allowed to be decathected, so that in the course of years it becomes not so much forgotten as relegated to limbo. By this I mean that in health the transitional object does not 'go inside' nor does the feeling about it necessarily undergo repression. It is not forgotten and it is not mourned. It loses meaning, and this is because the transitional phenomena have become diffused, have become spread out over the whole intermediate territory between 'inner psychic reality' and 'the external world as perceived by the two persons in common', that is to say, over the whole cultural field.

Parents react to the formation and the presence of a transitional object relationship with a child by organizing and establishing relevant child rearing practices with transitional objects in mind (Steier & Lehman, 2000). While parents may fulfill the role of protecting the transitional object, the object may not be able to be cleaned due to the risks of the object losing its meaning

("Teddies", 1994; Triebenbacher, 1994). Children are able to tell a change in the objects external texture and this can translate in to a change in the child's attachment and the meaning of the transitional object ("Teddies", 1994; Triebenbacher, 1994).

Children's Use of Transitional Objects

Infants who turn to the use of transitional objects generally have established a secure attachment with their mother or other attachment figures before establishing an attachment to a transitional object, indicating the child's healthy level of socioemotional development (Passman, 1987; Donate-Bartfield & Passman, 2004). The use of transitional objects begins in infancy, when the infant first begins to integrate the "not-me" possession into their daily patterns (Triebenbacher, 1996). Infants will turn to transitional objects as a substitute for the mother when she is unavailable, providing soothing qualities for anxious reactions, and provide comfort for the child when under stressful situations or when feeling vulnerable (Wolf & Lozoff, 1988; Triebenbacher, 1996; Ybarra, Passman, & Eisenberg, 2000; Fortuna et al., 2014). Transitional objects are used to smooth the acceptance of unfamiliar situations and the gradual separation from the mother or other established attachment figure (Free & Goodrich, 1985; Passman, 1987; Triebenbacher, 1996; Ybarra et al., 2000). Attachment to an inanimate transitional object is not indicative of an unhealthy parent-child relationship and is a part of a child's normal development (Lehman et al., 1995; Triebenbacher, 1996; Fortuna et al., 2014). Children's ability to establish and maintain attachment to a transitional object has previously been connected to the development of healthy separation-individuation and emotion (Lehman, Arnold, Reeves, & Steier, 1996). The typical healthy development of children allow them to be able to differentiate internal experiences from the external reality. Children's use of transitional objects shows support of their healthy development because they are able to distinguish the difference between

their object and what is taking place externally (Lehman et al., 1995; Passman, 1987; Wolf & Lozoff, 1988).

Children's Perceptions of Transitional Objects

Lehman, Arnold, & Reeves (1995), examined the relationship between child and transitional object from the perspective of the child. The goal of the study was to understand the child's beliefs about their transitional object and where these beliefs come from (Lehman et al., 1995). Eighty-one children between the ages of four and eight years were interviewed, out of the eighty-one children, 55% children had transitional objects (n= 45). Interviews about the transitional objects were conducted with all of the transitional object attached children. Children discussed the characteristics of the object, the object's history, why they used the object, if the parent(s) encouraged or discouraged use of the transitional object, and the children's attitudes about the object (Lehman et al., 1995).

Results of the children's interviews about their transitional objects characteristics revealed that the most prevalent topic was the objects texture. The texture was discussed in terms of the objects softness, furriness, or smoothness (Lehman et al., 1995). The children also described the objects cuddliness, smell, color, and temperature. The history of the transitional object revealed that most of the children believed they had possessed the object for a long time, receiving the object when they were a baby. All of the transitional objects in the study had been named and over half of the participants said that they named the object. Children were asked about how and when they use their transitional objects, identifying settings that they would most want their transitional object with them. The first setting choice for over half (55%) of the object attached children was at bedtime or naptime. The object attached children also identified

different emotional states that would make them want their transitional object. These emotional states included; sad, sleepy, scared, angry, and lastly, happy. Children revealed that the objects would help them in frightening or upsetting situations such as monsters or bad dreams. The children stated that they want their object because it would give them control over the situation because the object does what it is told to do and they can express freely to their objects because they won't tell anyone (Lehman et al, 1995).

Parent's Perceptions of Transitional Objects

To further explore children's use of transitional objects, Triebenbacher (1996) examined the attitudes and perceptions that parents have about their child's use of transitional objects. Mothers and fathers varied in their view of their child wanting or needing their transitional objects, with mothers responding that their child wanted or needed their object in more situations than the father. However, mothers and fathers agreed that their child wanted or needed their transitional object when: going to sleep; feeling tired or upset; and not feeling well. While parents agreed on scenarios where the object was wanted, they also agreed on scenarios where the child should not take their transitional object. Parents perceived that children's transitional objects should not be taken to church, out in public locations, or at school. Triebenbacher's study revealed that overall, both mothers and fathers understand the significance of their child's transitional object, and the importance of the child's attachment. In fact, parent's use of transitional objects in their childhood is related to their acceptance of their child's transitional object (Triebenbacher, 1996).

In addition to Triebenbacher's study (1996), Lehman et al., (1995) and Lehman et al. (1996) examined mother's perspective of their child's transitional object. Mothers revealed that 68% of their children had established an attachment with their object before the age of 18 months

(Lehman et al., 1995; Lehman et al., 1996). Interviews with mothers about their child's transitional objects centered around four themes: maternal descriptions of their child's object, maternal attitudes about their child's object use, maternal beliefs about transitional objects, and maternal practices with transitional objects. Maternal attitudes revealed that most mothers were pleased about their child's use of transitional object, as compared to the concept of being anxious about their use (Lehman et al., 1996). Mother's also discussed that some children have multiple transitional objects. These children were able to use their multiple objects interchangeably, and all of the objects were from the same category, i.e., one child had four blankets or one child used three diapers (Lehman et al., 1995). Mothers revealed that they believed the most important attributes of the selected object were the texture and softness of the object (Lehman et al., 1996). When asked their perception of a time when their child would most want their object, mothers chose bedtime or naptime significantly higher than any other event. Lehman, et al. (1996) also provided insight in mothers' perceptions of the functions or uses of transitional objects. Mothers perceived that transitional objects were most useful when the child was sleeping, separating from the parents, and mastering challenging tasks. The objects were believed to facilitate behaviors of comfort, security, supporting the child in feeling braver, and reducing fear. Lastly, the results revealed that mothers believed the objects to be supportive due to its ability to always be accepting of the child, and the child's ability to control the object allows the child to feel comfort by utilizing their own resources (Lehman et al., 1996).

Triebenbacher's (1996) and Lehman's (1996) studies on parental perspectives of children's use of transitional objects found may parallels. Parents in both studies understood the importance of transitional objects when the child was going to sleep, either at bedtime or naptime. Parents in both studies also agreed that their children most wanted/needed their object

when feeling upset or sad, and when they did not feel well. Overall, parents agreed that transitional objects would be needed by their child in settings where there was a separating from parents (Lehman, 1996; Triebenbacher, 1996).

Benefits of Transitional Objects in Different Settings

Transitional objects can assist in facilitating internalization and aid in the process of separation from mother or another established attachment figure (Free & Goodrich, 1985; Passman, 1987). The objects allow a child a place to direct their attention and attachment behaviors in the absence of the parent (Ybarra et al., 2000). In addition to assisting separation, transitional objects can provide comfort for children when they are experiencing situations that they perceive to be stressful (Ybarra et al., 2000; Fortuna et al., 2014). In some situations, the mere presence of the transitional object can promote children's adjustment and ability to cope with the situation they are encountering (Ybarra et al., 2000; Donate-Bartfield & Passman, 2004). In all settings, transitional objects are viewed to be beneficial because they allow the child to feel and experience some level of control, even in situations where they experience levels of anxiety, and allow the child to have their comfort under their own control (Passman, 1987; Fortuna et al., 2014; "Teddies", 1994; Triebenbacher, 1994). Transitional objects are attributed with providing the child a buffer against overstimulation, thus serving as a protective factor (Passman, 1987; Ybarra et al., 2000).

New and Novel Experiences. Mothers are often noted as the primary caregiver of children. While functioning in this role, mothers may witness the comforting and soothing properties of transitional objects on children, instead of fathers (Triebenbacher, 1996). While mothers note the importance of transitional objects for comfort, they also notice how children can turn to the transitional objects during their absence (Passman, 1987). When children enter

new environments with their mother and/or transitional object, they are more likely to explore and adjust to the new surroundings (Passman, 1987). In addition to utilizing transitional objects in new environments for adjustment, they can also serve a comforting function. Steier, and Lehman (2000) conducted a study examining the choices children would make between seeking the mother or transitional object for comfort in different scenarios. In one episode when the children encountered a clown, having a fear-provoking stimulus present, two-thirds of the children in the study relied on their object for comfort due to the absence of the mother (Steier & Lehman, 2000).

Sleep. The use of transitional objects for sleep was defined by Wolf and Lozoff (1988) as utilizing the object in the shift of the wake state to the sleeping state (Wolf & Lozoff, 1988). Children use transitional objects when falling asleep for comfort when the parent leaves ("Teddies", 1994). Optimally, during the first year of life, infants should develop self-soothing behaviors for falling asleep (Burnham, Goodlin-Jones, Gaylor, & Anders, 2002). Even at one year of age, infants are rarely able to sleep through the entire night without some awakenings or arousals, creating a need for these self-soothing behaviors (Burnham et al., 2007). When infants are developing their self-soothing behaviors, it is common for parents to promote the use of sleep aids. Many of the sleep aids that are used by children to facilitate sleep continue on and become the child's established transitional object (Burnham et al., 2007). In Free and Goodrich's study (1985), mothers stated that transitional objects made bedtimes a smoother process and children's separations from home easier. The use of transitional objects for sleep was analyzed by Wolf and Lozoff (1988) when they examined the parents sleeping habits in relation to the child's, in addition to the child's use of transitional objects. It was found that children who utilize transitional objects have better sleep management (Wolf & Lozoff, 1988). Children who sleep

alone, away from parents, are left to self-soothe and cope with the parental separation when the child is not readily able to fall asleep (Wolf & Lozoff, 1988). When children sleep alone, they are more likely to become object attached, because of the nature of transitional objects to calm in stressful situations (Wolf & Lozoff, 1988). In addition, mothers and fathers both agreed that children wanted or needed their transitional object when going to sleep (Triebenbacher, 1996).

Child Care Settings. The child care setting creates a place where the child must separate from any significant caregivers and attachment figures. Triebenbacher and Tegano (1993) explored children's use of transitional objects when separating from these significant figures in a child care setting. The study revealed that children utilized their transitional objects when separated from their caregiver, showing more touching behaviors with object after separation took place (Triebenbacher & Tegano, 1993). The stressful situation of separating may cause anxiety symptoms that manifest themselves in ritualistic touching behaviors with their transitional object for comfort (Triebenbacher & Tegano, 1993). In Fortuna, et al.'s (2014) twin study, examining the influence of child care settings on transitional object use revealed that children who spend full days there are significantly more object attached than the children who spent half days at the child care facility (Fortuna et al., 2014). The results of both studies support the notion that transitional object attached children may utilize their objects to reduce feelings of anxiety and support separation (Triebenbacher & Tegano, 1993; Fortuna et al., 2014).

Medical Settings. Parent-child separations are recognized as a cause for distress in children (Thurber, Patterson, & Mount, 2007). Transitional objects are documented as an attachment behaviors that can minimize the distress behaviors associated with separation from parent. Homesickness is defined as a behavior that is caused by an actual or anticipated separation from home (Thurber et al., 2007). Homesickness is characterized by longing thoughts

of home or transitional objects. There are physical and mental risk factors that are associated with homesickness, such as low perceived control, preseparation anxiety, little previous experience away from home, and expressed parental separation anxiety (Thurber et al., 2007). Hospitalized children may experience an unexpected separation in a completely unfamiliar environment that may be associated with large amounts of physical and/or emotional distress (Thurber et al., 2007). Physiological responses to anxiety can cause complications to care, prolonging the estimated time to heal and possibly delaying effects of anesthesia (Thurber et al., 2007). In 2009 alone, there were 6.4 million overnight hospital stays for children 17 years and younger, accounting for almost 17% of all hospital stays that year (Yu et al., 2011). Children's hospital stays last on average 3.8 days, with 2.3% of children being discharged to another hospital or institution (Yu et al., 2011).

Children often experience anxiety in anticipation of medical appointments or procedures, in addition to the exam appointment or hospitalization ("The Children's Hospital of Philadelphia", 2012). Free and Goodrich (1985) found that transitional objects were utilized by children in the hospitalized group (psychiatric hospital), much more often than their non-hospitalized counterparts when comparisons were made between the groups. Hospitalized adolescents revealed that transitional object attachment assisted in resolving separation issues and helped the adolescent develop their sense of self (Free & Goodrich, 1985). Even routine pediatric examinations have been identified as a time when children are distressed and passive to what is taking place around them (Ybarra et al., 2000). Mothers often accompany their children to their doctor appointments; however, there are many times that the mother may become disruptive themselves or influence their child's reactions through their own display of heightened anxiety. Ybarra et al., (2000) examined the use of security blankets in pediatric examinations

through a variety of combinations of the blanket and the mother (mother present, blanket present, mother and blanket present, or no supportive agent during examination). Children accompanied in their examination by their transitional object and were object attached scored significantly lower on ratings of distress than children not object attached. Object attached children reacted equal to children were not object attached, but had their mother present in the examination. These results reveal that during the stimulating and possibly stressful scenarios, transitional objects for object attached children can provide similar soothing qualities of attachment figures for children who are non-object attached. Utilizing transitional objects is also effective when parents are heightening the stress and anxiety behaviors for the child, as objects are inanimate and will not react to the situation (Ybarra et al., 2000). In addition to providing comfort, transitional objects can serve as a communicative link for patients to their nurses, doctors, or other caregivers in a medical setting ("The Children's hospital of Philadelphia", 2012).

Multidisciplinary Healthcare Teams

Teams are composed of more than one individual working together toward a common goal (Bannister, Wickenheiser, & Keegan, 2016). Teams in healthcare environments work together and through effective communication attempt to decrease length of hospitalizations, improve coordination of care, increase patient and family satisfaction, and improve patient's health outcomes (Bannister et al., 2016). Multidisciplinary teams include healthcare providers from a range of disciplines and different areas of expertise to support all entities of the patient and meeting all of the patient's needs (Gulati, Dix, & Klassen, 2014). Multidisciplinary teams can work effectively by having a common purpose, having openness, and utilizing individual roles and skills (Bannister et al., 2016). Effective teams recognize that sometimes the purpose will shift, and a patient's care may change over time according to the patient's health status, and

the team communicates these changes to all stay focused on the same goals for the patient (Gulati et al., 2014; Bannister et al., 2016). Teams are able to re-focus according to any changes by modifying interventions (Gulati et al., 2014; Bannister et al., 2016). Openness ensures that all team members will speak, listen, and connect with one another to keep the patients well-being and health in focus. Lastly, team members need to understand and respect each other's roles, supporting the member in identifying any needed tools or resources in fulfilling their role.

Family Centered Care. Family-centered care has been recognized as a goal for all medical facilities since legislation was passed in 1986 with Public Law 99-457 (Rosen, Stenger, Bochkoris, Hannon, & Kwoh, 2009). This legislature requires that the whole family be treated as recipients of services for children with special needs, involving family members in decision-making about children's health. The American Academy of Pediatrics defines the core principles of patient- and family-centered care: a) listening and respecting each child and family, b) ensuring flexible organizational policies and provider practices tailored to the unique needs of the child and family, c) honest and unbiased information sharing, d) providing and/or ensuring formal and informal support, e) collaboration with patients and families at all levels of healthcare, and f) recognizing and building on the strengths of individual children and families (American Academy of Pediatrics, 2014). Family centered care recognizes that families are collaborators with the healthcare teams. Delivering family-centered care occurs through the recognition that; 1) the family is the child's source of support; 2) children and families are unique and diverse; 3) parents are expert caregivers for their children; 4) family-centered care enhances staff competence; 5) there should be collaboration between families and healthcare providers; and, 6) family-to-family networking and support should be facilitated. Rosen, Stenger, Bochkoris, Hannon, & Kwoh (2009), found that to achieve the goals of family centered care, it

was best for all members of the medical team to meet at the same time with both the patient and family. Members of this medical team were recognized to be doctors, nurse practitioners, physician assistants, nurses, physical therapist, child life specialist, social workers, and rehabilitation specialists (Rosen et al., 2009; Gulati et al., 2014).

Evolving from the goals of family-centered care came the concept of person- and family-centered care (PFCC) that raises attention for medical professionals to focus on all components of an individual during their medical journey (Feinberg, 2014). Recognizing the whole person involves understanding their individual needs, goals, preferences, cultural traditions, family background, and important values that comprise who they are as an individual and how each person can contribute to their own medical state or wishes. The goal of PFCC is to give the patient and family the optimal level of care and to work as a truly integrated team alongside medical professionals who recognize the patient's needs extend beyond the hospital (Feinberg, 2014).

Child Life Specialist. Nurses are often considered the foundation of care for hospitalized patients and their families throughout their healthcare experience, meeting their needs throughout the course of their medical care (Kaddoura et al., 2013). Alongside nurses are child life specialist, who are working to ease many of the fears and anxieties of children and families in healthcare settings. Academy of Pediatrics (AAP) recognizes that child life specialists are central in the "establishment of therapeutic relationships with patients, siblings, and parents to support family involvement in each child's care" (American Academy of Pediatrics, 2014, p. 1471). Child life specialists are trained in combining developmental knowledge with their expertise in helping children/families overcome challenges related to healthcare, hospitalization, illness, and disability (Kaddoura et al., 2013). Child life specialist serve as a part of these teams,

supporting patients and families psychosocial-emotional needs. The mission of child life, as set forth by the Child Life Council is to strive to reduce the negative impacts of stressful events that can potentially affect the development, health, and well-being of children, and families. Child life specialists will work to embrace play as a healing modality as they work to enhance the optimal development of children, and youth through assessments, interventions, preventions, advocacy, and education (Child Life Council, 2016). Child life specialists work as a part of the multidisciplinary team alongside physicians, nurses, social workers, therapists, counselors, teachers, and parents to reduce anxiety and identify coping strategies for the child. The overall goal for the child life specialist is to provide emotional support and ease any experienced fears or anxieties (Kaddoura et al. 2013). Child life specialist value children, families, and the use of many tools to most effectively help them. These tools include play, building therapeutic relationships, communication, theoretical foundations of practice, professional collaboration, professional standards of practice, and research to guide practices and interventions (Child Life Council, 2016). Child life specialists do this by teaching effective age-appropriate coping strategies, and for many children this may come in the form of utilizing a transitional object. One of the goals of child life, is to develop skills that are applicable and transferable to other environments or situations where there is a potential for children to cope or master skill is placed at risk, ensuring their well-being in at all times (Child Life Council, 2016). Child life specialist continually work to minimize the potential negative impacts of disruptions in daily life, while helping the individuals maintain growth and development of skills (Child Life Council, 2016). They foster an environment that incorporates emotional support, encouraging understanding and cooperation by providing non-medical support and preparation for children in medical settings (Kaddoura et al, 2013).

Summary

A review of empirical literature reveals that transitional objects serve as a positive coping mechanism for children in a variety of emotional and physical states, including but not limited to: 1) new and novel experiences; 2) sleep; 3) child care; 4) medical settings and share common dimensions. All of these potentially stressful settings require some degree of separation of the child from their established attachment figure, which may elicit anxiety-like symptoms. When children are transitioning to the state of sleep, they turn to their transitional object for comfort while they are separated from their attachment figure. New settings and strange events can also elicit anxiety-like symptoms from children, leading them to look for a calming or soothing outlet. Novel and unfamiliar settings place children in high physiological states as they are responding to events that are causing them stress or anxiety, children then turn to their transitional object for comfort to lower their arousal state. The hospital is one setting that encompasses all of these factors: feelings of anxiety, stress, worry, homesickness, and concerns about separation in children. The review of empirical literature reveals that children's use of transitional objects within hospital settings remains largely unexplored.

The purpose of this study is to examine the attitudes of child life specialist about the presence and use of transitional objects and the policies/regulations regarding the presence and use of transitional objects in the hospital. This research study will answer the following research question: In what ways do child life specialists advocate for the presence and use of transitional objects during hospitalization?

CHAPTER 4: Methods

Sample

This study was approved by the Institutional Review Board at East Carolina University, has met ECU requirements and federal exemption criteria for research involving survey procedures. The survey was distributed nationwide via email in order to obtain a diverse representation of child life specialists working in healthcare settings. Inclusion criteria for the study were as follows: 1) The individual must be a currently or previously employed child life specialists, and 2) the individual must be a subscriber to the Child Life Council listserv. The first survey was distributed through email via the listserv on January 25th, 2016 and the last was distributed February 29th, 2016.

A convenience sample of 35 child life specialists comprised the sample and met inclusion criteria. Of the 35 surveys returned, 24 were completed for an overall completion rate of 68%. All of the participants were either currently or previously employed child life specialists.

Measures

The primary instrument used to assess the way child life specialists advocate for the presence and use of transitional objects in medical settings was a questionnaire constructed by the researcher. The questionnaire was distributed anonymously through an online survey generator, Qualtrics. An internet survey design was selected because of the convenience it provided in collecting data from a group of working specialists. Participants were able to respond to the survey at a time that was most convenient for them, without interrupting their schedules.

The instrument contained a total of 23 questions divided into 3 separate sections: 1) demographic questions, 2) current policies in their setting on transitional objects, and 3) individual attitudes about the use of transitional objects. The first section of the survey asked basic demographic questions such as gender, age, ethnicity, and level of education, as well as questions related to the age of population worked with and the primary department worked in, in the hospital. The second section of the survey began by informing the participant on the researcher's operational definition of transitional objects for the purpose of the research study. The survey then contains questions about the settings current policies and procedures regarding the use of transitional objects, and who participates in creating these policies. The final section of the survey contained questions about the individual's attitudes regarding the use of transitional objects, both in and outside of pediatric healthcare settings. Throughout the survey there were open-ended response options to give the participants the option to add any answers that were not represent and to express any additional comments they wished to share with the researcher about their experience.

Procedures

This was an exploratory study with data collected from child life specialists through an online survey tool, Qualtrics. The researcher distributed the survey via an anonymous link by email through the Child Life Council listserv. The email sent contained an informed consent and an anonymous link to the survey. The informed consent was provided indicating that there were no perceived harmful effects of participation and that participation was voluntary. Two reminders, at two week intervals, were sent through email via the Child Life Council listserv and all communications were conducted electronically. Participants spent an average of ten minutes to complete the survey.

Data Analysis

Descriptive statistics provided information about the sample demographics including gender, age, ethnicity, and level of education, as well as questions related to the individual's most common population worked with and the department where the individual worked. Descriptive statistics also provided information regarding how settings create policies and procedures, and what these guiding policies are regarding the use of transitional objects. Frequencies were used to determine patterns in the participant's attitudes and knowledge about the use of transitional objects in pediatric healthcare settings. Thematic analysis was conducted for responses to open-ended questions.

Potential Limitations

The method of recruitment posed a few separate challenges. The survey was open to all members of the Child Life Council listserv, and many of the respondents did not meet inclusion criteria by not completing the survey. In addition, this population is often asked to participate in research studies, and may not have the time to respond to all surveys. Lastly, many settings do not have rules or regulations guiding the use of transitional objects, and individuals from those settings may have not felt comfortable responding to a survey that asked them to report on policies and procedures with which they may not be familiar.

There is very limited research exploring children's use of transitional objects in hospital settings. There is theoretical and anecdotal support, but empirical data can expand opportunities to utilize healthy coping mechanisms during potentially stressful procedures. However, the limited knowledge in the area must be taken into consideration.

CHAPTER 5: Results

The survey shared through the Child Life Council yielded 35 responses from practicing child life specialists, 24 child life specialists completed the entire survey. The demographic profile for child life specialists participating in this research study is a white female with a master's degree working in general pediatrics. The sample ranged in age from 20-61+ years with a median age range of 26-30 years. Table 1 fully describes a demographic summary of the participants in the study. The participants report working with all pediatric age groups in their setting, 79% (*n*=19), Figure 1 fully describes the scope of ages of the participants' patients.

Current Policies and Procedures

The participants were asked about the current policies and procedures guiding patients' interactions with transitional objects in their medical settings. Five of the 24 participants reported that their healthcare settings have no current policies or specific guidelines in place guiding the use of these objects. Of those that have policies guiding the use of transitional objects (*n*=19), 89% (*n*=17) reported that multiple departments were involved in policy making. A variety of people are

Table 1

Demographic Summary

Characteristic	Category	Number	Percent
Gender			
	Female	24	100
Ethnicity			
	White	23	96
	African American	1	4
Age			
	20-25 years	4	17
	26-30 years	9	38
	31-35 years	4	17
	36-40 years	3	13
	46-50 years	2	8
	56-60	1	4
	61+ years	1	4
Level of Education			
	Bachelors	9	37.5
	Masters	15	62.5
Primary Department			
	Surgery	4	16.6

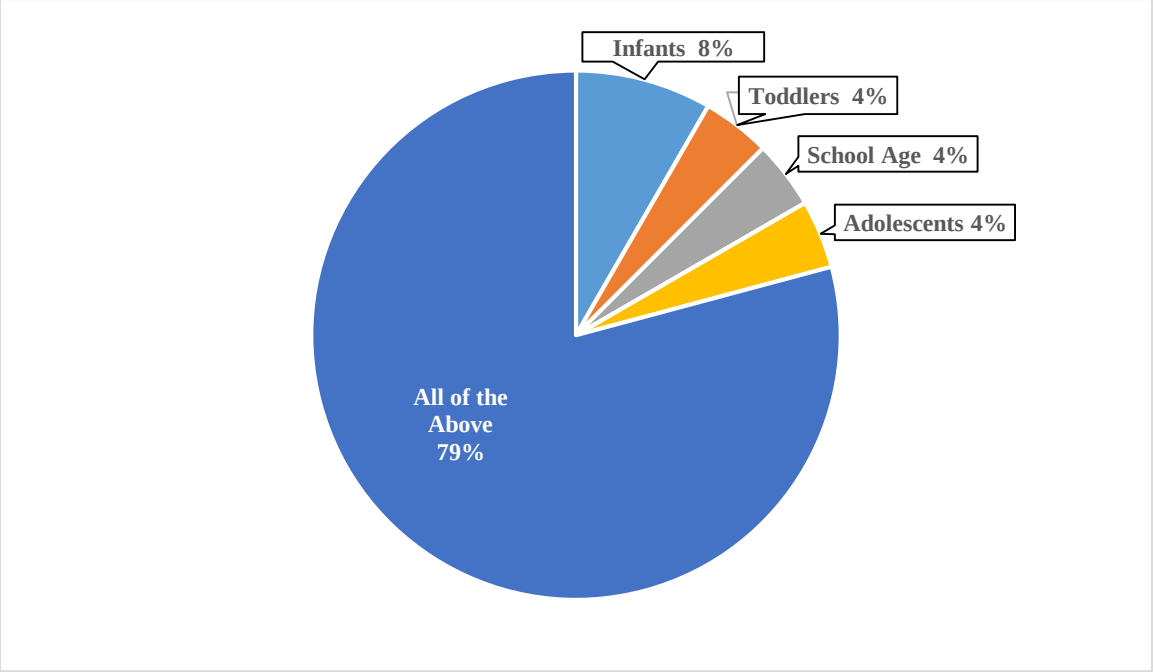
Table 1 cont.

Demographic Summary

Characteristic	Category	Number	Percent
	General Pediatrics	13	54.1
	NICU	1	4.1
	Outpatient/Clinic	4	16.6
	Emergency	1	4.1
	Ped. Immediate Care	1	4.1

Figure 1

Age of Children Worked With

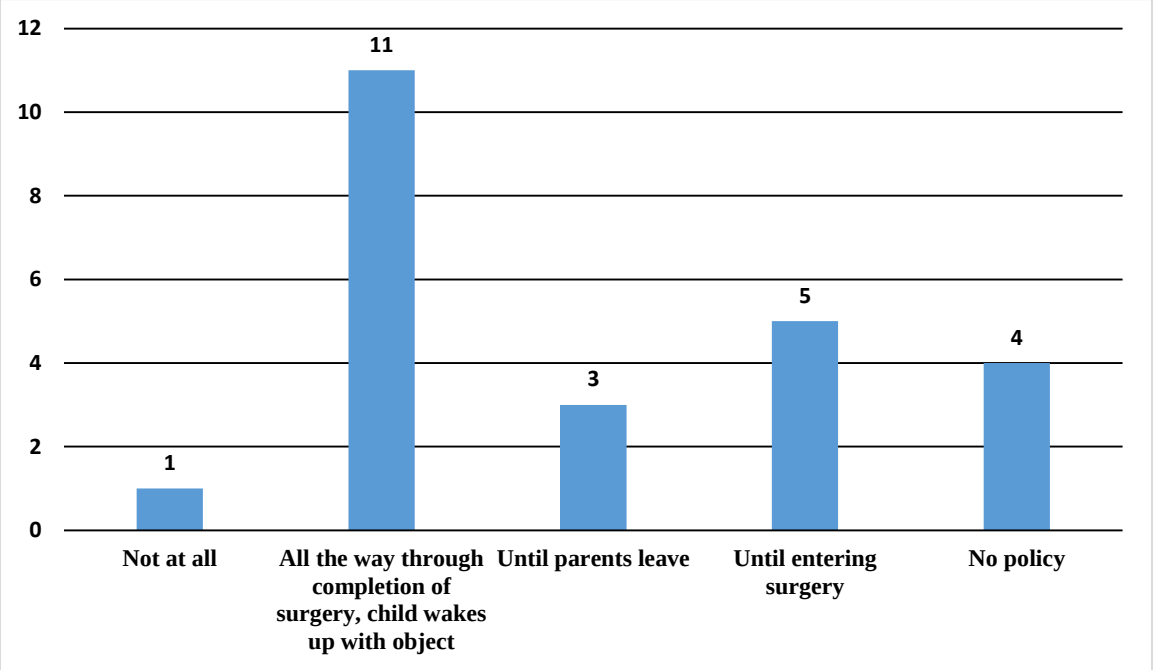


involved in considering or creating policies regarding the use in healthcare settings, the most commonly involved are the infectious disease team (*n*=14), physicians (*n*= 9), and child life specialist (*n*= 9). Out of the total 24 healthcare settings represented, five did not have policies regarding transitional; object use in the hospital setting.

Child life specialists reported on different areas of the healthcare setting in which children were allowed to have their transitional objects accompany them. All of the participants (*N*= 24) reported that transitional objects were allowed to accompany the child to the treatment and procedure rooms. When asked about accompanying the child to surgery, the majority of participants reported that the transitional objects were allowed to accompany the child to surgery (*n*=19) but the length of time the object was allowed to be present varied. Most of the participants (*n*=11) reported that their settings allowed the object to be present all the way through surgery and wake up with the object. The length of time that the objects can be present in surgical settings is represented in Figure 2. Three different guidelines were offered by three different participants when considering a child's use of a transitional object; 1) the areas of the hospital where the transitional object will be used; 2) setting limits on the use of stuffed animals; and, 3) whether the object can be wiped down.

Figure 2

Length of Time Object Allowed to be Present During Surgery

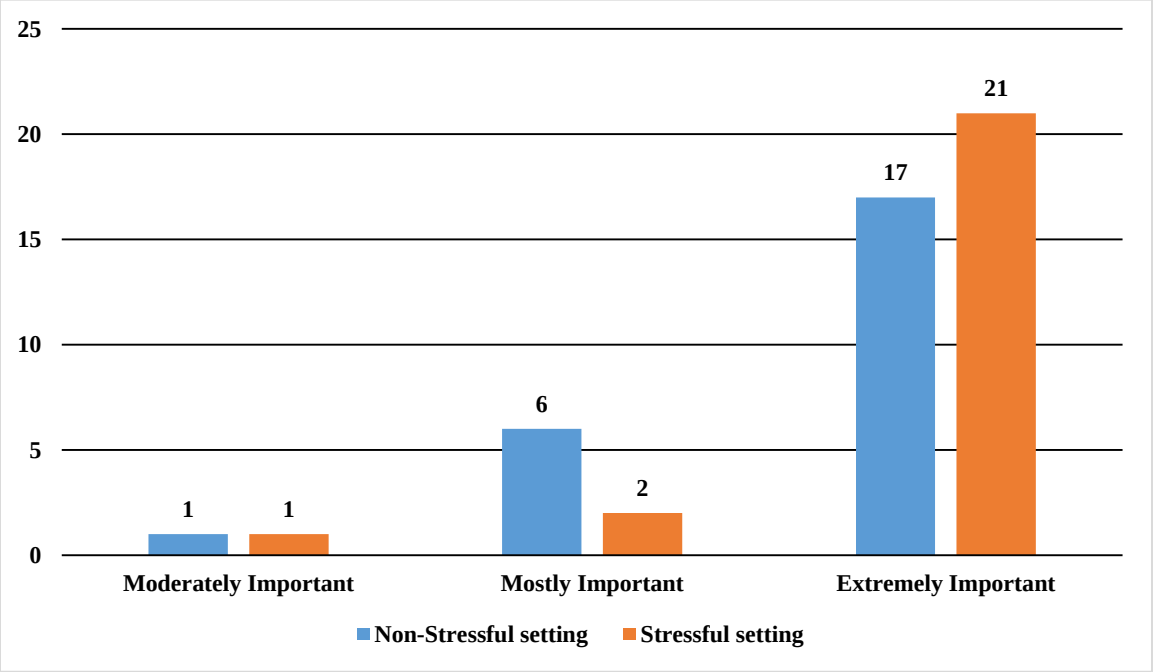


Practices: Perceptions and Attitudes of Transitional Objects

Perceptions and attitudes of child life specialists were analyzed using a five-point Likert type scale. When asked about how knowledgeable the participants feel about children's use of transitional objects, the majority reported that they felt mostly knowledgeable (*n*= 14), followed by extremely knowledgeable (*n*= 7), moderately knowledgeable (*n*= 2), and some knowledge (*n*= 1). The majority of participants reported that they believed transitional objects to be extremely important (*n*=17), followed by mostly important (*n*= 6), and one participant report the objects as moderately important in non-medical settings. However, when asked about their belief of the importance of transitional objects in stressful settings, such as the hospital, the majority of participants (*n*=21) reported transitional objects to be extremely important.

Figure 3

Importance of Transitional Objects in Non-Stressful vs. Stressful Settings

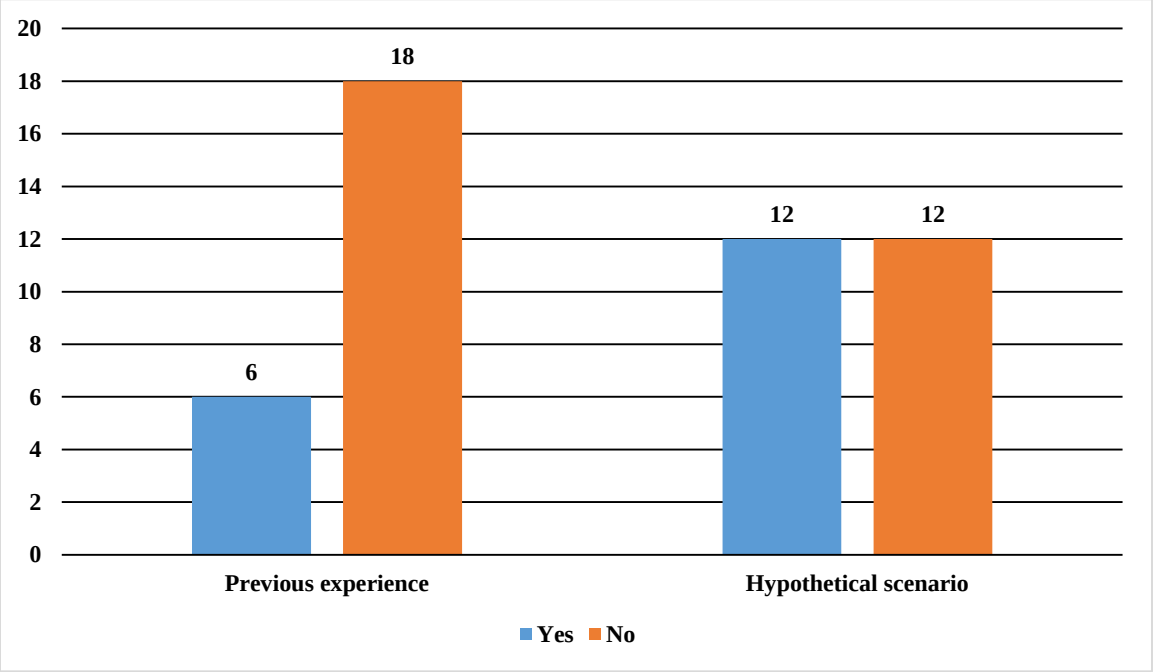


Child life specialists' practices with transitional objects were analyzed through previous experiences and a hypothetical situation. Participants were asked if they had ever differed in opinion from a patient's parents about the child's use of a transitional object in a healthcare setting, the majority responded no (*n*= 20), compared to the four that responded yes. All of the participants (*N*= 24) stated that they had previously prompted or created opportunities for children to use their transitional objects in their healthcare settings. The majority of participants (*n*=14) reported that they never viewed the child's transitional object as a substitute for parent(s) when parents were unable to be present, compared to participants (*n*=10) who did view the transitional objects as a possible substitute for parents when needed. Participants were asked if they have ever been in a situation where they allowed a child access to his/her transitional object, even though it might break the settings regulation, the majority responded no (*n*=18), they have not been in this situation. However, six participants responded that they have been in this situation and did chose to allow the child access to their transitional object, even though it violated regulations.

Participants were presented with a hypothetical scenario and asked if they were in a situation where they believed the child would benefit from having access to their transitional object, would they violate the settings policy and the responses were equal for no (*n*= 12) and yes (*n*= 12). Lastly, participants reported on their personal experiences with transitional objects. The majority (*n*= 23) of participants had a transitional object in their own life and one participant did not have an object that she defined as a transitional object.

Figure 4

Violating Hospital Policy in Previous Experiences vs. Hypothetical Scenarios



CHAPTER 6: Discussion

The findings of the study resulted in 24 completed surveys, only five of the participants shared that their healthcare setting did not currently have any policies or procedures guiding the use of transitional objects. Healthcare settings, such as hospitals and clinics are settings that require a degree of separation from attachment figures and elicit anxiety-like symptoms. Transitional objects offer children a healthy coping strategy as they navigate the potentially stressful healthcare environment.

Child life specialists are a part of the multidisciplinary healthcare team whose focus is on the psycho-social emotional needs of the patient and family. Their training combines their extensive developmental knowledge with their expertise in assisting children/families to overcome the challenges associated with hospitalization and medical settings (Kaddoura et al., 2013). Per the mission according to the Child Life Council (2016) child life specialists help to ease the fears and anxieties that are possible in healthcare environments though education, preparation, play, therapeutic interventions, and advocacy. By encouraging optimal development and protecting the child from potentially negative effects, child life specialist help identify and teach healthy coping strategies for the child and family.

For many children, age-appropriate coping strategies may come in the form of a transitional object. Advocating for transitional objects as a coping strategy helps ensure children's well-being at all times thereby minimizing the potential negative effects of hospitalization (Child Life Council, 2016).

Policies

Results revealed that current policies and procedures guiding the use of transitional objects are created by a true multidisciplinary team. The individuals participating in policy creation represent various constituencies with backgrounds and embodies different components of healthcare system. There is input from infectious disease teams, physicians, nurses, and child life specialist. Infectious disease teams are the most commonly represented, ensuring the cleanliness of the setting and overall health conditions for all the patients. Physicians and nurses represented the medical component, protecting the physical health of the patients. Lastly, child life specialists were represented on these multidisciplinary teams, contributing their knowledge of psychosocial-emotional support (Kaddoura et al., 2013). The team created by the combination of infectious disease, physicians and nurses, and child life specialists is a team that takes into account the total well-being of the child. Everyone on the team is working together to ensure that all aspects of the child, biopsychosocial needs, are supported.

When participants were asked about the length of time transitional objects were allowed to remain with children in various procedural settings, results showed that transitional objects were allowed to remain with the child for an extensive period of time. In all 24 settings, children were allowed complete access to their transitional object while in treatment rooms. When going to surgery, the majority of the participants reported the transitional object was allowed to be present with the child throughout the completion of the surgery, with the child waking up with their object. Allowing children to have their transitional object during surgery ~~is~~ supports the understanding of how transitional objects can soothe and calm the stress associated with surgery, unfamiliar places, and separating from parents (Free & Goodrich, 1985; Passman, 1987; Triebenbacher, 1996; Ybarra et al., 2000). Immediately prior to surgery, children will often

receive anesthesia. This process is analogous to going to sleep and children and parents both agreed when was going to sleep or anticipated sleep is a time when the transitional object was most needed and functioned to reduce any related anxiety-like symptoms (Wolf & Lozoff, 1988; "Teddies", 1994; Triebenbacher, 1994; Triebenbacher, 1996) This is a testament to professionals' recognition of the value of transitional objects for children who have formed an attachment to these objects. It also demonstrates an understanding of the increased need for children to have their transitional objects during these times of extreme stress and how child life specialists are advocating for their patients' needs. Lastly, facilitating children's use of transitional objects supports their relationships with their established attachment figures and the anxiety associated with separation from these individuals (Ainsworth et al., 19971).

Practices

Participants reported that they have and they would prompt or create an opportunity for a child to use their transitional object in the hospital. This finding illustrates that child life specialists are able to recognize and understand times when object attached children may benefit by utilizing their transitional object for comfort. This finding supports research by Lehman et al., (1995) who found that children often want their transitional object when feeling sad, sleepy, scared, angry, and happy. Children also reported that the objects would be beneficial in frightening or upsetting situations because the object would give the child control over the situation as supported by Winnicott's (1953) definition of transitional objects and their characteristics (Lehman et al., 1995). Child life specialists are trained to recognize when children are stressed or experiencing anxiety, and by creating opportunities for the use of transitional objects demonstrates how they support children, thereby facilitating healthy, positive coping in a stressful situation and advocating for the patient's needs.

The participants revealed that they are almost equally divided on how they use a child's transitional object in the absence of the care giver, almost half of the child life specialists revealed that they believed transitional objects could serve as a substitute for parents when they have to be absent. Winnicott (1953) recognizes that transitional objects are built from the attachment relationship developed with their established attachment figure. After establishing a secure attachment with caregivers, children may then develop an attachment to an object that is similar to the attachment with the caregiver (Winnicott, 1953). After the attachment relationship has been established with the "good enough mother", the object is able to represent many of the same qualities in the attachment relationship and is woven into the child's daily pattern (Winnicott, 1953). Object attached children are then able to utilize their object in the absence of their caregiver, when in unfamiliar places, providing many of the same soothing qualities and protective factors (Fortuna et al, 2014). The object is not able to fill the caregiver's absence, but provide some semblance of the caregiver, supporting emotional protection and a defense against anxiety-like symptoms (Fortuna et al, 2014; Lehman et al., 1995; Ybarra et al., 2000). Previous studies show that infants will turn to their transitional objects as a substitute for support when the mother is unavailable (Wolf & Lozoff, 1988; Triebenbacher, 1996; Ybarra et al., 2000; Fortuna et al., 2014).

The object is then able to support the child, similar to the attachment figure, as a defense mechanism to protect and soothe the child when they are experiencing anxieties (Winnicott, 1953; Lehman et al., 1995; Ybarra et al., 2000; Fortuna et al., 2014). As highlighted by Ainsworth, secure attachment styles support children in their exploration of the world and encourage the use of the mother as a secure base (Ainsworth et al., 1971; Ainsworth et al., 1978; Bretherton, 1992). The security of the child's attachment to parents or caregivers, directly

influences the child's daily habits (Donte-Bartfield & Passman, 2004). Even when the parents are initially present but need to leave, the transitional object can assist in smoothing the transition and acceptance of gradual separation from the attachment figure (Free & Goodrich, 1985; Passman, 1987; Triebenbacher, 1996; Ybarra et al., 2000).

Child life specialists have extensive training and education on theories of child development, as well as thorough clinical training experiences enabling them to effectively assess patients' and family's needs in the stressful situations that medical settings often present, thereby accurately "reading situations". By understanding the patient's/family's state through effective assessments, they are able to effectively identify healthy coping mechanisms that empower children. Participants reported that they find transitional objects to be extremely important for children in stressful settings and understand that children who are object attached will most often cope best with the use and support of their transitional object. Research by Lehman, Arnold, & Reeves (1995) found that children want their treasured object because it gives them control over the situation and they can express freely to their object (Lehman et al., 1995).

When asked about a hypothetical situation, participants revealed that they would be willing to go the extra mile and "bend any rules" if necessary for the well-being of the child. Supporting the notion that children cope in personal and individual ways. Child life specialists are willing to advocate for their patient's needs and support the coping mechanisms that most effective for the patient. Child life specialists are then able to best support and promote the psycho-social emotional well-being of the child.

Summary

The results of the study reveal the many ways that child life specialists are advocating for the use of transitional objects in in healthcare settings to promote the overall well-being of the child. Child life specialists utilize their knowledge and experience to advocate for the needs of their patients, recognizing that for some patients, the use of a transitional object may be an important coping mechanism, particularly in stressful situations. Transitional objects as a coping strategy can protect against many of the potential negative effects of hospitalization (Kaddoura et al., 2013). Transitional objects are able to soothe children when faced with the extreme stressors associated with hospitalization or medical treatment, knowing that they are able to cope in the way that best empowers them and meets their needs is reinforced by the child life specialists in these settings.

Limitations and Future Research

Limits of the study were present in the sample's demographic characteristics. The sample had very little gender and ethnic diversity, however, this is consistent with the demographics of other studies examining child life specialists (Ballard, Lookabaugh, McCullough, & Rosato, 2013). Therefore, instead of displaying a limitation of the study, the demographics present a limitation of the profession as a whole. Child life as a profession is not representative of our diverse world. The profession as a whole, is predominatly a homogenous group of white females. Another challenge of the study was due to the limited number of responses. This could be due to the limited population in general, and their work-day not including time for survey participation, instead focusing on and serving the patient population. Lastly, the Child Life Council Listserv was utilized to seek the sample, however, more and more people are utilizing the Listserv and it is being oversaturated.

Future research on transitional objects in healthcare settings may want to include and compare examination of specific hospital regulations regarding transitional objects to child life specialists' practices in corresponding settings. It is important to identify parallels between the policies and the actual practices and beliefs of child life specialists implementing the guidelines every day.

Lastly, moving forward in the study of transitional objects, it is imperative that we work to better understand the children's perspectives of transitional objects in healthcare settings. Additional insight provided by children would enable the multidisciplinary healthcare team to better understand the many functions that transitional objects serve in healthcare settings, especially in comparison to other daily events, and enable them to continue to advocate for sensitive patient-friendly policies regarding transitional object use. New procedures may include the use of transitional objects by proxy for children in isolation, for example placing a small stuffed animal into a sealable plastic bag. Another option would be for hospitalpersonnel to wash objects for patients, so that they undergo the same cleaning/sterilization process as hospital linens for children in isolation.

Conclusions and Implications

The current study was able to provide support, consistent with previous literature, illustrating the importance that transitional objects can provide for children in settings that are unfamiliar and have the potential to elicit anxiety-like symptoms from children. The study begins to fill a gap in the current in literature, by examining policies related to children's use of transitional objects in healthcare settings. Understanding the practices of child life specialists regarding the use of transitional objects in healthcare settings is the beginning of research that can open the doors leading to education and advocacy for the presence of these treasured objects.

While child life specialists are educated about the role and significance of transitional objects for children, particularly during times of stress and parent-child separation, they will want to continue efforts to educate other members of the healthcare team.

A teddy bear or a blanket, so simple, yet is a powerful coping mechanism for a child in a potentially stressful situation. Support and advocacy for meeting the psychosocial-emotional need of a child in healthcare settings can be a strong determinant of one's perception of the overall healthcare experience.

Specifically, in medical settings, professional development needs to return to the basics. It is necessary to expose the small everyday regular needs of the patient, and facilitating attachment is an essential need of children. Support of attachment recognizes the child's most basic and vital need that can be fulfilled by caregivers, as well as transitional objects. Truly understanding children's perspectives of transitional objects in healthcare settings will allow medical professionals to work together to create a medical environment that fosters all types of emotional support and coping that best suits the individual child.

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APPENDIX A: INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
4N-70 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · **www.ecu.edu/irb**

Notification of Exempt Certification

From: Social/Behavioral IRB

To: Katelyn Leitner

CC:
Sandra Triebenbacher

Date: 12/18/2015

Re: UMCIRB 15-002244
Transitional Objects in Pediatric Healthcare Settings

I am pleased to inform you that your research submission has been certified as exempt on 12/17/2015. This study is eligible for Exempt Certification under category #2.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

The UMCIRB office will hold your exemption application for a period of five years from the date of this letter. If you wish to continue this protocol beyond this period, you will need to submit an Exemption Certification request at least 30 days before the end of the five year period.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX B: RECRUIMENT LETTER

Re: Transitional Objects in Pediatric Healthcare Settings, Kate Leitner

Dear Child Life Specialist,

I am writing to inform you about an opportunity to participate in a research study about transitional objects in pediatric healthcare settings. This study is being conducted by Katelyn Leitner at East Carolina University. The study will examine the attitudes of child life specialist about the presence and use of transitional objects and the policies/regulations regarding the presence and use of transitional objects in medical settings. The research study will seek to answer the following research question: In what ways do child life specialist advocate for the presence and use of transitional objects during hospitalization?

Should you chose to participate, the study will be conducted through Qualitrics via survey. The survey will not consist of identifying information and will consists of three sections; demographics, policies regarding transitional objects, and attitudes about transitional objects. The survey takes about 20 minutes to complete.

Attached is a letter of consent, by taking the survey you are giving consent for your data to be used.

Qualtircs Survey link: https://ecu.az1.qualtrics.com/SE/?SID=SV_8B27ekSoX3dTIy1

A reminder email will be sent two-weeks after this date.

Thank you,

Katelyn Leitner

APPENDIX C: LETTER OF INFORMED CONSENT

You are being invited to participate in a **research** study titled "Transitional Objects in Pediatric Healthcare Settings" being conducted by Katelyn Leitner, a graduate student at East Carolina University in the Human Development and Family Science department. The goal is to survey as many individuals through the Child Life Council. The survey will take approximately 20 minutes to complete. It is hoped that this information will assist us to better understand the use of transitional objects in pediatric healthcare settings. The survey is anonymous, so please do not write your name. Your participation in the research is **voluntary**. You may choose not to answer any or all questions, and you may stop at any time. There is **no penalty for not taking part** in this research study. Please call Kate Leiter at 803-309-6201 for any research related questions or the Office of Research Integrity & Compliance (ORIC) at 252-744-2914 for questions about your rights as a research participant.

APPENDIX D: TRANSITIONAL OBJECTS: POLICIES AND CHILD LIFE SPECIALISTS ATTITUDES SURVEY

Demographics:

1. Age

   20-25 years 26-30 years 31-35 years 36-40 years 41-45 years

   46-50 years 51-55 years 56-60 years 61+ years

2. Gender

   Male Female

3. Ethnicity

   White Native Hawaiian Hispanic/Latino African American

   Asian Indian American Indian Other: Choose not to respond

4. Are you a certified child life specialist?

   Yes No

5. How long have you been certified?

   _____ Years

6. What is your level of education?

   Bachelors

   Masters

   Doctorate

7. In what department do you primarily work?

   General Pediatrics

   Pediatric Intensive Care Unit

   Neonatal Intensive Care Unit

   Pediatric intermediate Care Unit

   Radiology

   Surgery

   Emergency

   Outpatient/Clinc

8. With which age group do you primarily work?

   Infants (0-12 months) Toddlers (1-3 years) Pre-School (3-5 years)

   School-Aged (5-12 years) Adolescents (12-18 years)

   Young Adult (18-21 years) All of the above

Transitional Objects:

It is common for children to have a special object that provides comfort when they are tired, upset, or stressed. These objects could be blankets, stuffed animals, pacifiers, pillows, or even the child's thumb. These objects are often referred to as a lovie, binkie, attachment object, or transitional object. For the purpose of this research study, any object that promotes a sense of calm, comfort, and/or decreased stress is considered a transitional object.

As you respond to the following questions, please consider children's use of transitional objects within your medical setting.

Policies:

1. Who participates in creating policies/procedures about the use of transitional objects in your hospital (check all that apply):

   Infectious disease team

   Nurses

   Physicians

   Legal team

   Administrative members

   Child Life Specialist

   Social Work

   Other:

2. Are there specific guidelines to the types of transitional object items that are allowed?

   Yes, please describe.

   No

3. Does the transitional object need to be preapproved?

Yes, By whom?

No

4. Is the transitional object allowed to accompany the child to surgery, if yes for how long?
   No

   Until parents leave

   All the way until entering surgery

   All the way through surgery (child wakes up with object)

   Not applicable

5. Is the transitional object allowed to accompany the child treatment/procedure room(s)?
   Yes

   No

Attitudes: (5 point Likert-type scale)

1. How knowledgeable do you feel about children's use of transitional objects?

1	2	3	4	5
Not at all knowledgeable	Some knowledge	Moderate level of knowledge	Mostly knowledgeable	Extremely knowledgeable

2. How much do you value the importance/value of children's use of transitional objects in non-stressful situations?

1	2	3	4	5
Not at all important	Rarely important	Moderately important	Mostly important	Extremely important

3. How much do you value the importance/value of children's use of transitional objects in stressful situations, such as hospitalization?

1	2	3	4	5
Not at all important	Somewhat important	Moderately important	Mostly important	Extremely important

4. Have you and a parent ever had a difference in opinion about a child's use of a transitional object in the hospital?

Yes No

5. Have you ever prompted or created an opportunity for a child to use a transitional object in the hospital?
   Yes No

6. Do you ever view the child's transitional object as a substitute for parent(s) when the parent(s) are unable to be present?
   Yes No

7. Previously, have you ever been in a situation where you chose to allow a child access to his/her transitional object, even though it might break the hospital regulations?
   Yes No

8. Hypothetically, if you were ever in a situation in which you believe a child would benefit from having access to his/her transitional object, would you violate hospital policy?
   Yes No

9. In your own life, did you ever have an item that you would define as a transitional object?
   Yes No

10. Is there anything else you would like to share about children's transitional objects in medical settings?
    Yes

    No