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PLAY AND THE HOSPITALIZED CHILD

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Abstract

Play is the way that children are able to come to terms with reality. Through play children are not only able to revise their ideas and actions, but are also able to formulate ways in which they can put these ideas into use. Children who are separated from parents by reason of hospitalization experience severe anxiety and have very limited ways of coping with this painful experience. Play offers a medium through which the child may be able to express and then cope with some of these feelings. Play offers, as well, a window to the examiner, to observe the fright and pain and then, hopefully, provide some relief.

Résumé

Le jeu est la manière dont les enfants sont capables de concevoir la réalité. Par le jeu, les enfants sont non seulement capables de réviser leurs idées et leurs actions, mais ils peuvent aussi trouver des moyens de mettre en oeuvre ces idées. Les enfants séparés de leurs parents à cause d'une hospitalisation ressentent une anxiété sévère et ont des moyens très limités de venir à bout de cette expérience douloureuse. Le jeu constitue un moyen par lequel l'enfant peut s'exprimer et ensuite composer avec quelques-uns de ces sentiments. Pour l'observateur, le jeu se présente aussi comme une occasion d'examiner la peur et la douleur, et ensuite, il faut l'espérer, de pouvoir leur trouver un soulagement.

It is the author's view that play is the child's way of learning and that play is the child's most important method of coming to terms with the world he lives in and with himself (Weininger, 1979). The belief that play is critical to the emotional, physical, and cognitive development of children is shared by many cognitive psychologists and has been supported by much research during the past 10 years at least. Parents and others who have observed young children at play have undoubtedly experienced the value of play in the development of children.

There are several concerns, however, about play being perhaps *the* critical agenda for young children who have been separated from their families because of institutionalization or hospitalization. It is sometimes difficult to accept play as a therapeutic tool of crucial importance for very young children – those under 4 years of age – who are hospitalized because so often the reality of separation from the family, particularly the mother and especially in what are frequently traumatic

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circumstances, is virtually impossible to minimize.

There is probably no more painful experience for a parent –or for the medical professional– than watching a young child who is incapacitated both physically and emotionally. It offends our need, our deep and real psychological need, to care for our young. As parents it makes us feel helpless and guilty: we feel we should have been able to prevent this illness or this accident from striking at our beloved child. We feel negligent and inadequate when the child no longer sees us as all-powerful. The documented cases of parents needing medical or psychological help, siblings experiencing difficulty, and marriages breaking down because of the severe of longlasting illness of a child are legion.

The experience is no less agonizing for medical professionals – no matter how many times it happens. Physicians and nurses are trained on the stories of medical miracles; they work in an area where human error is not tolerated easily. The limits of human ability to "make it all better" are not easily accepted. In the past this has led to hospital staff isolating or denying the reality of children near death. Bureaucratic needs to have procedures go smoothly, understaffing, and an inability to deal with human fallibility, often led the incurable or terminally ill child to being pressured to "behave", "adjust", "settle in" to hospital routines (Weininger, 1975). Outward anger and grief were not encouraged for the human reason that the staff were as uncomfortable in dealing with them as are most of us. The work of people like Elisabeth Kubler-Ross (1969), made us very much more aware of, and sensitive to, the need of the dying child or adult and has profoundly changed work with them in many hospitals in the past few years.

Out of these circumstances arises our need to find a "miracle-worker" for use with children in hospitals. We know that maternal separation is an experience for the small child which is not unlike death in its effects on older children and adults; we know that as adults we feel enormously inadequate when faced with hospitalization of children. And so *we* need to believe that there is something we *can* do which will make this experience less traumatic for the child –and thus for the adults. Avoidance of reality, especially a painful reality, and the need for hope– even in hopeless circumstances –are both part of being human. Without these two related needs, would the human race have survived the disasters of the past? And so, although even such an important experience as play is not the cure-all for the trauma of hospitalization, there are ways in which it *can* be useful.

Separation

The most obvious place to begin is with an understanding of the process of childhood reaction to maternal separation. For over 30 years researchers have investigated the impact of temporary or permanent parental deprivation on personality development. Bowlby (1970) and many others have explored the nature of affectional bonding in humans, the effects of disruption of early attachment, and its possible causal effects on adolescent and adult pathology. We have a fairly cle[illegible] picture now of the importance of a stro[illegible] early, and unbroken bond between mother and child to normal human emotional development; it is no longer a hypothetical research area, but has become a factor in most of our work with young children. It is perhaps unfashionable to discuss this at a time when early childhood care in nurseries and day-care centres is –economically– a necessity for many families and –psychologically– a need for many young mothers, but it is there nonetheless.

We are all familiar with the visible reality of separation anxiety. The friendly and apparently undiscriminating 3-month-old baby who coos for everyone is often replaced at about 8 months with a baby who doesn't like anyone anymore –often daddy included – except mother. At this point the baby is just beginning to acquire object permanency and for many babies what is not visible no longer exists. As he realizes that mother isn't part of him he can be easily terrified by her absence because his need for her is so great. As he grows older he needs to explore and gain mastery over his surroundings, but mother is at the centre of his widening circle. The 2 1/2-year-old toddler can explore into another room quite happily –as long as mother is still sitting in the same spot when he com[illegible] back. The hysterical and nearly inconsola[illegible] small child whose mother is not there when *he* wants her is a familiar experience to most adults. In a hospital setting, the process of reaction to separation is very clearly observable over time, much more so than in a nursery school where the child learns quickly that the separation will end each day and his natural curiosity and desire for peer play overcomes his fear. The hospitalized child is usually in pain and the environment is drastically unlike home. The medical processes and equipment, the unfamiliar faces, and the pain or discomfort would be scary enough– even if mother were there. When she is not, the child's reaction usually follows a typical pattern which has been described by Robertson (1958).

Pattern

First, protest: the young child screams and cries, shakes his crib railings, bangs his head on the bed, throws himself around, looks anxiously at each door opening, expecting his mother. He exhibits a strong conscious need for her and rejects the overtures of nurses to comfort him. He expects that mother will answer his cries and distress and is grief-stricken at her loss; he is confused by his surroundings and cannot understand why she doesn't come to him.

Secondly, protest is followed by despair. He feels a continuing need for his mother and feels an increasing sense of hopelessness as all the behaviors which always bring mother rushing to his crib have failed. He becomes less active, crying monotonously and/or intermittently. He becomes withdrawn and apathetic, making no demands on anyone, often eating very little. He is in a state of mourning for his loss, very much like an adult reaction to the death of a loved one. Hospital staff often mistake this stage as "settling in" and react negatively to maternal visits because it is at this time that the child's grief and rage, which were becoming sealed over, are intensely displayed on the surface again. Nurses may say "he was quiet until his mother came– her visits upset him". Mother's disappearance, her abandonment of him in his obvious and expressed dismay and pain are of course upsetting to the young child. She finally came, just when he was sure she never would, and then she left again even though he needed her so much. His pain is redoubled as to his dismay is added a sense of betrayal.

The third stage is denial, which becomes more obvious the longer the hospitalization is prolonged. The child begins to show interest in his surroundings. This is usually perceived by hospital staff as a welcome sign; it is not – it is a danger sign and can be seen as the severe disruption of the maternal bond. It also bodes ill for the child's emotional development when he returns home. Because the child cannot tolerate the intensity of his own distress, he begins to make the best of his situation usually by repressing his feelings for his mother because of her betrayal and failure to meet his needs. He takes food more easily and begins to accept attention from the staff who see him now as settled in. He begins to show signs of rejecting his mother; he hardly seems to know her when she visits and no longer cries when she leaves. He may seem to prefer the handling of the nurse to that of his mother. Obviously, this can be very painful for the mother who doesn't understand what is happening or why. This denial seems to occur even when the mother visits daily. To some extent the child – especially one in real pain– has begun to expect security from hospital personnel who have succeeded where mother failed at alleviating pain. If the child is discharged during this period he has difficulty going to his mother, although at home he will gradually thaw out, often showing clinging, fearful, or regressive emotional behavior. If he has to be brought back to the hospital or to the physician –even for a check-up –, he may exhibit real terror.

The child who is hospitalized for a long time –two or more years –, like a child who permanently loses his family for any other reason, begins in this denial stage the process of adapting to a new and different life. In a situation like the death of the parents, placement with a new family succeeds to the extent that this tendency on the part of the child is successful –although there is some question whether replacement of early bonds is ever completely without long-term emotional or psychological damage. But in cases of institutionalization, it is at this point when the child begins to bond to the place rather than to an individual, since an individual relationship has been so unreliable in his experience. His behavior is superficial, his affection and smiles promiscuous, his attention very distractible. He becomes the little child the nurses and volunteers all love because he seems to love them and is easily satisfied by cuddling from anyone and by objects and goodies. He finds little satisfaction in relationships and needs the physical surroundings and routine of the hospital to be unaltered. This institutionalized child is the one who seems incapable of any but shallow attachments throughout his life and may even show signs of personality deviation later in life.

Research

Some research in the area of children's reaction to hospitalization has been done. Bergmann (1965), in collaboration with Anna Freud, wrote about work with children in Rainbow Hospital. She writes eloquently of the need for "mental first aid" plans which will help children to cope with their distress and anxiety through various methods. She especially emphasizes the danger and longer-term damage likely in cases of "perfect" patients who express no anger or distress and seem cheerful and co-operative but are most likely to experience pathological reactions later. She also describes depressed children who seem to resign themselves to their fate and to the hospital and for whom after-effects of hospitalization were sometimes "of frightening proportion and of long duration". One longitudinal study showed that stays of more than two years in hospital resulted even several years later in "difficulty in making and sustaining relationships; shallowness of attachment; immaturity; excessive stubbornness and self-centeredness; distractability and inability to concentrate, resulting in inadequate use of intellectual environment" (Robertson, 1958, p. 28). All of these were seen as the result of an environment which didn't meet the child's primary need of a warm and continuous relationship to a mother figure.

Short-term effects of hospitalization were studied by Prugh, Stark, Sands, Kirschbaum, and Lenehan (1953). A 100 children – average stay 8 days and aged up to 13– were studied. The control group of 50 were visited once a week for two hours by their parents who were not encouraged to participate in the ward care of the child. No organized program involving prevention of attachment and adjustment problems was offered to these children or to their parents. The experimental group of 50 children was visited daily by their parents who were encouraged to participate in their care. A special play program and much emotional support were offered to the children. The results were clear and quite predictable. In the control group 92°/o of the children showed behavioral disturbances in hospital and in 58°/o disturbed behavior was noted 3 months after returning home. In the experimental group 68°/o showed disturbed behavior in hospital and 44°/o after returning home. The conclusions were that the level of disturbed behavior in hospital and at home later is high no matter what steps are taken during hospitalization, especially in children under 3. Significant improvement was shown by those in the experimental group, especially older children.

Another study (Vaughan, 1957) of children admitted for a 5-day strabismus operation offers an unusual insight. The control group of 20– matched for age, sex, IQ, and socio-economic status– were not prepared in advance by interviews in terms of what to expect and did not receive extra reassurance from parents. Of this group, 40°/o showed disturbed behavior on the ward, 65°/o, one week later, and 55°/o, six months later. The experimental group, however, showed 55°/o disturbed behavior on the ward– a much higher number– but only 30°/o showed reactions one week later, and only 15°/o six months later. This would seem to indicate that the overt angry or anxious behavior, which so distresses parents and hospital staff, is indeed very functional psychologically and should be encouraged rather than repressed. The quite logical reaction of the children to real knowledge about what to expect, as opposed to sugar-coating or non-preparation, was "expressive behavior"– a reaction to separation and anxiety– which obviously made their adjustment after the fact easier. Again, age was clearly a factor in the adjustment process, as was length of hospitalization. While these studies would probably not be done today– because of ethical reasons– they do give us some understanding about the effects of separation from mothers and families in young children.

Vaughan's study (1957) of children in hospital showed that no amount of love and understanding would make up for the absence from the mother for children under 4; separation under any circumstances will be damaging to these children (Weininger, 1972).

Changes

In light of the above information, it is especially heartening to see so many hospitals encouraging rooming-in of mother with the child and delegation of many caring functions to the mother of the very young hospitalized child. Facilities are increasingly being provided to allow families to be near children hospitalized for a long time and to participate in their daily care. This would seem to be the most hopeful trend in terms of alleviating long-term damage. Obviously, these techniques are not always possible: the child who falls suddenly and severely ill and needs intensive or highly technical, specialized care is the exception. We must accept as inevitable that a child under 3 or 4 who is hospitalized– especially for a long time– is going to suffer both at the time and afterwards, no matter how much support, reassurance, and love he receives from parents and staff. This is because the process of normal human development which depends to a large extent on maternal bonding is severely disrupted.

So far the serious effects of hospitalization on the very young child have been discussed. For the child about age 5, the prognosis is not quite so grim. Although this child will just as surely miss his mother and family, there are many more routes available for providing help. To begin with, a child of school age is used to being away from home each day and to dealing with adults who provide specialized teaching or care of some kind. He can more readily accept the role of the physician, nurse, or technician in hospital. Second, he has more verbal skills and more understanding of what is happening to him and why. Most children, as one of the few beneficial results of massive television dosages in this day and age, perceive hospitals as helpful places. After all, on TV the patient always gets better and the staff are both attractive and articulate; no one makes mistakes and even very ill patients always look all right and seldom display overt grief or real pain.

Some of the paraphernalia of the modern hospital are quite familiar to many children in advance. For some children there is even a perceived pleasant side effect to hospitalization: they will get much more attention from their busy parents than usual and will be spared homework and household tasks. They may receive goodies and lots of concern from family, friends, and teachers. This sometimes makes going to the hospital more palatable, especially for children who are not used to dealing openly with their everyday fears.

Hospitalization on a short-term basis for the older child can be dealt with by careful preparation in advance, being honest with the child about the process, the pain, and the results he can expect. This honesty is important if trust in the parent and in the hospital staff is to continue; a sensible child knows already that needles do hurt and that many other hospital processes also are painful. Lying simply means that later the child might not believe the adult who is telling the truth about a method or its results.

Equipment

For many children in the 5-10 age range, who are especially fearful of body mutilation and physical pain, specific play therapy which provides doll or puppets and real medical equipment– allowing them to "treat" the doll and to play out and/or verbalize their own fears about what will happen to them – has been quite useful. By playing out what he imagines will happen, or what has already happened, the child deals with it emotionally as he does in normal day-to-day dramatic play. The observant adult gets useful clues about what frightens the child and the needs that should be fulfilled by parents or staff by the way in which he handles the materials and speaks to the doll. Ordinary play is also useful for mobile children at this age as it normalizes as much as possible the hospital setting. A play room full of things like those the child plays with at home or school– and being able to bring along and play with one's own favored toys– makes the environment more familiar and the hours pass more quickly. Being part of a peer group and seeing other children coping with illness and/or medical equipment like crutches or wheelchairs is helpful because to some degree then the child is able to continue the normal process of playing and discovering and exploring which makes up so much of his normal daily life at home and school.

Play helps adults to recognize that children are afraid of being abandoned and play can help the child understand the fearful unknown occurrences they will have in hospitals. Perhaps of greater importance is that the play of children can help us to recognize and then clarify the distortions, anxieties, and hurts children think they are going to experience as well as the inaccurate explanations which parents may have given them.

The major hurt and loss of close relationships engender anger and anxiety and it is these aspects which we regularly see in the hospitalized child. Some children may not act aggressively but may begin to show depression and withdrawal. Others act agressively and are frightened by their strong feelings. Both kinds of children look for the warmth and comfort of their family, especially their mother. When she is absent the child begins to "take out" his hurt and anger on the nearest individual. Those who work with children need to know not to take children's remarks "personally" – they are not aimed at the nurse or physician but often at the parent whose loss is keenly felt at these moments of great distress.

We need to recognize that the hostility expression is only part of the work of play and we must be attuned to the need for tenderness and warmth that the children expect from us. The nutritive aspects of care need to be shown to the child once hostility is evoked. Those who have difficulty accepting their feelings of tenderness and anger will find it difficult to allow expression of these feelings in children, and when children are with such people, they learn to hide their emotional reactions, expressing them in either distorted ways or introjecting them and developing guilt.

> Without suitable communication to enable the child to share his ideas during the actual period of stress, he may find methods that deal with his feelings in a pathological manner. These methods create difficulties in themselves, while the stress may go unrecognized and permanently unresolved (Petrillo and Sanger, 1972, p. 99).

It is in the provision of effective facilities and of understanding personnel, movies, arts and crafts, extra entertainment and goodies, and visits from children's heroes that some adults can feel useful in mitigating the hospitalization process. Of equal importance, however, is the provision of constant open emotional support, lots of chances to discuss what is happening, and communicating strongly the sense to children that it is all right to be afraid and to display this fear and that no one wants or expects them to be perfect, smiling through everything.

Acceptance

It has to be very clear from what we *do* as well as what we *say* in our interactions with these children that we accept their anger, their dismay, their pain, and their homesickness; we have to let them know we will be there as parents or staff when they need to cry, to whine, to complain, to have a temper tantrum, to say nasty things, or to cling in ways we might normally think aren't appropriate in terms of their age. We always need to remember that no matter how grown up a child may act or sound or look, he is *not* an adult; even an older adolescent has many fears and doubts which are not rational and which we as adults who have already lived through hospitalization at some time or other may not have. Probably every child who is going to receive a general anaesthetic is afraid that he won't wake up again. And every child who has a cast on expects that when it comes off the limb will be just like new again– we tend to tell him so– and he is unprepared for the muscle atrophy and initial weakness or immobility. Many children with unfamiliar symptoms or with symptoms like some horrible disease they have seen on TV, are sure their parents are lying and that they are going to die; and how many of us can honestly say that we haven't been frightened by some symptom into worrying about cancer? Thus we cannot wait for children to come forward verbally with these fears: *we* need to introduce them sensitively into the conversation as normal fears.

Our methods of alleviating anxiety and distress in children are several, then: honest preparation for the experience in advance as often as possible; normalization of the physical setting within the hospital; maximum parent involvement in the treatment procedures; open and honest dialogue and counselling; normal play opportunities and facilities as well as play therapy about specific anxieties related to treatment; constant emotional support and comfort and permission to display strong negative feelings from staff and family. These must be provided to individual children by those most appropriate at a given moment: a parent, a nurse, a social worker, a play therapist, a best friend or sibling, a physician, or another patient who provides what is helpful to a particular child. The more dialogue goes on among hospital staff and between staff and parents, the more the parents are encouraged to be involved and helped to deal with their child's hospitalization, the more likely it is that the child will receive support through interaction which is necessary to minimize the effects of the illness and the hospitalization.

There is the work to be done with terminally ill children in this respect: the children we feel the worst about and seem to be able, realistically, to do the least for– the ones who seem to need a miracle. Here the critical question is: What are we trying to achieve, and for whom, and why? If we want to find a technique– play therapy or something else– which asks the child to forget about his impending death, to behave normally, and co-operate with medical procedures no matter how painful, so that *we* can feel we have done everything possible to save the child, then that technique is irrelevant. If, on the other hand, our goal is to *help* the child to make the painful transition from life to death, which includes denial, depression, anger, a "why me?" feeling, and rejection of those adults who have failed to cure him – plus often disruptive behavior and visible grief– then such techniques should be supported. But the first step is honestly accepting that it is *not* easy to give up life – for any of us– and particularly for any child who is old enough to understand the concept of death but who lacks the adult's sad knowledge that the world isn't fair and that death strikes at random. If we can't accept that and the very understandable anger of the child who believed adults had the knowledge and the power to control everything, then we shouldn't be working with such children. To deny them their right to grief and anger in favor of "acceptable" behavior and tidy channeling of their feelings so that *we* are not uncomfortable, is a hostile and unfair burden to add to those least capable of handling it.

Play Therapy

The play therapy program at the Memorial Sloan-Kettering Cancer Center in New York (Adams, 1976) was designed to facilitate the expression of feelings of stress, confusion, and anxiety, enhance children's feelings of mastery, foster adaptive behavior, and increase co-operation with medical treatment in children who had malignant and terminal diseases.

For many of these children repeated hospitalization and painful treatment were interspersed with periods of remission and hopefulness. This kind of situation maximized stress, fear, and depression in children for whom hope consisted only of the possibility of medical science finding a cure before the disease destroyed them. Hospital staff felt that, although anxiety and fear were certainly appropriate responses, in some cases they were dysfunctional and made the child's living (and dying) more difficult. The play therapy program was developed over 18 months and served 200 children who attended at least 4 sessions. The goal was to deal with children's fear of separation (under the age of 5), fear of mutilation and pain (6 to 9), and fear of death (10 and over), which were seen as the major fears in severely ill children. The program sought to find ways in which children could express these anxieties verbally, behaviorally, and symbolically. Because of the semi-private room isolation of this particular hospital setting, the program was designed as a group play experience that would provide opportunities for catharsis and reality testing, for the development of subliminatory channels, and for the development of insight. In this way the child could re-enact, face, and master their anxieties at the same time as their sense of isolation was reduced.

The program did not involve children who had to stay in bed or were prone to serious acting out but included those facing or recuperating from surgery and especially those who had been noted to have a tendency to withdraw from others and suppress their feelings. The sessions were run by a social worker and a staff nurse on a rotating basis. Regular hospital materials such as syringes, needles, intravenous tubing, bottles, suture sets, tongue depressors, stethoscopes, masks and gloves, bandages, and so forth were used as part of a mobile "play hospital" on a wheeled cart furnished to look like the pediatrics unit. The cart was also equipped with dolls and puppets dressed to represent patients, parents, and staff.

The mothers of the very young children were part of each session to minimize anxiety. The case studies indicated that often children as young as 2 would provide for the doll what they needed themselves; observant mothers would then respond with physical contact, warmth, and reassurance. The results showed a marked adjustment to medical procedures and in some terminal cases "ability to separate from mother with security and no manifest anxiety". It should be mentioned here that as is often the case in any kind of therapy with children, it is difficult to ever know whether it was the method being used– in this case play therapy– or the nature of the interaction between adult, parent or staff, with the child which was most effective. In this program both were probably essential: play therapy with an uninvolved or non-nurturing adult would have had no value whatsoever and interaction with a loving adult who had no idea about the child's immediate need nor the ability to provide for it would have been equally useless.

The play therapy program chiefly presented children aged 4 to 8 with an opportunity to vent their rage in a limited way which was not risky for themselves or other children. Physician and nurse puppets and dolls got rough medical treatment in a manner which allowed reality testing; fearful children benefitted vicariously from the catharsis of other children. The staff were given an opening to reassure children that such treatment would not be given to them and to see what kinds of treatment each child feared most. Thus staff and parents could help him to cope if and when such treatment was necessary.

Children from 9 to puberty were seen as requiring a sense of mastery over their situation which could be increased if they understood exactly what was going to happen to them medically; the therapy sessions were much more verbal and encouraged discussion of treatment they were administering to the dolls and that they were receiving themselves. This led to more open discussion of fears and depressed and angry feelings and to role-play situations they might have with their parents and their physicians. Improved co-operation with treatment and adjustment to the reality of the disease were noted in this age range. Children who were dying were encouraged to continue to be hopeful and openly express their feelings through communications to and about the dolls so that staff knew what was most frightening to each child about dying and could try to deal with it and to get parents to accept the fear and provide needed comfort as well.

The designers of this program seemed most realistic about their inability to find something which would make children "all better"; they stressed the importance of keen diagnostic skills and the ability to formulate quickly a treatment approach geared to the individual child– both in terms of maximizing the effectiveness of medical treatment and in working through their eventual death.

This play therapy program was also quite realistic in its goals and sought by and large the welfare of the child, not the adults involved. It was, however, much more than play: it was about the total interaction between child, parent, and hospital. It was not, nor should it have been promoted as, the only major tool in the treatment of the hospitalized child who was severely or terminally ill.

Summary

In summary, it must be reiterated that even in the case of short-term hospitalization, there is no way– particularly with very young children– that we can completely nullify the results of the anxiety and fear caused by maternal separation coupled with the trauma of illness and the environment of the hospital. Use of all the approaches mentioned earlier – including ordinary play and play therapy – will be more or less helpful to particular children. But we must be prepared as parents, medical staff, and teachers, to cope with the after-effects of hospitalization; and perhaps realistically, the best way to do so is to encourage the child to play after he returns home from the hospital so that he has a chance to try to work through his experiences in the most natural way for him. If we watch and listen we will know to some degree what is still bothering him. Then through continuous physical and verbal reassurance we can hope to make him eventually feel as safe and secure as he did before the hospitalization occurred.

In cases of long-term hospitalization, we must recognize the danger of psychological institutionalization which happens when the maternal bond breaks down. Perhaps we will have to admit defeat and accept that very young children largely raised in institutions will have problems because that is not a normal way to raise children. In the case of terminally ill children play therapy can be a valuable tool when used as described in the Sloan-Kettering model. It can be seen as a method of focusing and improving interaction between the child and significant adults and between children who share a common bond. If it makes the death of even one child easier for that child it must be seen as helpful by all of us, even if we are uncomfortable with open responses to death and our own powerlessness.

Play is very important to every child's normal development (Weininger, 1979). When children are hospitalized their normal development is interfered with in some very major ways and merely insuring that they still get to play in hospital will not alter that reality. Play may help to normalize children's hospitalization in some ways and it may help adults to help children deal with anxieties by knowing more exactly what is bothering them right now, but it is not a miracle worker, a cure-all. A clear and honest understanding of what is involved in children's hospitalization and of our own adult needs around it, is our best hope for providing the supportive, open, caring, reassuring interaction with the sick child –whether verbally, through cuddling, or through play– which will minimize the long-term effects for the children we want so badly to "make all better".

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