Parents’ Perceptions of Play-Therapeutic Interventions to Improve Coping Strategies of Liver-Transplanted Children: A Qualitative Study

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It is challenging for families to cope with the multifaceted stressors that arise when a child has undergone liver transplantation. The aim of the present study was to investigate how coping strategies can be supported by play-therapeutic interventions. Semistructured interviews with parents of 9 live-transplanted children were conducted. The findings show that play-therapeutic interventions allowed liver-transplanted children to cope with their illnesses and with hospitalization more effectively. According to parents’ perceptions, the play-therapeutic interventions helped children to overcome their fears; children learned to deal with emotional stress, and developed stable self-esteem.

Keywords: coping strategies, family therapeutic intervention, liver transplantation, play-therapeutic intervention, qualitative research

Families in which a child experiences a liver transplantation face multifaceted stressors concerning both the daily functioning and issues related to treatment and uncertainty (Compas, Jaser, Dunn, & Rodriguez, 2012). The whole family constantly worries about the child’s chronic health condition (Kaller, Langguth, Ganschow, Nashan, & Schulz, 2010). An important aspect is that chronically ill children have to stay in hospitals frequently. In addition to the medical issues related to the transplantation, they may develop behavioral and emotional problems resulting from the stays in hospital (Salmela, Salantera, & Aronen, 2010). Individual stress perception during the hospital stay (e.g., when undergoing an operation or experiencing pain) has a major impact on coping with illness (LeBlanc, Goldsmith, & Patel, 2003). In addition to stress

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factors related to the transplantation, psychosocial stress factors including strong medical treatments and the threatening experience of fear of death also influence chronically ill children substantially (Theofanidis, 2007). Fukunishi and colleagues (Fukunishi et al., 2001) postulated that psychiatric and psychological disorders such as anxiety and low self-esteem are very likely to occur during the first 3 months after transplantation. Therefore, children need support from professionals to learn how to express their feelings, particularly their anxieties (Morana, 2009).

Psychotherapeutic interventions have been employed to lower children’s traumatic stress levels and to assist them in developing adaptive coping styles (Morison, Bromfield, & Cameron, 2003). Children and their parents need to understand and cope with the transplantation and the concomitant psychosocial problems. Coping with disease traumata can strongly influence the healing process of patients after transplantation. Patients with active disease-coping strategies yield higher quality lives than those with depressive coping strategies (Nickel, Wunsch, Egle, Lohse, & Otto, 2002). Coping denotes cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. Coping thus is a collection of purposeful, volitional efforts that are directed at regulating aspects of the self and the environment under stress (Compas et al., 2012).

The complexity of pediatric liver transplantation and its consequences necessitates that therapeutic interventions should address coping strategies during the whole transplantation process, taking into account the preparation for the operation, the operation itself, and annual checkups. Even before suitable transplants are found, children have to learn to cope with their fears in preparing for the actual transplant. After the organ transplant children have to learn how to cope with possible problems such as rejection reactions or compliance in taking medications (Wu, Aylward, & Steele, 2010). Thus, therapeutic interventions need to be specifically tailored to support children in developing relevant coping strategies for the different situations. Most existing therapeutic interventions after pediatric transplantation aim at long-term therapeutic support in a psychotherapeutic practice (Taylor, Franck, Gibson, & Dhawan, 2005). In this study, however, we focused on therapeutic interventions that support children in the hospital after transplantation. According to Scholten and colleagues (2011), therapeutic support in a hospital has to integrate children’s individual experiences with medical treatment, specific characteristics of the families, and the structure of work in the hospital. Evidence exists that therapeutic interventions involving the whole family can help to develop effective coping strategies; conversely, such strategies are affected by characteristics of the family (Weisz & Gray, 2008). Long-term interventions concerning coping strategies therefore include assessment of existing parental support and suggestions for future adaptations (LoBiondo-Wood, Williams, & McGhee, 2004).

A recent review showed that directive and also nondirective play-therapeutic interventions are increasingly used for inpatient and outpatient settings in children’s hospitals to prevent and reduce anxiety and distress. The finding revealed that these play-therapeutic interventions are often more successful than other therapeutic interventions (Gold, Grothues, Leitzmann, Gruber, & Melter, 2012). Play therapy is considered suitable for children because they can find ways in play to show their interests and talents, express their feelings, practice growing up, experience their own identities, develop a sense of self and other, rehearse social roles, and strive to understand their
real-world lives in the fantasy worlds they create (Timberlake & Cutler, 2001). Play-therapeutic interventions address issues such as processing pain, regulating externalizing behavior, and managing the chronic illness (Landreth, 2001). In the context of hospitals, play-therapeutic interventions are used first to prepare patients for medical procedures and second to help them develop strategies to cope with their stresses and fears (Gold et al., 2012). As such, play relates to many areas of adaptive functioning in child development, including coping and emotional regulation. Children experience real-life situations by playing similar scenes, and, in that way, cope with hospitalization (Moore & Russ, 2006).

At the Children’s Hospital Regensburg (Regensburg, Germany), therapeutic interventions were developed to support children after liver transplant. It comprises elements both of play-therapeutic interventions and systemic family therapy (Gold, Grothues, Gruber, & Melter, 2013). The combination of play-therapeutic interventions and systematic family therapy is seen as advantageous, because both children and parents are considered. On the one hand, children are better able to show their emotions (e.g., fight with pillows) and they learn in a playful manner to cope with their own emotions like fear, stress, or anger. On the other hand, parents are supported as they receive advice and assistance to better deal with their children’s illnesses and the accompanying factors. Retzlaff (2008) described the benefits of combining family therapy and play therapy as suitable to integrate children in a systemic therapeutic setting.

The purpose of the present study was to describe parents’ experiences with systemic family-therapy and play-therapeutic interventions. The parents’ points of view were investigated concerning emotional stress and coping strategies of their children after liver transplantation.

METHOD

Participants

Nine parents of liver-transplanted children, including seven mothers, one father, and another legal guardian, participated in the interview study. The parents’ children, six girls and three boys, between 3 and 14 years of age ($M = 9.66$, $SD = 3.67$), had undergone pediatric liver transplant and stayed in the Children’s Hospital Regensburg for several days. All children were hospitalized at the time of the therapeutic interventions. Seven children had undergone liver transplant within the last 5 years. The other two children had liver transplants more than 5 years ago. That means that these children received therapeutic support during a later hospitalization (e.g., when they stayed in hospital because of medical complications or had to undergo retransplantation). Table 1 provides more information about the children, in particular, about their medical condition.

Intervention

The therapeutic interventions developed at the Children’s Hospital Regensburg aimed to help children to cope with their current health statuses. The over-
seeing therapist held a degree in education and specialized in systemic family
therapy and play therapy, with an additional qualification in crisis intervention. The
therapist had 4 years of professional experience in systemic family therapy and play
therapy. Moreover, the therapist successfully completed emergency-medicine train-
ing and had some basic medical knowledge. The children took part in directive and
nondirective play-therapeutic sessions while the parents had systemic family-ther-
apy sessions. The family and play-therapeutic interventions took at least 2 weeks
and the whole family—parents and siblings—were involved. The children had
therapeutic support 5 days a week, each session lasting for 45 min. The parents
participated in two or three sessions a week.

The interventions included aspects of the children’s physical, cognitive, and
emotional stages of development. They comprised six different therapy compo-
nents.

### Building Relationships and Diagnoses

In the first session, the therapist tried to build trust for a good relationship
between patient and therapist. Diagnoses were assessed as starting points for the
therapeutic interventions. To explore psychosocial difficulties such as anxiety,
depression, social problems, somatic complaints, or delinquent behavior, parents
and children filled out several diagnostic questionnaires. In a first play setting, the
children were invited to play whatever they wanted. In this stage, the role of the
therapist was as an observer, with the goal of gaining basic information about each
child. Each child’s play was supported by nonverbal acknowledgment such as head
nodding, facial expression matching the child’s, open and relaxed body expression,
and eye contact. Usually parents did not take part in this session except when the
children wanted them to be present. Depending on the time the children needed to
build relationships, this phase took two to three sessions.
**Stress Reduction**

Based on the results of the diagnoses, play-therapeutic interventions were used to reduce stress provoked by invasive medical procedures, hospitalization, and anxiety (Shipon, 1999). The interventions dealt with stress reduction, identification and dissolution of mental blockades, and their possible causes from psychic and emotional stress. Playing here was thus viewed as a method to facilitate children to express their feelings. The therapist invited the children to show their feelings by either asking them to draw their actual emotions or to do handicrafts of their current emotional state. Other techniques to reduce stress were to play music, to engage in mental journeys and visualization exercises, or to show anger by screaming loud or engaging in a pillow fight. After these exercises, the therapist and each child discussed the experiences and the related feelings expressed. The children could decide whether they wanted their parents to be present or not in these sessions. This part of the intervention was the beginning of each therapeutic session and took place whenever children showed signs of stress.

**Coping**

Children and their parents were informed about the illnesses and their appropriate responses (e.g., liver transplant, therapy, nutrition). Each child and his or her parents jointly attempted to develop adequate coping strategies to deal with the illness. These coping strategies aimed to increase the confidence in handling one’s own life situation. A psychoeducational element focused on the process of accepting one’s own illness. In this setting, children often preferred playing “doctors and nurses.” This scenario represented the current real-life situation and it helped the children to handle their hospitalization and therapeutic interventions. The task of the therapist in this setting was to verbalize the emotions the children expressed in play. Moreover, visualizations were used to facilitate children’s understanding of what happens in the different situations (e.g., a teddy bear got a new organ). The therapist was ideally seen as a constant companion, explaining the difficult things happening in the hospital (e.g., different diagnostic interventions like MRI or biopsy) and the feelings the children could not classify. The children were also trained to engage in physical activity or use relaxation techniques to cope with their feelings. Relaxation techniques focused on breathing, dream-journeys, and paintings of fear monsters.

Again the children could decide whether parents were present or not in these sessions. Coping sessions are considered necessary before new medical procedures are introduced, new medication is prescribed, a new diagnosis is set, and after the transplant itself. As soon as children understand their situations and feelings, they are generally able to change their ways of coping with illness and hospitalization. Depending on the respective situation and how quickly children were able to apply the relevant coping strategies, four to six sessions were scheduled.
Individual Problems

Individual problems related to divorced parents or “mobbing” at school often accompany and aggravate disease-related problems (Taylor, Franck, Gibson, Donaldson, & Dhawan, 2009). These aspects were also covered in the therapeutic interventions, as they influence quality of life. For instance, a long stay in the hospital can make it difficult for both parents and their children to maintain social contacts (Webb, 1995). The therapeutic interventions were aimed at considering both individual and disease-related problems. In role plays, the therapist assisted the children to take in different perspectives by playing various roles. In that way, the children were able to see a problem from different viewpoints and could learn to take action in different ways. Problems such as social insecurity or aggressive behavior can be treated during play. In role plays, the therapist can provide direct feedback. Usually, children do not want their parents to take part in these sessions. This part of the intervention took between one and three sessions. In many cases, the therapeutic intervention was continued as an outpatient therapy when the children returned home, as the time during hospitalization was often too short to deal with all individual problems sufficiently.

Coping With Everyday Life

The children were prepared to get along with their illnesses in daily life. The therapeutic interventions addressed taking care of everyday medication, following rules with regard to restrictions in daily life, social integration, and future life prospects. In the therapeutic interventions, role plays were used to practice mastery of such daily-life situations. In general, these therapeutic sessions focused on school children and young adolescents aged between 6 and 14 years who started to take personal responsibility for themselves and who learned how important it is for them to take their medicine regularly. Together with the therapist, they practiced how to talk to their friends and classmates about their disease and they also experienced these situations in role plays. It was considered important that these children were able to take care of their medications themselves. In cases of young children (younger than 6 years old), the therapeutic sessions focused on a shared understanding between parents and children about the children’s illnesses. Together they learned to stick to routines, make agreements with regard to behavior and medication, and respect the limitations. For this part of the therapeutic intervention, one to two sessions were scheduled.

Parental Coaching

To cope with their own emotions, parents obtained parental coaching. During the coaching they were invited to talk about their own problems and fears. The therapeutic support sessions for parents were provided in addition to the children’s play-therapeutic interventions and took place twice or three times a week for 30–45 min. The coaching started with the visualization of the family on the family or
system “board” to analyze family relationships. The illness was represented as a special guest of the family. The relationships among the family members—including the “guest”—were analyzed and problems identified. Together with the therapist, parents’ problems were discussed and solutions put forward. This part of the intervention addressed the whole family. Therefore, the whole family—parents and siblings—took part in at least one or two session.

**Instruments**

Based on a systematic literature review, a semistructured interview was developed to collect data on parents’ experiences with therapeutic interventions. The focus was on parents’ perceptions of their children’s emotional stress and the development of coping strategies. Parents were expected to be better able than children to reflect on their situations with regard to the influences of the illness, the hospitalization, and the therapeutic support. Some of the children who participated in the play-therapeutic interventions were still too young to explain their emotions.

A field manual was used during the interview. Open-ended questions were used, which allowed participants to describe their experiences and opinions with regard to the therapeutic interventions and perceived changes in coping strategies. Before conducting the interviews, the field manual was sent to a multidisciplinary team to discuss comprehension and content. Then, the interview was pretested with four subjects. The pretest served to check the sequence and understanding of the questions and to estimate the scope of the answers and the duration of the interviews. The interview included three main topics: psychosocial problems, coping, and experiences with the therapeutic interventions. The interview included the following questions: (a) What is most stressful for your child concerning his or her illness and hospitalization? (b) How did your child cope with his or her illness before the therapeutic intervention? (c) What are your experiences regarding the therapeutic intervention? and (d) How did the therapeutic interventions change the coping strategies?

During the interview, more specific questions were raised to clarify responses and to gain a better understanding of relevant topics and their possible interrelationships. This happened to point out interrelationships between behavior, emotions, the management of the disease, stress, and psychosocial problems.

**Procedure**

The whole family took part in the therapeutic interventions. In this study, however, only one parent per family was interviewed, because usually only one parent stayed in the hospital for the child’s entire stay. The first author conducted the interviews. The aims of the study were first explained to the participants. A written consent was obtained before participation in the interview; participation was voluntary. Each participant was interviewed individually on the last day of his or her child’s hospitalization for about 1 hr in a separate room.
at the hospital. All interviews were recorded and transcribed verbatim. Quo-
tations from the protocols, which are presented in the Results section, were
translated into English.

Analysis

Coding, organization, and analysis of the data were done by the first author
using MAZQDA 10 software (MAXQDA, 2010). The categorical framework was
derived deductively from prior research in the investigated domain and consisted of
four major categories: emotional stress, existing coping strategies, experiences with
therapeutic interventions, and development of new coping strategies (see Table 2).
Each category was divided into several subcategories, for example, the emotional
stress category was further subcategorized into anxiety, somatic complaints, de-
pression, social problems, behavioral problems, family problems, and problems at
school. The categories were clearly defined by the physicians on the research team
based on the research literature about psychosocial problems of children after
pediatric liver transplantation.

For each interview, the overall trends, patterns, relationships, exceptions, and
alternative explanations were examined, and then the interviews were compared
with each other (Berg, 2004; Maxwell, 1996). The findings were discussed with an
independent team of psychosocial experts for consensus. These experts were four
psychologists, three pedagogues, one social worker, and one pastoral worker. All
experts had family-therapist training and were experienced in providing therapeutic
support for children and families. Moreover, they were part of a supervising group
for therapists. In case of disagreement, the categorical framework was adapted until
joint agreement was reached.

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<th>Table 2. Categorical Framework</th>
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<td>Categories</td>
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<td>Emotional stress</td>
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<td>Existing coping strategies</td>
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<td>Experiences with the therapeutic interventions</td>
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<td>Development of new coping strategies</td>
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RESULTS

The results are presented with regard to the four major categories, emotional stress, existing coping strategies, experiences with the therapeutic interventions, and development of new coping strategies. Interview extracts are used to illustrate parents’ experiences.

Emotional Stress

The interviews showed that 90% of the parents expected the Children’s Hospital to provide professional medical support as well as psychosocial support for coping with emotional stress. The participants experienced diagnostic procedures as emotionally stressful, especially the painful ones. Liver transplant, long stays in the hospital, and extensive medication were mentioned as stressful. For instance, a 5-year-old boy with fear of injections panicked when the doctor came into his room. The mother described an incident in one of the play-therapeutic interventions in which her son showed his fears by playing doctor with his teddy bear and telling the therapist of the teddy bear’s fears. Anxiety and helplessness concerning the clinical environment and invasive procedures were reported to be traumatic for all children.

Furthermore, parents mentioned that their children were afraid of medical complications and of the possibility of dying. One girl described this fear by painting a picture of her death. According to the parents, children also feared to never recover and thus be forever different from other children. A quote of a mother puts this fear into words.

Mrs. A.: She often tells me that she wants to be the way other children are and wants to do the same things, like horseback riding and dancing. Due to the long stays in hospital and all the issues we have to take care of, it is very difficult for her to find friends and to integrate in her class.

According to the parents, most children experienced limitations because of their illnesses. It was stressful that they felt that they could not lead a normal day-to-day life and that illness affected relationships with peers. Some children attended special schools because of their medical problems, which often resulted in depression and antisocial behavior.

According to the parents, children found it difficult to cope with the emotional stress caused by illness and hospitalization. Parents indicated feelings of guilt as stressful and leading to marital problems. One mother described these feelings as follows.

Mrs. U.: I often wonder what I did wrong so that my child is so ill. The discussions about this theme result in the fact that I and my husband argue a lot. I know that I have no time for my husband as I take care of my child, and I know this is a problem, too. But there are also financial problems due to the illness of our child, so it is necessary that he goes to work while I spend time with my child in hospital.

Seven parents indicated that they had reduced the number of social contacts since their children had become ill. They each indicated that they had to cope with a chronically ill child and long hospitalizations, which also often resulted in drastic changes of career and life plans.
Existing Coping Strategies

When asked about internal and external coping strategies, participants described their ways of coping with the chronic illness and their children’s transplants. All parents reported that their children always hoped for a better future. Parents said that they had the feeling that their children blocked out issues concerning transplantation. The results indicated that repression and denial were common coping strategies. The interviews showed that eight children used such strategies prior to and after transplantation. A father described this as follows.

Mr. K.: She didn’t want to talk about the transplant and she also didn’t want to know what the doctors said in the ward around or at the time of the examination. And I think that a child is too young to understand all this medical stuff. Prior to transplantation, she often retreated into her shell.

Four parents indicated that their children showed intensive emotions. Parents interpreted these emotional reactions as a coping strategy. However, in those situations, parents expressed feelings of helplessness in deciding whether to confront their children with frightening information or to protect them from reality. In one case, a father mentioned that his son tended to respond with aggressive behavior when anyone began to talk about the transplantation issue. During the therapeutic interventions prior to transplantation, this boy preferred to play as a monster who loved to gorge on doctors and nurses. The father thought that this play behavior showed his son’s fears and inability to cope with the situation.

Parents mentioned that they also felt traumatized, as they perceived the liver transplant to be life threatening. Prior to the therapeutic interventions, they felt unable to develop appropriate strategies to cope with their situations and looked for help. All parents reported to be at a loss for words when it came to talking about the illness with their children. Some parents indicated that this feeling stood in their way toward developing new coping strategies for themselves. However, the parents were aware of the importance of getting involved in the management of the disease and in the healing process.

Experiences With the Therapeutic Intervention

Eight parents mentioned that therapeutic interventions were necessary, not only for their sick children, but also for themselves and siblings. Most parents indicated that they were not familiar with therapeutic interventions. After their first experiences with family and play-therapeutic interventions, most parents perceived these interventions as an appropriate method to support the children in coping with their fears and problems. The following quotation illustrates their experiences.

Mrs. F.: After transplantation, it is important that the children have the opportunity to cope with their emotions. They must have an arena to show all their feelings and to talk about good and bad things. Play therapy is a method that facilitates the expression of the feelings.

The parents identified five main issues that improved after play-therapeutic interventions: confidence, psychosocial stress, coping with illness and hospitalization, individual problems (social, family issues, anxiety, school problems, etc.), and
coping with daily life and normalization. According to the parents, children preferred puppet plays, mental journeys and visualization exercises, role play, playing hospital or doctor and nurse, and also drawing and crafting. Moreover, the parents reported that their children felt supported by the fact that the therapist accompanied them to examinations and surgery during their stays in hospital. Parents appreciated that their children also experienced moments in which they could laugh together and act as healthy children.

Development of New Coping Strategies

Subsequently, parents perceived that their children learned to talk about their feelings through participation in the play-therapeutic interventions. Crying, talking and drawing helped to release emotional stress. Some parents indicated that they lost their fear to speak openly with their children about the transplantation and its complications when they realized how many issues their child had already understood. The quotes of two parents describe their impressions with regard to the play-therapeutic interventions.

Mr. B.: Playing hospital and playing in a fantasy world helped her in bringing the past, present, and future together.

Mrs. P.: The therapeutic help really resulted in quality of life for my son.

Other parents reported that their children even played “hospital” at home after play-therapeutic interventions, and that the newly defined strategies to cope with fears and sleeping problems were simple but most effective such as dream-journeys or paintings of fear monsters. For some children, physical activity or relaxation techniques, such as taking slow deep breathes or progressively tensing and relaxing different muscle groups, were used to help release emotions, reduce anger and bad feelings. For many parents, the most important aspect of the play-therapeutic interventions was the guidance and support of the therapist during hospitalization and medical procedures, as the following quote of a mother shows.

Mrs A: For my child, the therapist had been something similar to a best friend in hospital, with whom she could talk and face all difficulties in hospital.

According to parents, play-therapeutic interventions helped their children to successfully deal with illness and hospitalization. Parents experienced that the children overcame their fears. Moreover, parents indicated that their children learned to deal with emotional stress, and they developed stable self-esteem.

DISCUSSION

The present study investigated parents’ perceptions with regard to family and play-therapeutic interventions to improve coping strategies of children with liver transplants. In this section, we discuss parents’ perceptions about emotional stress, existing coping strategies, experiences with the therapeutic intervention, and the development of new coping strategies and relate our results to previous research in
the domain. Then we present some limitations of our study and ideas for future research. Finally, we conclude with practical implications.

Our findings show that parents perceive limitations in the daily lives of themselves and their children due to the chronic illness. Emotional stress, fear, depression, and antisocial behavior were problems parents mentioned in the interviews. Similar results were also found in a study by Theofanidis (2007). He reported that children with a chronic illness and hospitalizations have fear of rejection, low self-esteem, insecurity related to limited educational prospects, fear of restrictions inflicted by the situation, and anxiety about how others will react to their illness, especially the reaction of peer groups.

In our study, parents' experiences revealed that most children and also parents themselves do not have available adequate strategies to cope with illness and hospitalization after pediatric liver transplantation. These findings confirm results of related studies, which have determined that often neither children's nor parents' strategies are adequate to cope with emotional stress and anxiety (Compas et al., 2012). In our study, we found that repression and denial were common coping strategies. Similar findings have been reported in the domain of pediatric oncology. Haag, Graf, and Jost (1991) showed empirical findings of seriously ill patients, who tried to deny their illness, and in that way, reported less anxiety.

Both children and parents need support after pediatric liver transplantation to cope with difficulties encountered during all stages of a child's illness (Carlson & Bultz, 2003; Tong, Lowe, Sainsbury, & Craig, 2010). Results of our study show that parents experienced the play-therapeutic interventions as important contributions to improving the psychological health of their children. Moreover, our findings match the results of other studies about play-therapeutic effects in general, and in particular, concerning the decrease of the fear of hospitals (Shipon, 1999; Li & Lopez, 2008). From the parents' points of view, play-therapeutic intervention helped children to develop new coping skills during their hospitalizations. Similar experiences with play therapy have also been reported by Nabors and colleagues (2013). They found that medical play was a mechanism for imaginative coping and working through stress related to medical experiences. Although these findings are promising, there are some limitations in our qualitative interview study that need to be addressed in future research.

Limitations and Future Research

First, this study focused on parents' experiences with the presented therapeutic interventions only. Although parents' experiences were positive with regard to the therapeutic interventions, it would be interesting to further investigate these effects. In future research, an experimental research design with pre- and posttest measures could examine the use of coping strategies in more detail. Second, only a small sample could be recruited for this study because the pediatric transplant center of the Children's Hospital Regensburg was at its initial stage when this study was conducted. However, the number of young patients undergoing liver transplantation is generally relatively small. A third limitation of this study is that the interviews were conducted with parents only and not with the children undergoing
liver transplantation. Future research should also consider and analyze the perspectives of the children and peers participating in the therapeutic processes to gain insight into their thoughts and feelings with regard to psychosocial care.

Despite these limitations, the present study revealed a number of ideas on how to improve, upgrade, and develop therapeutic interventions for children after pediatric liver transplants.

**Practical Implications**

The interdisciplinary cooperation between hospital and home care will play an increasing important role in the health-care system of the future. Family and play therapists are members of the hospital’s therapeutic team. They can provide information to the medical staff about the psychosocial circumstances of families. Nurses usually do not have sufficient time to interact with families as therapists do, and they are not trained to solve diverse problems regarding the fears families encounter. The results of the present study thus help to identify several aspects that are important for providing therapeutic care in the hospital. Among the most supportive issues are the following: accompanying the child during the stay in hospital for examination and surgery, spending some time with the children, and playing games and having fun with the children so that they can behave normally and forget for a period of time that they are seriously ill. The components of the therapeutic interventions we have described have formed a comprehensive basis for therapeutic work with children in hospital. The add-on value of psychosocial care for sick children does not only include addressing patients’ satisfaction, but also the perceived effectiveness of the entire treatment process, including life posttransplant.

Mental health issues in general are expensive (Carlson & Bultz, 2004). In cancer care, however, it has been shown that psychosocial care can provide considerable long-term cost savings to overburdened health-care systems (Carlson & Bultz, 2003). Having therapeutic staff for preventing and helping with psychosocial problems in hospitals can be seen as a worthwhile investment. Future studies should attempt to investigate explicitly the cost-effectiveness of therapeutic interventions.

The number of chronically ill children will increase (Melnyk, Feinstein, Moldenhauer, & Small, 2001). Therefore, it is important to have a therapeutic concept available that fits the needs of these children. Our study has shown that therapeutic support at an early stage (i.e., best before the actual transplant and during a long hospitalization), is a helpful experience for children and parents. Play-therapeutic interventions, in which real life situations can be played and different feelings can be expressed and processed, were perceived effective. Future studies have to investigate these interventions more systematically.

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