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# “Are staff bias’ affecting the way pediatric patients develop and cope within the hospital setting?”

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“Are staff bias’ affecting the way pediatric patients develop and cope within the hospital setting?”

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Child Life Online--Advanced Standing

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## **Abstract**

Gender stereotypes are pervasive in our culture – ingrained by long-standing biases (both conscious and unconscious) (Higgins, 2018). The way boys and girls begin to understand and mitigate their world are often related to the gender stereotyping that society has constructed. However, stereotypical expectations not only reflect existing differences, but also impact the way boys and girls interpret themselves and are treated by others. This paper will focus on the way gender stereotyping of hospitalized pediatric patients may impact coping, treatment, and overall care. The author has chosen to examine language especially as it relates to gender specific analogies, incentives for procedures, normalizing activities, gender biased statements and their implications on coping. The author will discuss the potential for next steps that focus on education of staff as well as modeling and reframing of gender biased statements for both staff and caregivers.

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## Introduction

Common phrases such as “She’s just being a dramatic teenager” and “He’s a big boy, he’s tough and brave” are something I hear on a daily basis both in and outside of work. Everytime I hear these comments, I ask myself, was I ever one of those “dramatic teenagers”? What does it mean to be a “dramatic teenager”? Who defines dramatic and why do we feel as if teenagers are just deemed being dramatic or seeking attention? Do they deserve less care than others? How do statements like these affect the care, coping, and staff relationships with patients? These thoughts and comments have peaked my interest in how we treat humans depending on his or her gender, especially within a hospital setting.

In a fast paced environment such as the pediatric emergency department in which staff don’t have a lot of time to build rapport with patients and families, should staff base decisions about treatment, care, and coping on a patient’s gender? More often than not the medical team with the best of intentions will offer a barbie doll to a girl and some race cars to a boy. In a busy pediatric emergency department are making these quick assumptions based on gender stereotypes doing more harm than good? What are the potential effects of gender biased comments made by staff and does gender stereotyping have an effect on a patient’s ability to cope causing long-term effects?

Throughout my time at Bank Street, I’ve had numerous classes where gender has been an integral part of the discussions. Bank Street has given me the opportunity to grow in my knowledge and understanding of gender and gender stereotypes. It’s taught me how making an assumption about a child based on gender can affect the child and families hospital experience,

the child's ability to cope and staff's ability to develop positive relationships based on authentic interactions rather than assumptions based on gender.

For the purposes of this paper, I will be looking at theories of gender identity development, how patients are treated, specifically focusing on stereotypes associated with what a girl or boy can do, interests, and assumptions about characteristics associated with a specific gender and what is expected of them in a hospital setting. By focusing on gender based staff prize box requests, incentives, language, and expectations, this paper aims to develop a way in which staff members become more aware of their comments and the effects it can have on a child or family being treated in the emergency department.

## **Definitions**

Throughout the paper, there will be terms and theories that need to be defined ahead of time in order to understand the meaning behind them. The term "sex" refers to biological differences; chromosomes, hormonal profiles, internal and external sex organs (Nobelius, 2004). "Gender" will also be utilized throughout. This term describes what society and individuals delineates as being male or female. Another term that will also be seen is "stereotype". When this term is used, it means a standardized mental picture that is held in common by members of a group and that represents an oversimplified opinion, prejudiced attitude, or uncritical judgment (Merriam-Webster's collegiate dictionary, 2018). One other term one may need to understand is gender identity. This term relates to how one psychologically perceives oneself as either male or female (Killermann, 2015).

## Literature Review

Gender development starts in utero. “Prenatal genetic testing allows for pre-delivery determination. Ultrasound assessment of genitalia in the second and third trimester is also used” (Van Meter, 2016). It is from this moment on that parents, based on societal norms and stereotypes, begin to lay the groundwork for what it means to be a boy or a girl. Since gender in contemporary Western society involves creating differences between boys and girls from the moment they are named a boy or girl (Martin, 2011), caregivers will determine the color of the baby’s room, toys will be bought based on gender, and hopes of future aspirations for the child will be grounded in stereotypical male female occupations, expectations and roles. Gender reveal parties, posting videos, and instagramming pictures are ways to tell society what gender their baby is by typically using socially accepted colors of pink for girls and blue for boys. “Some people say that our ideas about femininity and masculinity come from nature. People who believe this say that men are naturally masculine and women are naturally feminine. Those who believe that nature is responsible for gender traits may argue their case by pointing out that, in general, women do behave according to feminine stereotypes and men do behave according to masculine stereotypes” (LaTour, 2014). A new study in the *Journal of Adolescent Health* found many norms around gender, what's expected of boys and girls, become entrenched in adolescence and have negative impacts that carry into adulthood (Dastagir, 2017). A women’s

blog, written by Laura Bates, the founder of the Everyday Sexism Project, says, “There’s nothing wrong with an individual child choosing to identify with any of these roles” (2015).

Children develop and use an ingroup/ outgroup schema to categorize and organize items in their environment as “for them” or “not for them,” respectively, based on what culture has deemed appropriate for each gender (Weisgram, et. al., 2014). Exposure to explicit messages about gender roles "boys play rough" or "girls are sweet" and implicit information about males and females such as the prevalence of female teachers in preschools is posited to aid the process of stereotype formation (as cited in Shenouda, 2013). Most people employed in science, technology, engineering and math (STEM) fields, for example, are men; most people in caretaker positions, such as nurses and early childhood teachers, are women (LaTour, 2014). Dr. Spinner, a developmental psychologist at the University of Kent in England, says that traditionally masculine toys like blocks and puzzles encourage visual and spatial skills, while traditionally feminine toys encourage communication and social skills and if children only play with one, then they are missing out on a whole host of skills (as cited in Klass, 2018) and are only encouraged in one way, which again gives them the information that they are only capable of doing those particular jobs.

## **Toys**



Although many factors may shape toy interests, gender differentiation of toy preferences may be a result of explicit verbal labeling such as parent, grandparent, or advertisement claiming and/or implicit labeling through labeling toys, clothes, and even baby items like diapers, sippy, cups or bottles as masculine and feminine by using colors, toy type, or images of trucks and dinosaurs for boys and princesses and butterflies for girls (Weisgram, Fulcher, & Dinella, 2014). During the preschool years, children exhibit definite preferences for gender role stereotyped toys and activities and tend to reject cross-sex stereotyped toys and activities due to being programmed to like them and not given opportunities to explore other toys. (as cited in Oncu, 2012).

Weisman et al state, one way children acquire knowledge about the gender-typing of toys is through explicit gender labels provided by socializing agents such as parents, family members, peers as well as stores and corporations who often advertise items in a gender specific way. These powerful agents, give leadership and affirmation to children, rewarding them with praise or imposing sanctions for certain behaviour (Martin, 2011). The developmental intergroup theory (DIT) postulates that children must first establish that gender is an important characteristic of people (Shenouda & Danovitch, 2013). Gender schema theory provides a theoretical framework that explains the cognitive processes behind these judgments and gender typed interests (Weisgram, et. al., 2014).

## **Societal messaging**

Around the globe, schools, parents, media and peers reinforce the myths that girls are vulnerable and boys are strong and independent (Levine, 2017). Even though children's television shows, movies and books are less gender-stereotyped than previous eras, frequently, males are still shown as strong and brave, powerful and dominant. Female characters typically appear submissive, emotional, and primarily focused on romantic relationships (Oswalt, n.d.). Although there is nothing inherently wrong with expressing femininity or behaving in a gendered manner, stereotypical female behavior may potentially be problematic if girls believe that their opportunities in life are limited because of preconceived notions regarding gender or if they avoid the types of exploration and activities that are important to children learning about the world in order to conform to stereotypical notions about femininity (as cited in Coyne, 2016). But what is this doing to a child? For example, the increased risk of anorexia and bulimia in girls likely reflects perceived social pressures to adhere to culturally prescribed norms for body shape and size (AAP, 2000). It's making boys not feel secure in their masculinity. It's making them act out or become aggressive, which leads to further problems in the future such as suicidal ideations, depression, or physical or sexual violence. This is all a result from feeling shameful or humiliated if they show emotions. Boys are conditioned that they ought not be weak, wrong, soft, fearful and ought to not fail (Vallejos, 2013). According to the report, a lifetime of viewing

stereotypical media becomes so ingrained it can ultimately affect kids' career choices, self-worth, relationships, and ability to achieve their full potential (Knorr, 2017).

## **Language**

Even in this modern day, language still plays a great role in defining gender, to the extent that it affects gender roles in society (Racoma, 2014). According to a study in *The Journal of Pediatric Psychology* last year, parents are “four times more likely to tell girls than boys to be more careful” after mishaps that are not life-threatening but do entail a trip to the emergency room (Paul, 2016). Chaplin et al. (2005) showed that fathers attended more to girls’ submissive emotions, such as sadness and anxiety, than to boys’, whereas they attended more to boys’ disharmonious emotions, such as anger and laughing at another, than to girls’. While adults will often say soothing things to a crying child to get them to calm down, boys are more likely to be told by parents, teachers and their peers that they shouldn’t cry and that they should suck it up instead (Sumano, 2018).

## **Healthcare**

Many studies have reported that emergency physicians and nurses frequently undertreat pain and that most emergency department patients do not receive adequate, timely analgesia

(Yanuka, 2008). Despite the presence of published evidence-based standards of care specific to pain assessment and management, pediatric patients are inconsistently and/or inappropriately assessed for pain (as cited in Habich, 2015). If females are considered dramatic when expressing pain, while boys aren't crying while they experience pain, children typically go undertreated due to staff member's assessments and bias. Pain decreases their quality of life considerably because it reduces their opportunities for socialisation and learning when they miss school, hampers their ability to pursue leisure activities, as they cannot practice sports, disrupts their sleep and generally complicates family life (Cozzi et al., 2017).

Despite group-level parallels, at the individual level, children who were highly gender-typed in one way (e.g., wearing a lot of pink dresses) were not necessarily gender-typed in another way (e.g., playing frequently with dolls) (Halim, et. al., 2013). The first study, led by Children's Hospital Boston researcher S. Bryn Austin, ScD, indicates that kids who fail to adapt traditional gender stereotypes as children are at a significantly greater risk for physical, sexual and psychological abuse during childhood (Underwood, 2012). As stated previously, if boys always play rough and are always super heroes, does this mean they always have to be brave? If girls are sweet, are they seen as being too sensitive? If we continue with these gender biases, they can lead to greater risks for long-term chronic pain, physical and sexual abuse in childhood, and negative coping (Grinberg and Larned, 2017).

“Gender norms that say women should be polite and quiet lead many women to suppress their feelings in their relationships. It’s also apart of the reason why women survivors of sexual assault or sexual harassment don’t speak out about their experiences until later in life” (Sumano, 2018). Child abuse can directly trigger PTSD, increase the risk of exposure to subsequent stressful events, and increase the conditional risk of developing PTSD following exposure to subsequent stressful events (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Dr. Jack Turban, a psychiatrist at Massachusetts General Hospital, where he studies pediatric gender identity, said of the study: “The mental health significance of these societal gender expectations was striking. What we have learned over the past several years is that shame and stigma are dramatic risk factors for mental health problems. When children are shamed for gender ‘atypical’ interests, they become anxious, depressed and isolated.” (Levine, 2017). According to Dr Pereira, “Trying to live up to these unreal ideas of masculinity and femininity leads to a range of problems; low self-esteem, bullying, physical and verbal violence, health problems and a tragic loss of potential in our young people. Therefore, we must promote ideas about gender which are less rigid, and recognise there are many ways of being a man and a woman” (2014).

Gary Barker, the international director of Promundo, an organization that engages men and boys around the world on issues of gender equality, states, “Men who have more rigid views of what it means to be men are more likely to have suicidal thoughts, more likely to be

depressed, less likely to report they're happy with life overall, less likely to take care of their health, more likely to own guns, the list goes on (as cited in Weingarten, 2015). Certain behaviour is encouraged, ignored, praised or emphasised, depending on whether the child is a boy or a girl (Martin, 2011). Shenouda suggests that by the time they begin elementary school, children have acquired gender norms and apply them to judgments of a person's occupational knowledge and competence, as well as their own preferences and future aspirations (2013).

However, researchers are concerned that the gender differences in toy interests and toy play may be linked to gender differentiation of cognitive abilities, career interests, social interactions, behavioral tendencies, and many aspects of their physical and psychological development (Weisgram, et. al., 2014). The degree to which children espouse gender early on could set in motion lifelong individual differences in displays of masculinity or femininity (as cited in Halim, et. al., 2013). In one new study, a majority of millennials surveyed argued that gender shouldn't define us the way it has historically, and individuals shouldn't feel pressure to conform to traditional gender roles or behaviors (Kott, 2014). And even President Obama is getting in on the norm-questioning trend: While sorting holiday gifts for kids at a Toys for Tots in December, the president decided to place sporting equipment in the box for girls (as cited in Weingarten, 2015). Zimmermann says, "We know that these stereotypes that are being shaped and reinforced can be linked to a lot of different things from educational and occupational goals to academic ability to social development and it is really important to have children get this broad range of experiences" (2017). A gender theorist, Kate Bornstein, at a recent New America event, noting that geography, religion, and family attitudes are all contextual factors that can

alter one's perception of gender as a determinant of identity, states that as long as we hold onto the notion that gender is a constant, "we'll keep doing things to keep the lie in place" (as cited in Weingarten, 2015).

## **Background / Developmental Perspective**

A June 1918 article from the trade publication *Earnshaw's Infants' Department* said, "The generally accepted rule is pink for the boys, and blue for the girls. The reason is that pink, being a more decided and stronger color, is more suitable for the boy, while blue, which is more delicate and dainty, is prettier for the girl." (Maglaty, 2011). But now, it's the opposite. In the 50s and 60s after World War II ended, things changed a bit. Indeed, the '50s and '60s are full of pink moments, from the strawberry-colored Chanel suit Jackie Kennedy wore on the day JFK was assassinated to Marilyn Monroe's hot pink strapless dress from *Gentlemen Prefer Blondes* (Conrad, 2015). However, it didn't stay like this for long.

Around the 1970s, during the women's liberation movement, which promoted the anti-feminine message, the unisex look became society's norm. The Sears catalog even pictured no pink toddler clothing for two years keeping things more gender neutral. Then around 1985, things began to change. Jo B. Paoletti, a historian and author of *Pink and Blue: Telling the Girls From the Boys in America*, believes society's thoughts on gender changed when more caregivers were able to find out the sex of their child before the birth.

As of today, gender is still an issue. Although there have been evident progresses, many alarming issues regarding gender discrimination still prevail today; therefore, total gender equality must be made a global priority as a fundamental step in both human development and

economic progress (Kamrany & Robinson, 2018). “When asked whether the future of gender was evolution and extinction, Barker, Nyong’o, Wallace and Bornstein all said they hoped for extinction. But at the same time, each acknowledged how difficult that goal would be to achieve. Beyond the power dynamics, there’s a level of comfort in well-worn identities. “It’s easy to sit in these old roles that we’ve watched and to feel a certain comfort in their stability in a world that feels kind of hard to understand.”” (Weingarten, 2015). As a society, we no longer believe women should be restricted to certain jobs or that fathers are ill-suited to tend to babies. So children’s play should reflect modern cultural norms, rather than be boxed into 1950s-era stereotypes driven by marketers’ desire to segment the child audience for maximum profit (Hains, 2015). But unfortunately, it takes the community as a whole to make a change on this issue.

Looking around, whether it’s at the park, in a classroom, or even in one’s playroom, children exemplify early childhood gender development. Girls will pretend they are mothers, princesses, or teachers while boys are running around saving the world as superheros or digging in the dirt as construction workers. These examples and process of development are defined as gender typing. Gender typing is the process of developing gender roles, or gender-linked preferences and behaviors valued by the larger society (Berk, p.375). While children will develop this on his or her own, society plays a huge part in persuading them one way or the other. In video games, fairy tales, and movies society has attached the norm of a princess needing help from a prince. While there is nothing wrong in pretending to be a princess, as many real world princesses make decisions and have ruled countries, there is a problem when she appears to be dead and needs to be rescued by a prince who sexually assaults her. Just as it’s



okay to pretend to be a superhero, but it's not okay to tell boys they can't show emotion by crying.

The moment parents find out if a child is a boy or girl, gender stereotyping begins. Boys starting at birth are programmed to be “doers” to take action. A boy's nursery will be painted blue with animals, given trucks and cars that expand imaginations and rescue people from fires, and they will be dressed in dinosaur t-shirts encouraging exploration and science. A girl's nursery will be painted pink with flowers, they will be dressed in sparkly t-shirts and dresses, given baby dolls and tea cup sets that promote the “natural” order of nurturing and caring for others as well as not to look beyond the home for self fulfillment. How often do we heedlessly shower little girls with platitudes about prettiness and looks, or comment on how “big and strong” their brothers are growing (Bates, 2015). Girls subconsciously learn they can't build or construct but to value her appearance and looks more, while boys learn to be industrious and look for girls that are pretty. Giving children the connotation that they have to act in a particular way, play with specific toys, and like certain things. If they don't, they aren't “normal” in society's eyes.

Theorists, Lawrence Kohlberg and Sigmund Freud, both studied development and how discovering gender impacts development to connect to societal norms. Kohlberg is a 20th century psychologist. Kohlberg's theory of gender identity development describes how young children learn to understand their gender, and what being that gender means in their everyday life (Oswalt, 2008). This theory is organized into three specific stages. In the first stage preschool children determine differences between being a boy and a girl, however they still believe that gender is something you can change. During school age years, children will understand gender as

a constant and unchangeable. They will start to organize gender-related activities that they see their caregivers doing, such as mom cooking dinner folding the laundry, while dad mows the lawn. As they begin adolescents, they will fully understand gender, the stereotypes associated with it and be able to make decisions about one's gender and the choices they make.

Freud's assertion in 1924 that biology is the key determinant of gender identity, for instance, was for years a hegemonic idea in both law and culture (Weingarten, 2015). Sigmund Freud was the founding father of the psychoanalytic theory. He believed that connection to the same sex partner was crucial for long term mental health and sex drive. However, Erik Erikson is also a theorist that was influenced by Freud's theory. Erikson believed that due to different genital structure lead males to be more intrusive and aggressive and females to be more inclusive and passive (Killermann, 2015). This all connects with how children start to understand gender and believe due to that gender they have to act a certain way.

Albert Bandura is another theorist that focuses on development through social interactions. Social learning theory, with its emphasis on modeling and reinforcement, and cognitive-developmental theory, with its focus on children as active thinkers about their social world, are major current approaches to understanding children's gender typing (Berk, p. 375). This theory focuses on four main principles: attention, retention, reproduction, and motivation. Children gain information (retention) from his or her caregivers (reproduction) by grabbing his or her attention through encouragement (motivation). If a parent or caregiver assumes a child will like a specific toy or praise based on his or her gender then the child will eventually start to believe this.

Jean Piaget is also a theorist that observed and focused on the cognitive development of

children. The goal of the theory is to explain the mechanisms and processes by which the infant, and then the child, develops into an individual who can reason and think using hypotheses (McLeod, 2015). Thinking about how this relates to gender is by a child constructing the world around them, therefore understanding what society determines gender to be. This theory allows a child to develop his or her own hypothesis about gender, however this typically does not happen until adolescence when they start making decisions on his or her own.

Another approach to gender-role identity is the gender schema theory, which is an information-processing approach that combines features from the social learning theory and the cognitive-developmental theory to explain how environmental factors and children's perceptions work together to form gender-role development. According to gender schema theory (Bem, 1981), the association between child gender, parenting, and child behavior is likely to be influenced by parents' gender-role stereotypes.

## **Rationale**

A video called *No More Boys and Girls: Can Our Kids Go Gender Free?'* shows a short glimpse of an experiment that was designed to test men and women's gender stereotyping when playing with boys and girls. The boy was dressed as a girl and the girl was dressed as a boy without the men and women knowing. Each person chose toys based off the gender they believed the child was due to the outfits they had on. Sophie, whom was biologically a boy, was dressed in a pink dress and the male playing with him stated "I automatically went for the pink fluffy toy because I saw it was a girl". Another one of the adults stated, "That really astounded me because I thought I was somebody that had a really open mind" (BBC, 2017). This experiment proves

that people may not be aware of his or her biases about stereotypes and gender, but they can be very impactful.

The pervasive nature of the stereotypes lead girls to being seen as needy and helpless, while they view boys having strong limits. If men were encouraged to engage emotionally with others and with the world, they could live more well-adjusted lives with less pressure, more love and a broader idea of what they are capable of (LaTour, 2014). Once girls become teens they are seen as vulnerable and in need of protection leading many teens (and later women) to hide their assertiveness in order conform to society's beliefs (Sumano, 2018).

If one cannot help what gender they are, then why should they be punished or treated any differently? Society is stuck in past "gender norms." The literature found on gender stereotypes stems from observations and studies within a school or one's personal life, however a lot of the same findings could be applied to a hospital setting, where staff have made statements and decisions of care based on their own gender stereotype assumptions. The following are personal accounts heard and experienced by this author in a pediatric emergency department potentially leading to continued research and programmatic plans to develop education training and discourse around the implications of continuing to base decisions on gender stereotypes.

### **Witnessed Staff Comments**

Research on gender stereotypes and potential implications of care was begun after hearing staff members make biased and prejudicial comments based on gender stereotypes. The comments often come from the emergency department staff, however patients' caregivers and/or families also make some of these gender stereotypical comments as well. The problems arise

around the language that's used, the assumptions about toys one may want to play with, the incentives that are promised, and the expectation differences between boys and girls. While staff members believe some of the comments are helping patients, the above research points to ultimately promoting negative stereotypes and coping. Researching studies and examining different theorists' perspectives on gender, reinforces a need to better understand the impact of the comments patients experience everyday. Having gender biases can affect one's ability to perform an assessment, even without realizing it, he or she can negatively affect a patient from the very beginning of his or her admission. During triage it is the responsibility of the triage nurse to determine the acuity and pain level of a patient. Depending on the criteria and if the nurse was implicitly biased based on gender may predict if and when the patient is seen or how his or her pain is tended to. According to the research studies on pain mentioned previously, we learned that pain is not adequately assessed nor treated. The long-term effects of untreated pain include chronic anxiety responses and intensified pain sensitivity through adolescence (Ramira, 2016). Indeed, inadequately treated pain increases the pain experienced during subsequent episodes as well as fear of care, or phobia, a loss of confidence in adults, and behavioral and anxiety disorders (as cited in Drouineau, 2017).

Some of the reasons one's pain may not be properly treated could be gender biases of staff members, not adequately assessing the patient, and not having the time to continuously check in with the patient due to a fast pace, understaffed emergency department. Limited improvement in ED analgesic practice is most likely a result of entrenched opinions among ED staff (Yanuka, 2008). However, this is not acceptable and children will endure both long and short term problems as a result.

In the previous literature review it states that pain can decrease the quality of life for a patient, as well as if someone states they are in pain then they are in pain. The following is an example of a female teenage patient not being adequately treated or believed she is in pain. Upon arriving to the emergency department due to abdominal and back pain, she was asked to rate her pain on the pain assessment scale ranging from 1 being the least amount of pain to 10 being the worst pain she's ever had. She rates her pain a 10 out of 10. However at this point she does not receive pain medication. When the nurse is asked about why she did not provide pain medication, the nurse stated that she believed the girl wasn't in pain due to intermittently laughing with the doctor, but instantly crying when anyone else walked into the room. Unfortunately, it may never be fully understood why the nurse made this determination. It could be due to the lack of understanding about pain, gender bias or a combination of both. However, other comments made by staff members leads to the possibility that one factor may have been because she was a teenage girl. Comments such as "girls are so dramatic" and "she has period cramps, she needs to get used to it" categorize females as being dramatic and is considered gender stereotyping and as research has shown, leads to females feeling like they can't express themselves truthfully. "Once girls become teens they are seen as vulnerable and in need of protection leading many teens (and later women) to hide their assertiveness in order conform to society's beliefs" (Sumano, 2018) and even become victims of violence.

Once blood work and an ultrasound were completed for this patient, which showed that she had kidney stones, the patient did finally receive pain medication. This patient was in pain in the emergency department for over an hour until she finally received adequate medication. If staff are basing decisions on gender then the facilities that strive to provide care and support are

in actuality exacerbating and/or starting a series of long-term problems, such as mental health issues, physical or sexual abuse, and negative coping abilities.

It is not only girls who are subject to gender bias. Another comment that is made frequently is “wimpy, white boy”. This comment is typically made either during assessments or procedures. The characteristics of a “wimpy, white boy” is crying in pain, anxious, scared and unable to cope. Comments like these encourage boys to feel as if they are being thought of as a “sissy or wimp”, when in reality crying should be an acceptable reaction and release of tension and fear. However, all too often men grow up with the belief that crying is a sign of weakness (Sumano, 2018). The following is an example of a 7 year old boy that is brought into the emergency department as a trauma patient. He was riding a lawn mower and hit a stump, resulting in flipping off backwards with the lawn mower tumbling over him. This patient continually told staff members “I didn’t even cry” and he felt proud of himself for that. As he continued to tell staff members this, they responded with, “That’s so brave”, “You’re such a big boy”, and “You’re tough”. While it is okay for a child to be proud of oneself, it’s the reinforcement of the stereotype from staff that make this problematic. This is what promulgates the message that boys should not show emotion. He feels as if to prove himself as being brave and masculine, then he better not show his emotions. This is explained in video called, *The Mask You Live In*. It’s about how boys wear masks to shield all their emotions, fears, and perceived weaknesses. They are taught from a very early age not to cry and to suck it up. Boys learn to bury those emotions potentially leading to men who are angry, violent, and unable to form lasting relationships (Representation Project, 2013). When the sharing of emotions is labeled as

“female characteristics” and the societal understanding is that females are weak and men are strong.

Gender stereotyping is also demonstrated through the use of language during procedures. Often staff use gender specific analogies for medical devices and equipment as a way to soften or explain a tool. For example, during an IV(intravenous therapy) or a blood draw, a medical device called a J-Tip is utilized. This is a needleless device that uses lidocaine to numb a child’s skin. It uses compressed air to break through the top layer of the skin. To prepare patients for the sound it makes and the sensation they may feel, staff members base their language choice and analogy on the gender of the patient. For boys, the noise is described as the sound a “rocketship” makes. For girls, it’s described as an “Olaf kiss” from the movie Frozen. After an IV is placed, an “arm board” is used to help secure the IV line. This is a small board with gauze wrapped around the board and is taped to the patient’s arm or hand decreasing mobility and increasing the length of time the IV line will stay in the vein. Again the analogies are gender based, for boys it’s known as the spiderman web thrower, but for girls it’s known as the princess pillow. Even in the analogy boys are offered an analogy that promotes actions and strength whereas girls are encouraged to be passive by keeping their hand still on the “princess pillow.”

Staff using these analogies most likely do it with the best of intentions believing they are more relatable and fun when they use these terms. It is also possible in the fast paced environment of the ED that medical staff uses what they have in order to develop quick rapport with his or her patient. There will be some patients who respond positively to these analogies. However, it also does not promote choice but provides an image of how they should be, act, and/or respond to stressful and anxiety producing situations. Dr. Zimmermann, a developmental



psychologist, said “Children should be free to play with the toys they enjoy — toys should not be ‘assigned’ by gender” (as cited in Klass, 2018). By telling a boy he now has a spiderman web thrower, the staff are telling the patient he has to conform to bravery as defined by versions of TV superheros. In other words, he needs to be brave and brave means holding still and not showing emotions. By telling a girl that the J-Tip is like an Olaf kiss is not only making assumptions that she likes princesses, but reinforcing the stereotype of princesses needing to be passive and lacking a voice of her own. Gender-typing of toys, explicit labels, and gender-typed colors are cues that children may use to classify toys and form stereotypes about which gender should play with them (Weisgram, et. al., 2014).

Small toys and prizes are often given to children after a procedure is complete as an incentive or reward as well as toys are provided to children waiting to be seen by the doctor or admitted to the inpatient hospital. These are normalizing activities that encourage play and often decrease stress for both caregiver and patient while enduring long waits in the ED. Often the child life specialist is asked by staff to bring a truck for a young boy to play with or a stuffed animal for a little girl. Another example is a staff member stated why she chose the specific toy for the child by saying “I got her this frozen toy, because what little girl doesn’t like frozen”. Toy choices are another way staff members may be unintentionally promoting gender stereotypes and taking away a choice for a child by deciding for the child what he/she might like to play with. It’s the assumptions of what the child would like to play with that also matters. Young children are not always equipped, as most adults are, with the critical tools to analyse and probe information-what is presented as fact is often absorbed without question” (Bates, 2015). Children are not only in an intimidating environment, not being able to make choices about the

healthcare treatment they are receiving, and yet when a choice is possible staff are taking away that choice by choosing the toy for the child.

This also happens when staff members use incentives to motivate a child to perform a specific behavior in order to complete a procedure or assessment. Rigid gender stereotyping promotes inequality between the sexes and can set young people up to expect and accept power imbalances within relationships later in life (“Talking to Young Kids”, n.d.). Some of these comments include but are not limited to: “If you are brave, I will get you this...”, “If you are good while I do xyz, I will get you a prize”, or “If you take your medicine like a big boy or girl, then I will get you a prize”. Who defines what it means to be “brave” or “good”? Do they ever receive a prize when they aren’t “brave” or “good”? And who determines the criteria and sets the expectations? Are the expectations different for boys and girls?

In reality, bravery doesn’t mean fearlessness, but means doing something even though we’re scared. To become brave, children need to learn to tolerate feeling scared and not let fear hold them back (Kennedy-Moore, 2016). However, this is rarely explained to a child beforehand by medical staff. To a child brave may be based on images from TV, movies, family members and expectations from staff with statements like don’t cry be a big boy/girl. As discussed in the social learning theory a child learns from social and environmental factors how to behave and respond to certain situation. Children using what they know from what they have seen and learned will apply the behavior to the situation, hoping its the correct reaction. When they are rewarded with both verbal praise and/or incentive prizes children learn to repeat the behavior. Therefore, a child will learn that even though he or she may not act appropriately when they are asked to, they will still receive a reward in the end. Medical procedures are difficult for children

and often children respond with a flight or fight response however, “how parents reward or discipline behaviour that adheres to accepted notions of gender. For example, through statements such as ‘boys don’t cry’, or ‘boys will be boys’ to excuse inappropriate behaviour” (“Talking to Young Kids”, n.d.). They’ll learn that people will accept an “okay response.” These types of responses from either parents or staff can lead to negative coping which reinforces coping strategies that may actually increase stress and anxiety rather than decrease it.

Throughout the day, I’ll hear comments such as “she’s a teenage girl, so she’ll probably be dramatic”, “she’s just being a brat, so she doesn’t deserve your services, and he’s an older boy, so he should be fine and not need distraction”. Staff members make these assumptions without giving the patient an option. According to the Child Life Council’s standards of clinical practice, “Whenever possible, children will be encouraged to take an active role in their own care and will be involved in decisions regarding health and wellness”, which includes support and education for healthcare procedures and hospitalizations (2001). While staff members are not only limiting a patient’s choice, they are also going against the hospital’s mission statement and the pediatric bill of rights. The mission statement of the hospital in which these comments were made states, “to promote optimal health for the region's infants and children by providing patient- and family-centered care, education, research and child advocacy” (2009). The Association for the Care of Children's Health (ACCH) developed the first Pediatric Bill of Rights to affirm their mission to ensure family-centered, psychosocially comprehensive, and developmentally appropriate care to children and their families (Mott, 2014). Patient and family centered care is vital in the hospital setting and a child life specialist can assist in providing that well-rounded care.

## **Child Life Importance/Implementation**

A child life specialist is a professional that helps children and families cope with the stress and uncertainty of illness, treatment, and injury (ACLP, 2018). While the field is continually growing, child life specialists are primarily located in children's hospital to enhance coping and promote development during a hospital visit and/or stay. According to the Code of Ethical Responsibility for Child Life Council Members, principle 3 states, "Individuals shall have an obligation to serve all children, youth, and families, regardless of race, gender, religion, sexual orientation, economic status, values, national origin, or disability". Child life specialists provide individualized services to all patients and families. Those services include but are not limited to normalization, preparation, procedural accompaniment, coping techniques, and support for families. An important part of my job is to meet patients and family members where they are at, which includes assessing developmental understanding of reasons for admission, treatment and procedures, coping, and interests. I use this information to develop a child life plan that does not make assumptions about a child's likes and dislikes based on gender. Using gender specific terminology, analogies and incentives in a hospital setting can ultimately lead to negative coping and long-term complications. This can potentially contribute to misconceptions about gender that can result in the child's perception of self being affected by societal gender norms. The hospital becomes one more place that reinforces the stereotypes.

According to the Child Life Competencies, defined by the Child Life Council, a child life specialist has "the ability to represent and communicate child life practice and psychosocial issues of infants, children, youth and families to others" (2016). A child life specialist's role is to

educate not only a patient, but also family and staff members. Education for both staff and parents about gender and the importance of not making choices for a child based on assumptions regarding gender is important. A child life specialist can provide alternative suggestions for analogies, toys, and incentives as well as model and reframe statements from caregivers and staff, educate about the developmental level of the child and the implications of gender stereotyping on coping.

Parents are also one of the biggest advocates for their child. Among the types of caregivers, studies with parents showed the highest accuracy at assessing their child's pain, as there was almost no difference in parent's assessment of pain and their child's self-report of pain (Ruben, Blanch-Hartigan, & Shipherd, 2018). It's important that parents speak up for their child. This will encourage boys and girls to vocalize choices and make decisions on their own. Popular culture wants to make children's decisions for them: what they wear, what they eat and drink, what television shows and movies they watch, what video games they play and what music they listen to (Taylor, 2011). Therefore, parents need to teach their children how to make good positive choices for themselves. Educating parents about the healthcare setting and modeling appropriate non gender specific coping and responses is one way a CCLS can support parents in establishing healthy coping in the hospital regardless of gender. Research shows that when a child shows symptoms of illness, gender stereotypes may cause parents to perceive their daughters as more vulnerable than their sons (as cited in Berk, p.405). However, "If we caution and condition fear into girls at a young age, this fear will manifest as "deference and timid decision making" later in life" (Neefs, 2016) and if we don't allow boys to express how they feel then they will learn to hide their emotions and potentially leading to maladaptive behaviors.

Another way a child life specialist can be beneficial is by being non judgemental, meeting a child and family where they are at, and using non-gender specific terms. Children and families come into the hospital from all different backgrounds, lifestyles, and differences, but that doesn't determine how they should be treated. According to Elisha Goldstein, Ph.D., it's vital to "be aware when the brain is automatically judging a situation or a person, and we can pause and get some perspective" (2013). While the emergency department is a fast pace environment, it's still important to take some time with patients and families. Quickly to judge can lead to other complications. As a child life specialist, it's imperative to develop a trusting relationship through play, education, and support with patients and families in order to individualize their care and provide the services they need. For example, when asked for normalization toys or to bring a prize after a procedure, asking the child and/or family what he or she may like helps build rapport while not making assumptions and giving the patient a choice where their decision making is limited. Giving children choices helps them feel like they have some power and control over what they do (Mincemoyer, 2016). It also helps to change an unfamiliar environment into a more friendly environment by providing them with something they are familiar with, enjoy, and find comfort in.

Lastly, a child life specialist is trained to promote positive coping and allow opportunities for self-expression. A child life specialist supports a child's ability to cope by reassuring and validating the child's feelings. Offering the child an outlet to express emotions by telling them that it is okay to feel upset, scared, or any other emotion, while simultaneously providing positive and specific praise, such as "I know this is hard for you, but you are doing a great job at holding your arm still" creates a supportive environment based on the needs of the whole child

not the singular factor of gender. Throughout preparation and procedural support, a child life specialist may avoid the word “brave” because it has different definitions for different people children may express what it means to be brave to him/her in a variety of different ways. A child life specialist can also assess a patient and clear misconceptions ahead of time to enhance coping and ask the child to define the word “brave”, so that he or she understands what the staff member means and develop clear expectations for coping.

The issue of gender stereotyping will continue to have negative effects on children if something doesn't change. A child life specialist can provide opportunities through education, assessment, and modeling that allow children and youth to express themselves freely, not based on societal norms of gender, and educate parents and staff members on the importance of this. I, as the child life specialist in the pediatric emergency department, will begin providing education to caregivers and staff members about gender specific comments and the negative implications it can have on a patient. According to the Association of Child Life Professionals code of ethics, principle 5 states, “Individuals shall promote the effectiveness of the child life profession by continuous efforts to improve professional services and practices provided in the diverse settings in which they work and in the community at large” (2000). By using the key components of this project to create a staff presentation and flyer for healthcare professionals working in an emergency department will provide an educational opportunity for staff to discuss and share the implications of gender stereotyping patients on treatment, care, and coping. Flyers can be created and dispersed throughout the emergency waiting, and treatment rooms providing staff members and caregivers alternative language that promotes coping not gender stereotypes.

Signage can include appropriate language to use for each developmental age, tips for supporting children, and strategies that build rapport and provide choice.

Through assessment and modeling, a child life specialist can bestow the most powerful messages kids will absorb. When you actively role-model gender equality, speak out against stereotypes, and challenge outdated ideas, kids will hear that loud and clear” (Knorr, 2017). It can change the way they view gender roles which transforms the future generations in believing there aren’t specific roles for being a boy or a girl. Staff members and caregivers will also pick up on the language that is utilized by a child life specialist and begin using gender neutral terminology. A child life specialist has “the ability to integrate clinical evidence and fundamental child life knowledge into professional decision-making” (Child Life Competencies, 2016) and will make a difference in children’s lives because of it.

## **Conclusion**

Change is slow. Cultural shifts happen in stages, not overnight — hence the pushback (Hains, 2015). "We need to view gender as more of a system," Mmari said. "One of the problems is we typically look at things on an individual level. So we feel like if we just empower girls, make them feel good, then we'll change. But the problem is they go back to their homes where they're given messages from their parents that are contradictory. They go to the schools where they're given messages from their teachers that are contradictory. They look at the media — it's a whole system out there that's transmitting these inequitable norms, and so we have to think of it more on that level." (Dastagir, 2017). Still, Freud’s theory isn’t yet dead; enduring gender norms show us that the bodies we’re born into still govern lives of women and men around the world



(Weingarten, 2015). Child life specialists play an integral role in changing how boys and girls treatment and experiences are affected by gender stereotyping both in and out of the hospital setting. Through modeling, education and collaboration with staff and caregivers child life specialists can strive to create a safe equitable environment that amplifies the voices and agency of all children regardless of gender.

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