Stephanie Hopkinson Honored with the 2013 Mary Barkey Clinical Excellence Award

At the Opening General Session of the 31st Annual Conference in Denver, Colorado, CLC presented the fourth annual Mary Barkey Clinical Excellence Award to Stephanie Hopkinson, MA, CCLS, a child life specialist at Kaiser Permanente Los Angeles Medical Center. The Child Life Council established the Clinical Excellence Award to recognize child life specialists who have demonstrated exemplary child life care and a high level of clinical skill.

The CLC Board of Directors chose Stephanie as the recipient for this award based on her distinguished history of leadership and commitment to quality psychosocial care in the clinical setting. Throughout her career, Stephanie has demonstrated a passion for collaboration and thoughtful communication, dedication to professionalism and ethical behavior, an enthusiasm for her work, and, above all, commitment to the well-being of patients and their families.

The ten criteria developed for the Mary Barkey Clinical Excellence Award focus on key areas for the provision of quality psychosocial care. With the permission of her colleagues who submitted Stephanie’s name for consideration for the award, we are pleased to share excerpts from several exemplars in the nomination materials as evidence of just a few of the ways that Stephanie Hopkinson has exemplified clinical excellence in child life.

Models exemplary practice of child life through critical thinking, inquiry, evaluation, and a commitment to continuous improvement

As an accomplished child life specialist, Stephanie is amazingly humble and wonderfully committed to effective

Child Life Alphabet

T is for Teaching

Shannon LeCompte-Mahan, MS, CCLS, Children’s Hospital of Pittsburgh of UPMC, Pittsburgh, PA

Teaching is one of the most important roles we have as child life specialists. It is something we do on a daily basis in so many different ways, whether intentional or unintentional. We educate patients and families about what to expect during hospitalization and how to subsequently cope. We educate multi-disciplinary team members through formal in-services, as well as informal demonstration. We also educate about developmentally appropriate practices through active participation on multi-disciplinary committees such as patient- and family-centered care and pain council. Furthermore, we educate volunteers, child life assistants, and child life practicum and intern students in many of the same ways. We tailor how we teach to meet the psychosocial and developmental needs of our audience, both children and adults. We use wide-ranging modes to teach, from verbal explanation and visual demonstrations to hands-on play with toys and real medical equipment.

Providing in-services to the multi-disciplinary staff throughout the hospital and in the community is not a new concept, as its importance has been ingrained into our profession since the child life research project was discussed in detail in the publication of Psychosocial Care of Children in Hospitals: A Clinical Practice Manual (Gaynard, et
Giving it Your All

Diane Hart, MA, CCLS, EDAC

I was recently asked, “What have been the most rewarding and challenging parts of being the CLC President this past year?” While the question seemed simple enough, I found it more difficult to answer than I expected.

I would suspect that for any of you who have led a charge—whether you chair a committee or task force, volunteer for a community organization, or contribute to a cause you are passionate about—you focus on giving it your all. Having the privilege of being immersed in numerous aspects of the Child Life Council this past year has enlightened me as to just how many people give it their all, each and every day, on behalf of the association’s members.

Gone are the days where a committee or task force exists just because it may be a good idea. Also gone are the days when a committee sits idle for months or years at a time. I may be found at www.childlife.org. Acceptance of advertising does not indicate or imply endorsement by CLC.

The work productivity of the association’s members, to my surprise, is unprecedented, which I have come to appreciate even more in the past two years that I have been on the Board of Directors. I have now attended several American Society of Association Executive (ASAE) meetings, and through these meetings have concluded that CLC volunteers are among the most hardworking, productive, and conscientious members of any professional association. To illustrate my point, here are just a few of our committee and task force accomplishments this past year:

- The Academic Preparation Task Force has been working on an academic endorsement process as an interim step moving institutions closer to accreditation.
- Thanks to the Evidence-Based Practice Committee, child life specialists have access to a set of three new interactive learning modules designed to support a child life specialist in the development of his or her own EBP project.
- The Internship Accreditation Task Force focused on creating the minimum standards for a child life clinical internship. These standards were aligned with the exam blueprint and the documents prepared by the previous Internship Task Force related to curriculum and evaluation.
- The Research and Scholarship Committee has been working with the Board and CLC office staff on creating a research agenda to identify future research possibilities that will document the economic value of child life services.
- The Practicum Task Force has been exploring the variety of child life practicum experiences that exist. They conducted surveys of both clinical and academic settings that provided them with a wealth of information and resources.
- The Academic Preparation Task Force, Internship Accreditation Task Force, and the Program Standards Task Force met in person during the first weekend in March to move forward on their respective charges, as well as to address some common issues among the three groups.

Behind every industrious committee and task force is another team of people who give it their all, and that is the CLC staff. We are so fortunate to have this “dream team” working tirelessly on our behalf. They make it look easy, but have you considered the hours it takes to plan an annual conference? The expertise it takes to coordinate a Certification Exam? The knowledge and skill it takes to secure a substantial donation? The talent it takes to communicate every CLC update and initiative to its stakeholders? I am very grateful to have worked alongside such an amazing team. Some of the behind-the-scenes work accomplished this past year in the CLC office includes:

- Securing a $250,000 grant from The Walt Disney Company to further CLC’s strategic initiatives, including research on play, leadership development, and international outreach
- Hiring a new Deputy Director, Colleen Maguire; a new Manager of Professional Resources and Services, Alli Floryshak; and a new Strategic Program Initiatives Manager, Joe Lindahl
- Conducting and publishing the results of a profession-wide salary survey
- Furthering work on assembling an iPad applications database for child life specialists
- Helping coordinate and support the numerous activities undertaken by CLC’s committees and task forces

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FROM THE EXECUTIVE EDITOR

Teaching and Learning in the Child Life Community
Jaime Bruce Holliman, MA, CCLS

What an exciting time to be a part of our child life community! We as a profession are growing and developing, defining who we are and how we want to be viewed by the health care community. And our hard work and high standards are paying off!

The Focus Review Board editorial team is also working toward further growing and defining our publication to meet the changing interests of our readers and reflect current events within our community. This summer we are happy to introduce our first themed issue, which, as you may notice, focuses largely on learning and teaching, from the child life clinician, child life clinical educator, and child life academic educator perspectives. But this issue is not only for the student or educator; it is also for those child life professionals who endeavor to be life-long learners. Some of you may have recently attended CLC conference in Denver, and hopefully you returned to your department and your practice filled with renewed energy and new ideas to implement. Some of you may have stayed behind to “man the fort” and discovered that you wanted to learn more about an area that you do not typically cover. This issue is not only about being a teacher, but also about being a learner.

Contributors to this issue include clinicians, clinical supervisors, university educators, and researchers who are committed to moving the field forward by creating standards for the education of the next generation of child life specialists. One Focus article explores teaching methods and the development of critical thinking skills in new child life specialists, while the other compares the qualities of an educator to those of a clinician. A personal reflection article in Bulletin complements the Focus content with a first-person account of the transition from clinical child life specialist to academic instructor, and “‘T’ is for Teaching” shares one child life department’s commitment to teaching others within their own department and multidisciplinary teams.

I hope you enjoy this themed issue of Bulletin and Focus and that it encourages you to continue to learn and grow in your own practice.

Investigating Child Life Practicum Programming
Jennifer Guilliams, CIMI, CCLS, Children’s Hospital at Memorial University Medical Center, Savannah, GA
Linsey Hammon, CCLS, Cook Children’s Medical Center, Fort Worth, TX

In 2012, the Child Life Council Practicum Task Force (PTF), an extension of the Education and Training Committee, began examining and collecting information regarding current child life practicum program practices and organization.

In response to a charge issued by the CLC Board of Directors, the Practicum Task Force released two surveys via email: one to clinical practicum settings and one to child life academic programs. These surveys were designed to collect information to help the task force identify common standards and guidelines currently in use for practicum experiences. A total of 60 clinical sites responded to the clinical survey (41% response rate) and 33 academic programs responded to the academic survey (47% response rate) from across the United States and Canada.

The results of these surveys depicted a broad and diverse picture of child life practicum experiences. The surveys specifically looked at different programming components such as the type of child life practicum setting, number of students accepted per semester, number of practicum hours required of each student, level and type of supervision, additional assignments, and a general overview of the institution’s philosophy about practicum programs.

Survey Results
Practicum students per program. Clinical sites reported a range of one to twelve practicum students being accepted each semester, with the majority (80%) of clinical sites accepting one to three students each semester. The majority of academic sites reported having 10+ students enrolled in a practicum course each semester; however, this question did not differentiate hospital-based child life practicum placements from other types of practicum experiences accepted by child life academic programs. Please visit the CLC Member Directory at http://www.childlife.org/Membership/MemberDirectory.cfm.

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Personal Perspective

Reflecting on My Journey from Clinician to Academician

Cara Sisk, MA, CCLS, Tennessee Technological University

My journey to becoming a child life specialist began in the spring of 1991. I was a junior in college, and a friend shared that she was majoring in child development and pursuing child life. It was exciting to hear about this “new” profession that would both utilize my educational background and incorporate therapeutic work to benefit children and families. I proceeded to graduate with a bachelor’s degree in elementary education, attend graduate school, complete an internship, and earn a master’s degree in human development and family studies. I began working at St. Jude Children’s Research Hospital in 1995 after a full year of looking for a child life position. Yes, even in those days, the field was competitive!

Eleven years of working as a child life specialist at St. Jude was an excellent learning experience. At the time I began working, the Child Life Department was comprised of only a director and myself, so I began my clinical work receiving referrals from all areas of the hospital. I became unit-based as our team grew larger, and later progressed to an age- and diagnosis-based caseload serving inpatients and outpatients. I have been fortunate to work with pediatric patients from birth to young adulthood throughout my clinical career.

In August 2011, I became the child life program director and instructor in the School of Human Ecology at Tennessee Technological University where I was hired to create a new child life academic program. I enthusiastically accepted this opportunity as I enjoy sharing the child life mission, educating others, and developing new programs. That’s not to say I didn’t feel some apprehension; I did. Although I’d never worked in academia and hadn’t been the “newbie” in years, I had faith in my experience, skills, and knowledge of child life.

From my experience, a vital consideration in making this transition is adapting from therapeutic practitioner to academic authority. University instructors need a skill set that includes evaluating student performance, communicating assessments, and assigning grades, which seems quite the contrast from cultivating therapeutic relationships with patients and families. Another vital piece is learning the climate of a new institution, as each is very distinctive. This is an area I continue to explore as it takes time to fully understand the hierarchy and history of a university. I know there will be other challenges; however, I am confident that my coping and self-care skills will continue to serve me well.

My best advice for others looking to transition into academia is to know yourself well and carefully examine what is required to be a successful academician. It is crucial to candidly evaluate your strengths and weaknesses and how each relate to education. I suggest having many years of clinical experience in various areas of the hospital with patients of all ages to build skills, gain confidence, and ensure credibility before training new child life specialists. An array of experiences in clinical and non-clinical aspects of child life is beneficial for program development, course creation, assessment planning, student engagement, and classroom management.

Another piece of advice I offer is to make sure you are comfortable working independently. I am the only faculty member with child life expertise and am solely responsible for representing all that we value in child life to our school, college, and university. It is also the first time in my career that I have not had officemates, and it took a few months to acclimate since I was accustomed to daily interactions with child life colleagues.

I’m often asked if I miss working with patients at the hospital. My response is mixed: yes, because I loved the daily interactions and the opportunity to make a positive impact on children and families in the health care setting; and no, because I am now privileged to work with young adult students who are passionate about learning the child life profession. Erikson refers to my current stage of midlife psychosocial development as generativity versus stagnation, which emphasizes the importance of investing in and exhibiting the virtue of care for the next generation (Erikson, 1959). My new roles as teacher and mentor

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Effective University Educators and Clinicians: A Practical Examination of Specific Qualities and Considerations for Course Development

Katherine Bennett, MEd, CCLS, Monroe Carell, Jr. Children’s Hospital at Vanderbilt, Nashville, TN; Lipscomb University, Nashville, TN
Laura Gaynard, PhD, CCLS, University of Utah, Salt Lake City, UT

INTRODUCTION

Translating child life specialists’ clinical skills into university classrooms can be a challenge. Recently the Child Life Council (CLC) added an academic requirement for certification eligibility. Beginning with applicants for the November 2013 certifying exam, all those seeking certification as a child life specialist must complete at least one child life course taught by a Certified Child Life Specialist (CCLS). The course, or courses, must include six identified content areas (Child Life Council 2011). (See Table 1 for a thorough, descriptive listing of required course content.) This change in requirements demonstrates the Child Life Certifying Committee’s desire to enhance the preparation of child life professionals with knowledge of the core competencies of child life practice. By having a CCLS teaching the course, or courses, students will have the opportunity to learn about a specialized career from someone who has demonstrated expertise in this area. In this article, readers will be challenged to think about the concepts surrounding qualifications for teaching in a university setting as they relate to the skills utilized in clinical practice as a Certified Child Life Specialist. Emphasis will be placed on the value of collaboration between veteran child life academic professionals and those who are just beginning to explore the role of teaching. The questions of “What makes one, as a clinical child life specialist, qualified to teach at the university level?” and “How does one prepare to teach topics related to child life practice at the higher education level?” will be addressed. An examination of the overlapping and outlying characteristics between effective clinical skills and classroom teaching abilities as supported by evidenced-based literature will help guide child life specialists in identifying qualities important for success in the university setting. A thorough explanation of the collaborative process between more experienced academic child life educators and child life clinicians new to the academic arena in the process of course development will be included. This collaborative process will describe suggested steps to be taken by the practitioner in the beginning stages of class development for an undergraduate course.

Any CCLS can potentially be approached to teach college-level classes regarding child life practice and theories effective university educators and clinicians a practical examination of specific qualities and considerations for course development

Table 1. Required Content Areas for Course Taught by a Certified Child Life Specialist

1. Child Life Documents – This will provide knowledge and understanding of the Official Documents of the Child Life Council (CLC) including the Code of Ethical Responsibility, Child Life Competencies and Standards of Clinical Practice, the Child Life Mission, Values and Vision Statements, and the Code of Professional Practice.
2. Scope of practice – This will provide an introduction to the spectrum of child life practice in direct and non-direct services in pediatric health care, including a historical review of the profession and its development in the evolution of children’s healthcare.
3. Impact of illness, injury, and health care on patients and families – This will illustrate, within the context of developmental theory, the stressors and developmental and psychosocial treatment issues that affect the health care experience of a child and family, including siblings.
4. Family-Centered Care – This will provide an understanding of the key principles of patient- and family-centered care, including principles of respect and dignity, information sharing, supporting participation in care, and collaboration in relationship to child life practice.
5. Therapeutic play – This will provide students with opportunities to examine elements of play, benefits of play, and various therapeutic play modalities for the clinical setting.
6. Preparation – This will include both historical and current perspectives on the rationale for and techniques and outcomes of preparation, as well as accepted preparation methods for healthcare encounters and life-changing events.

* Adapted from Child Life Certifying Committee Eligibility Requirements available at www.childlife.org continued on page 2
related to child life care. The new eligibility requirement for the certifying exam may prompt the work of many clinical CCLSs to extend into the classroom. As clinical child life specialists, we are expected to provide in-service style education to fellow health team members and to students who are pursuing becoming CCLSs. However, preparing and implementing a university-level course in a face-to-face classroom or an online context is quite different than these situations.

Teaching is not a strength that comes without extensive thought and consideration for the content, structure, and delivery of the courses and involves abilities that not all clinicians possess. Principle 8 of the Child Life Code of Professional Ethics states “Individuals have an obligation to engage only in those areas in which they are qualified and not to represent an obligation to engage only in those areas in which they work” (Child Life Council, 2012). Considering the recent changes in requirements for child life coursework, it is relevant for child life specialists to reflect upon the idea of teaching at the university level, the processes involved with course development and implementation, how or if it will directly impact their practice, and if the required skills to teach at the university level are ones they possess.

The CLC website outlines curriculum recommendations for undergraduate and graduate programs of study (Child Life Council, 2010b). The CLC has also delineated the following recommendations for faculty credentials: 1) a minimum of a master’s degree or post-baccalaureate advanced training in child life, child development, or closely related field; and 2) Child Life Certification (Child Life Council, 2010a). Based on these recommendations, practitioners should continue to reflect not only on their own credentials, but also on their personal strengths and abilities that may or may not make them an ideal candidate to teach in the university classroom.

The characteristics of effective educators in clinical settings and in the classroom are reading and considering these concepts” (Yair, 2008). Effective educators tend to demonstrate communications that have clarity and immediacy (Ginsberg, 2007; Hativa, Barak, & Simhi, 2001; Sherman, Armistead, Barksdale, & Reif, 1987). Clarity, in this sense, refers to an instructor’s ability to stimulate students to absorb course content in a meaningful way (Ginsberg, 2007). Immediacy refers to an instructor’s ability to communicate mental and physical closeness (Ginsberg, 2007). This means that an instructor might say things like “as we are reading and considering these concepts” instead of “as you are reading and considering these concepts.” This style of communication creates closeness within the group and lets students know that the instructor genuinely cares about them and the topic (Ginsberg, 2007; Hativa et al., 2001). Other qualities of effective communication between instructors and students include authenticity, expressiveness, enthusiasm, and a general sense of caring (Gentry, Steenbergen-Hu, & Choi, 2011; Ginsberg, 2007; Turner, Palazzi, & Ward, 2008; Yair, 2008). Educators who continually solicit feedback about their teaching practices and are reflective about their own teaching practices also tend to positively affect the engagement of students (Hativa et al., 2001; Sherman et al., 1987; Turner et al., 2008).

Certain personal qualities of effective educators can positively impact learning and motivation of students. When instructors give attention to certain practicalities like beginning and ending class on time and coming to class well prepared, they communicate respect for the students and a passion for

About the Views Expressed in Focus

It is the expressed intention of Focus to provide a venue for professional sharing on clinical issues, programs, and interventions. The views presented in any article are those of the author. All submissions are reviewed for content, relevance, and accuracy prior to publication.

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characteristic in an educator’s effectiveness. Research involving qualitative practices and student report indicate that an instructor’s ability to build relationships with students is beneficial to learning (Gentry, Steenbergen-Hu, & Choi, 2011; Ginsberg, 2007; Yair, 2008). Furthermore, when instructors have a humanistic view of students and provide support throughout the learning process, their communication of concepts is more effective (Gentry et al., 2011; Ginsberg, 2007). An educator’s ability to adapt teaching styles and presentation of material to learners’ needs is also noted for being a contributing factor to effective learning and increased motivation (Hativa, Barak, & Simhi, 2001; Yair, 2008). Being creative and providing information in useful ways is listed as a characteristic of “outstanding” educators (Yair, 2008).

Building relationships with students requires communication. Effective educators tend to demonstrate communications that have clarity and immediacy (Ginsberg, 2007; Hativa, Barak, & Simhi, 2001; Sherman, Armistead, Barksdale, & Reif, 1987). Clarity, in this sense, refers to an instructor’s ability to stimulate students to absorb course content in a meaningful way (Ginsberg, 2007). Immediacy refers to an instructor’s ability to communicate mental and physical closeness (Ginsberg, 2007). This means that an instructor might say things like “as we are reading and considering these concepts” instead of “as you are reading and considering these concepts.” This style of communication creates closeness within the group and lets students know that the instructor genuinely cares about them and the topic (Ginsberg, 2007; Hativa et al., 2001). Other qualities of effective communication between instructors and students include authenticity, expressiveness, enthusiasm, and a general sense of caring (Gentry, Steenbergen-Hu, & Choi, 2011; Ginsberg, 2007; Turner, Palazzi, & Ward, 2008; Yair, 2008). Educators who continually solicit feedback about their teaching practices and are reflective about their own teaching practices also tend to positively affect the engagement of students (Hativa et al., 2001; Sherman et al., 1987; Turner et al., 2008).

Certain personal qualities of effective educators can positively impact learning and motivation of students. When instructors give attention to certain practicalities like beginning and ending class on time and coming to class well prepared, they communicate respect for the students and a passion for
the topic and education in general (Gentry, Steenbergen-Hu, & Choi, 2011; Ginsberg, 2007; Hativa, Barak, & Simhi, 2001; Turner, Palazzi, & Ward, 2008; Yair, 2008). Also, educators who are organized in their delivery of information, and, as mentioned previously, adapt their delivery of information to the needs of the learners are identified by students as exemplary and effective (Gentry et al., 2011; Ginsberg, 2007; Hativa et al., 2001; Turner et al., 2008; Yair, 2008).

Lastly, knowledge of the topic by an instructor is also a characteristic of effective teaching in higher education. However, knowledge alone does not seem to be an indicator of effectiveness. Combined with the characteristics presented above, a thorough knowledge of the topic supports an instructor in instilling motivation and understanding in students (Gentry, Steenbergen-Hu, & Choi, 2011; Hativa, Barak, & Simhi, 2001; Nicholls, 2005; Sherman, et al., 1987; Turner, Palazzi, & Ward, 2008; Yair, 2008). Educators who are themselves continuous learners and demonstrate the ability to admit their gaps in knowledge are more effective in their educational efforts (Gentry et al., 2011; Hativa et al., 2001; Yair, 2008). Educators who have high expectations of students’ abilities to learn the topic, coupled with the supportive, humanistic view of students mentioned earlier are more effective in their teaching practice as well (Gentry et al., 2011; Turner et al., 2008; Yair, 2008).

**Characteristics of Effective Clinicians**

A wide variety of factors can impact the effectiveness of clinical child life care, including individual characteristics of the CCLS. Researchers have examined the professional education and training, along with the personality features, that lead to successful clinical interactions. Although no evidence-based research exists related to CCLS characteristics that lead to the most effective outcomes in child life care, there is an increasing body of outcome literature related to counselors and psychotherapists on this topic. Exploration of the literature related to music therapy, art therapy, and recreation therapy yielded results similar to that found regarding the child life profession. Theoretical and descriptive articles exist in the literature reflecting philosophical grounding of the various professions related to values, principles, and best practice (e.g., Desai, 2008; Harris & Landreth, 2001; Moncrief, 2007), but there is no outcome research related to individual clinician factors and effectiveness of care. Hence, the summary of research reported here reflects information from the literature related to counselors, play therapists, and psychotherapists.

Carl Rogers was one of the first psychotherapists to conduct outcome research regarding the characteristics of effective clinicians. In 1961 Rogers found that therapists who were most helpful in facilitating change with their clients were those who helped clients feel understood, supported clients in feeling a sense of freedom to make choices, and established and maintained a trusting relationship with clients. Conversely, therapists who were perceived by clients as ineffective exhibited emotional distance from clients, a lack of interest, or too much sympathy. In a second study, Rogers explored the establishment and maintenance of the trusting relationship. Results indicated that therapists who were effective in maintaining relationships with clients shared three main elements: sensitivity to client’s attitudes, understanding of client’s feelings and perceptions, and ability to demonstrate warmth without becoming overly involved emotionally.

Following Rogers’ lead, numerous researchers further explored the question “What makes an effective clinician in regard to clinician characteristics?” Briefly summarizing the research between the 1960s and 1990s, clinicians who were either rated as effective by clients or who had effective outcomes were consistently found to be intuitive, accepting of and/or patient with clients and their processes, relationship-focused, empathic, attentive to clients’ needs, alert, and open (Janowsky, 1999; Jansen, Robb, & Bonk, 1972; Nelson & Stake, 1994; Ricks, 1974; Wicas & Mahan, 1966). Conversely, clinicians rated as non-effective by clients, or those who had less effective outcomes were observed to be less relational, more directive with clients, more anxious, more emotionally reactive to clients, and more controlling, rigid, and dogmatic (Ricks, 1974; Wicas & Mahan, 1966). Jansen, Robb, and Bonk (1972) also found that practice counseling students who were less successful than their peers were significantly less optimistic, less emotionally stable, more hypersensitive, less objective, less accepting of human frailties, more anxious, and less cheerful.

In more recent literature, the American Psychological Association (APA) Task Force on Evidence-Based Practice in Psychology provided a report in 2005 summarizing research to date regarding clinician characteristics (Lavant, 2005). The findings of this task force showed the process of effective clinicians to include: assessment, systematic case formulation and care planning, clinical decision making, intervention implementation, and monitoring of patient progress. In regard to clinical characteristics, the task force reported that effective clinicians demonstrated appropriate evaluation of care, use of research evidence in practice, an understanding of the influence of individual and cultural differences on care, appropriate use of available resources, a cogent rationale for clinical strategies, and continual self-reflection and acquisition of skills.

A 2011 report by the APA Task Force on Evidence-Based Therapy Relationships concluded that there was evidence in the literature regarding practitioner qualities that affect positive outcomes. These included empathy, consensus with client in regard to goals, positive regard for client, sensitivity to client feedback, formation of alliance with client(s), and collaboration with others (Norcross, 2011). Fitzgerald, Hendriksen, and Garza (2012) explored the perceptions of counselors regarding the effectiveness of their interventions with traumatized children. In a qualitative, multi-measure study, the authors found several common themes related to counselors’ self-assessments of effectiveness. These themes were: building a relationship (defined as having a positive therapeutic relationship with client), providing individualized treatment, and practicing integrative interventions.

In a two-session psychological intervention for siblings of pediatric cancer patients, effective results were found for psychologists using a developmentally-appropriate approach that was tailored to individual needs and addressed siblings’ personal concerns regarding their brother/sister’s illness (Prachal, Graf, Bergstraesser, & Landolt, 2012). Additional research in the health care environment further supports the value of the individualized approach. The National Health & Medical Research Centre (2003) focused on a variety of health team members beyond the psychosocial team, and reported survey data reflecting patient preference for professionals
who provide information in a sensitive and reassuring way and who interact with patients as individuals.

Review of the play therapy literature indicates that there are personal characteristics such as patience, flexibility, and enjoyment of children that all clinicians need to effectively work with children (Nash & Schaefer, 2011). In regard to the qualities of an effective play therapist, Nalavany, Ryan, Gomory, and Lacasse (2005) found that experienced play therapists rated the personal characteristics of empathy, warmth, and genuineness as the most essential. These same play therapists also considered theoretical knowledge and technical skill to be less important and easier to acquire.

**Comparison of Characteristics**

Comparison of the characteristics specific to effective educators and clinicians reflect quite a few common qualities for use in both the classroom and clinical practice. The manner in which instructors approach their students mirrors the way clinicians approach their patients in many ways, and certainly impacts effectiveness. In Figure 1, the overlapping characteristics are apparent. Both clinicians and educators are more effective when demonstrating respect for patients and students. Similar to respect, effective clinicians and educators are both sensitive and responsive to the needs and feedback of their patients and students. When patients and students are treated as individuals and clinicians and educators seek to build individual relationships, effectiveness is also increased. Finally, professionals who are themselves continually learning and reflecting upon their practice are more effective as well. This is the case for both clinicians and educators.

Although the overlap in the qualities of effective educators and clinicians is considerable, these qualities will need adaptation to the new environment and process. Adjustment to a new environment is positively impacted when collaboration and mentoring occurs between child life professionals new to the classroom setting and those who are more experienced in the academic realm.

**A Collaborative Process**

The child life profession encompasses various experience levels and areas of expertise. In regard to the development of child life courses, collaboration between those currently teaching at the university level and those who have only recently entered the academic realm (or are considering taking this step) can yield a synergistic result that would not occur without such collaboration.

Clinicians who lack classroom experience can gain much from seasoned university faculty regarding presentation methods, curriculum content, prerequisites for child life courses, syllabus creation, and planning of the specifics of a course (e.g., textbooks, assignments and evaluation methods). The reverse is also true: current child life educators can gain insight from clinicians regarding the most pertinent issues occurring on the “front lines” for child life specialists as well as updates on clinical skills and resources. Detailed coverage of all of these topics is not within the scope of this article; however, child life specialists are encouraged to reach out to more seasoned university faculty for guidance in teaching strategy and techniques.

**A Model for a Collaborative Process**

A model for a collaborative process for university course development is shown in Figure 2. To begin the discussion of a collaborative process for university course development start on the left side of Figure 2 at “The call to teach.” The first step for a child life professional in considering a role in higher education is simply the “call” to teach, which may come in different forms. Universities, becoming aware of the need for courses relevant to child life practice, may contact someone they perceive to be qualified to teach this course or these courses. In other instances, a child life professional might contact a university to explain the need for additional course offerings. In either situation, a clinician will make a decision to either take on this new professional role or decline. The decision-making process can be informed and supported by consultation with more experienced academic child life professionals.

At this beginning stage, child life clinicians should ask themselves “What qualifies me to teach this course (or these courses)?” CLC recommendations for qualifications have previously been reviewed in this article. The university may also have requirements for faculty members. Clinicians will need to explore these requirements with the university to be certain all requirements are met prior to initiating course development.

**Details of early course development.**

The next few steps illustrated in the flow chart may occur in a different order than depicted, or these steps may occur concurrently. This is a fluid process with much interaction between the child life specialist and the university as clarifications are communicated. The child life specialist should ask for details about the university’s expectations:

- How many credit hours does the proposed course/courses provide students?
- Is the time provided for the course(s) adequate to cover the material?
how to prepare for these duties.

Creating a syllabus. If the child life specialist determines that moving to the classroom setting is advantageous, course development and planning may begin. One of the first items that may seem pressing is writing the syllabus. A syllabus, by definition, is an outline of a course of study (Merriam-Webster, 1999). Students tend to view a syllabus as a guide to what to expect during the class semester or quarter. For this reason, care should be taken to write a syllabus that is thorough, informative, clear, and realistic in regard to the time each topic requires. Many times the university will be able to provide a syllabus template to clarify expectations regarding the content of a syllabus.

Writing a syllabus sometimes seems like a large task that is simply a requirement of the university. From another perspective, a syllabus can also be an opportunity for an instructor to proactively lay out a realistic plan for coverage of material in a finite timeframe. The instructor should ask himself or herself “Can a particular amount of material be explored in a specific amount of time?” “Will the pace of the class be too fast or too slow for the students?” “Should specific material be taught in one class or in multiple classes for thorough understanding?” This type of reflection may aid the instructor in making recommendations to the university about how the material should be taught. Again, consulting with more experienced academicians can increase the depth of this professional reflection. In fact, when making recommendations it can strengthen a statement to be able to base it on the experience of both oneself and others. For example, if an instructor advocates for a course to be a three credit hour course instead of a two credit hour course, it can strengthen the instructor’s message if she is able to draw from supportive experience of professors who have many years teaching similar topics in the university setting.

Development of course content. In developing the course content, attention also needs to be given to the knowledge level of the learners who will enroll in the class. Questions to ask are outlined below.

- Are there any prerequisites to the course(s) that would allow an instructor to assume a certain level and type of knowledge for incoming students? For example, if students have already completed some child development classes, an instructor teaching about child life practice would not have to spend as much time on basic development information and could delve into concepts of child life more quickly.

- Do all of the students have a common academic background? For example, will the course(s) that you are developing draw only from child and family development students or also from students with academic backgrounds in psychology, sociology, medicine, etc.? 

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Continued on Focus page 6
continued from Focus page 5

- What year in school are the students you will be teaching? Only upper division undergraduate students, a wide variation, both undergraduate and graduate students?

Significant variation in these factors can offer both pros and cons for an instructor: On the one hand, when discussing issues in class, having a combination of students from a variety of academic backgrounds and different years in school (e.g., a range of students from sophomore to graduate level) can lead to very lively and interesting discussions. On the other hand, this mixture of students can be frustrating when trying to meet the needs of such a wide variation of interests, needs, and previous academic preparation for child life courses.

Knowing students’ level of knowledge will inform the way in which an instructor introduces the course material. Introducing material in an organized, logical manner will help students understand and absorb concepts. For instance, students will need to explore the basic elements of psychological preparation before learning how to put together a preparation book or kit. New instructors can also gain insight into the introduction of new material by consulting with more experienced academic child life professionals. Sharing ideas and having conversations about course structure can prevent new instructors from making choices that may hinder their students’ learning. For instance, suppose a new instructor had planned to discuss assessment of children’s needs in a hospital setting, but many of the students did not have a thorough understanding of basic child development theory. The instructor might continue the discussion and wonder why many of the students were struggling to grasp the concepts or participate in discussions. The guidance of a more experienced child life academic professional could help this new instructor to consider the prerequisite knowledge of the students before moving ahead into more advanced concepts.

Finally, if after all of this examination, planning, and reflection, the instructor and the university decide to move forward with registering students for the course(s), there is more planning to be done. The instructor must now get very specific in preparing for each class meeting. By using the learning objectives of the course, the instructor can stay focused on the scope of the class. It helps to constantly revisit the learning objectives to ensure students are exposed to the material they were expecting.

Staying organized and planning ahead aid in a more focused, well-received course (Jahangiri & Mucciolo, 2012). For instance, it is important for an instructor to be knowledgeable and well prepared to teach a class on a certain topic. This is supported by literature (Turner, Palazzi, & Ward, 2008) that was discussed in the section about characteristics of effective educators and clinicians. Some instructors find it helpful to use lesson plans to organize the coverage of material, while others prepare to involve their students in focus group activities during some class periods. It takes a different type of preparation for different forms of in-class presentation of topics, but all need preparation ahead of time.

**Conclusion**

Translating child life specialists’ clinical skills into university classrooms can be a challenge. Based on the new course requirement for certification, many child life practitioners are being asked to step into this setting. Clinicians should not automatically agree to teach without first asking informed questions about the university’s expectations for both the course and the professional. Also, child life practitioners should educate themselves about the specifics of the new CLC academic requirements and any additional changes to the academic preparation of child life specialists. Forming relationships between child life academics working in university settings and those in clinical contexts will increase the consistency of information being shared among professionals and those seeking to become certified. Child life specialists considering entering the classroom should also take time to reflect upon the characteristics, both overlapping and diverging, of effective clinicians and educators to determine their personal readiness for teaching at the university level. By being more informed, all child life professionals will be able to more accurately address the need for quality education of child life specialists.

**References**


A major goal of higher education today is to foster students’ critical thinking skills, whether in the classroom or the clinical setting. The development of critical thinking skills is crucial to prepare child life students for autonomy and a higher level of decision making, essential for success in the complex health care environment. According to Behar-Horenstein & Niu (2011), “Critical thinking requires the application of assumptions, knowledge, competence and the ability to challenge one’s own thinking” (p.26). This article will explore three different teaching methods: evidence-based learning, problem-based learning, and active learning, and examine how the application of each in the child life field aids the learner in developing critical thinking skills. When implemented effectively, these methods stimulate child life students to become lifelong learners.

**ADULT LEARNERS**

Students in child life are adults; thus their success in learning occurs when the teacher has an effective understanding of adult learning concepts. The influential work of Malcolm Knowles (1990) is summarized here to include the following adult learning principles: need to know (purposive behavior), the learner’s self-concept (self-direction), the learner’s experience (what they bring to learning), a readiness to learn (developmental appropriateness), an orientation to learning (task-centered or problem-based learning), and motivation. Knowles’ concepts are described in more detail in Table 1, adapted from the Child Life Council Internship Supervisor’s Manual (2012).

**EVIDENCE-BASED LEARNING**

Our colleagues in both medicine and social work have explored various techniques for effective evidence-based teaching (Davies, 2000; Gillam & Gillam, 2008; Hart & Harden, 2000; Howard, Allen-Meares, & Ruffolo, 2007; Tuchman & Lalane, 2011). According to Sackett, Straus, Richardson, Rosenberg, and Haynes, evidence-based

**Table 1. Summary of Knowles’ Adult Learning Concepts**

Since the work of Malcolm Knowles in the early 1970’s, tremendous growth has occurred in the amount of information available on adult learning, much of which still refers to his original six characteristics of adult learners.

- **Need to know:** Adults learn best when convinced of the need for learning and tend to be goal-oriented and value understanding of what learning will occur (learning objectives) and how learning will be conducted (learning methods).
- **Self-concept:** The self-concept of adults is important to their learning process, particularly as it relates to their sense of self-direction and autonomy. By engaging adults in a collaborative process of assessing their specific learning needs and developing action plans for moving forward, adult learners ultimately take increasing ownership of the goals and direction of their learning.
- **Prior experience:** Adult learners’ prior experience informs the perspectives with which they approach each new learning experience. Their perspectives can serve as a resource for learning, shaping new learning by enhancing insight and understanding, as well as having the potential to inhibit new learning. Adult learning is enhanced when prior experience is acknowledged, articulated, and valued.
- **Readiness to learn:** For adults, the relevance of learning objectives to current situations promotes their inclination for learning. Connect and highlight the usefulness of content to real practice situations for adult learners.
- **Orientation to learning:** Adult learners have a very practical approach to learning, with a more problem-solving orientation rather than subject-centered. Presenting content in real-life contexts benefits adult learners.
- **Motivation to learn:** Adult learners tend to be more motivated by internal rewards (e.g., increased confidence, self-esteem). Because adult learning involves the learner’s ego, respect in the relationship between learner and teacher is very important; the learning environment must be felt by the learner to be safe and supportive to reduce the fear of judgment during the learning process.


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practice (EBP) is defined as “clinical decisions that are based on the careful and reasonable integration of knowledge obtained from external evidence (published research) and internal evidence (clinical evidence and patient needs)” (2000, as cited in Gillam & Gillam, p. 212). The Child Life Council Evidence-Based Practice Position Statement (Child Life Council, 2010) cites Sackett, Rosenberg, Muir Gray, Haynes, and Richardson when defining EBP as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients” (1996, p. 71).

The fundamental training of child life professionals affords many opportunities to incorporate the elements of EBP beginning in the academic setting. Classroom assignments such as diagnosis presentations draw students into the clinical literature when conducting research to strengthen their assignment. The present day access to information from the most up-to-date sources available (published research) challenges students to streamline plethora of data into understandable and meaningful concepts. Likewise, in the clinical setting, a child life intern presenting a case study needs to support exploration of a particular child and family’s experience with discoveries gleaned from both current literature and the clinical expertise of the intern’s supervisor and colleagues (clinical evidence).

Many internship programs require students to complete a project. Conducting a needs assessment and a literature review to support the essence of the project is yet another way to incorporate evidence-based learning into child life education. Likewise, many of the assignments required of interns in the Child Life Clinical Internship Curriculum (Child Life Council, 2011) lend themselves to inclusion of evidence-based learning. The modules on assessment, play, medical/health care play, and psychological preparation, for example, can be linked directly to the CLC Evidence-Based Practice Statements (http://www.childlife.org/Resource%20Library/EBPStatements.cfm). Additional evidence-based practice modules that would be helpful for child life learners can be found on the CLC website at http://www.childlife.org/Resource%20Library/EBPModules.cfm.

**Problem-Based Learning**

Problem-based learning (PBL) is a strategy in which students work together to solve complex problems using theory, foundational knowledge, and verbal and written communication. Realistic case studies mimic actual situations during which students are able to apply acquired knowledge. Instructors facilitate this skill set development by “modeling strategies of progressive inquiry and problem solving” (Tuchman & Lalane, 2011, p. 331). Students identify aspects relevant to the case, drawing on their current knowledge. They then raise questions, research answers, and engage in discussion. As adult learners, students using PBL are moving from dependency to self-directedness, learning best when they solve problems, and synthesizing their knowledge when given an immediate opportunity to apply it (Gillam & Gillam, 2008). In the medical model of PBL, where PBL first originated in the 1950s and 60s, an accurate diagnosis and treatment plan is identified. Instructors present less information to students in the PBL model and engage as a catalyst for student-generated exploration. Instructors/clinicians encourage student participation by assessing discussion, asking questions about their process, and suggesting new aspects to consider (Mayo, Donnelly & Schwartz, 1995).

For example, in the academic setting, an early introduction to PBL can occur when pairs of students are assigned a case study and are challenged to use theoretical support when identifying, planning, and evaluating potential child life interventions for the patient and family. This case study process could also be used on an exam to test a single student’s application of PBL. Additionally, this case study method of PBL is helpful in the clinical setting when introducing an intern to a type of case not otherwise experienced directly, such as a bereavement or end-of-life situation.

The rich case studies described in *Making Ethical Decisions in Child Life Practice* (Child Life Council, 2000), for example, lend themselves to stimulating discussion among child life learners, whether in the academic or clinical setting. After introducing the principles of professional ethics, including the concepts of beneficence, respect for persons, justice, veracity, and the like, the facilitator’s questions can lead students down a path of discovery and problem solving when using these essential principles. Students applying these principles to the cases described in the book will process together over what is “right” or “most ethical” in a specific situation. The complexity of the cases cited stimulates examination from a variety of perspectives and results in the continued development of critical thinking skills. Consider the following case, adapted from *Making Ethical Decisions in Child Life Practice*.

Per the protocol, a urology nurse refers a patient to you for preoperative preparation. The child, a 9-year-old girl with chronic reflux, is in clinic with her mother for the pre-op appointment; surgery is scheduled for two days from now. You gather your teaching kit and head to clinic, knowing you have only 30 minutes before you are to meet with a new volunteer. In clinic, the urology nurse has just finished giving the mother some instructions and nods for you to go in to see the family. As you pass the nurse, she remarks, “Thanks for coming. She had a hard time with today’s exam.” You introduce yourself to the patient and mother and explain the purpose of your visit. The child appears curious about the teaching materials you’ve brought. But, before you can proceed, the mother says she does not really want your services for her daughter. She offers no explanation, but politely dismisses you with a smile and “thank you very much anyway.” She gathers their paperwork and belongings to leave.

The case above, when used in either the academic or clinical setting, is an excellent example of a clinical situation that a child life specialist might regularly experience. Discussion surrounding this case uses PBL to explore setting priorities, developing skills for interviewing families, evaluating aspects of response from both the child and mother, and applying ethical principles.

**Active Learning**

The concept of active learning, which is a combination of listening to a lecture, writing a response to a proposed situation, and applying learned information to simulated scenarios, involves important learning strategies such as discussion, critical thinking, class presentations, and group work such as role-playing (Paulson & Faust, 1998). The American Association for Higher Learning Task Force on Best Practices in
Higher Education published an article in 1987 focusing on active learning, including a review of the literature on academic teaching and how students learn (Chickering & Gamson, 1987). Seven principles for good practice in undergraduate education were noted here, with two focusing on student participation—promoting active learning (ways students learn outside of a traditional lecture) and teamwork by students. The benefit of students working together expands and enhances their knowledge through sharing thoughts and reacting to others’ ideas. A study by Astin (1993) looking at student outcomes found that interactions with peers and with faculty substantially aided in individual growth, scholastic success, and personal fulfillment. The transmission of learning is not a result of a unidirectional approach on the part of the teacher teaching, but from students participating in their learning through listening, reading, discussing, and critically thinking, using the skills of application, analysis, synthesis, and evaluation (Chickering & Gamson, 1987).

Active learning promotes self-awareness and the ability to apply knowledge to “real life” situations. Active learning engages students in higher-order critical thinking skills and dialogue promotes greater understanding of content and communication skills, whereas lecture promotes memorization through the recollection of data. (De Caprariis, Barman, & Magee, 2001). The role of teacher as facilitator in the modern classroom has taken the place of the former role as supplier of information. Lectures that promote discussion, critical thinking, and group activities help to develop independent thinking skills. Revel and Wainwright (2009) inferred that faculty and students found that a successful class experience consisted of student involvement, a process by which students could distinguish important aspects and apply information to course material, and the ability of the instructor to make the topic realistic. Activities should be interesting and increase a student’s understanding by asking for student comments during lecture, promoting group discussion, role-playing, and writing personal reflections (Angelo & Cross, 1993; Carbone, 1998; Frederick, 1987; McKeachie, 2002). Students retain information at a higher rate when they earnestly participate in an activity that reinforces a concept (Jenkins & Pepper, 1988). Short lecture combined with application-based activity is an effective way for students to understand information.

Six years ago, a lab section was added to two child life courses at The University of Akron. In the lab, participating students apply what they have learned during the lecture component of a particular topic and receive a demonstration of how a child life specialist could communicate effectively with a child, family members, or staff during interactions. Nine competencies were developed, with three extrapolated from the evidence-based practice statements of the Child Life Council on assessment, psychological preparation, and therapeutic play (Child Life Council Evidence-Based Practice Statement, 2007; 2008a; 2008b). Additional competencies were created based on suggestions from the university’s child life advisory board members, representing common situations child life specialists encounter. Examples are: introduction and assessment; therapeutic play; medical play; preparation for IV start; preparation for surgery and/or medical procedure; educating medical/nursing students/staff/community/volunteers about children’s development; advocating for a child/parent; angry or upset child/parent; and bereaved sibling/parent. Incorporated into all competencies were the tenets of knowledge and skill taken from child life competencies, found in The Official Documents of the Child Life Council (Child Life Council, 2002). The instructor initially reviews each competency with the

**Figure 1. Sample Competency**

<table>
<thead>
<tr>
<th>CHILD LIFE COMPETENCY</th>
<th>Foundation Knowledge and Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV Preparation</td>
<td>Knowledge and skills gained through classes, assessments, and experiences. Instructor or CCLS will date and sign when competency achieved.</td>
</tr>
<tr>
<td>Assessment and Meaningfully Interact With Child and Family</td>
<td>Purpose of visit</td>
</tr>
<tr>
<td>Child</td>
<td>Age (6,8-12,12-18); gender (male, female); developmental level (Erikson, Piaget); acute vs. chronic (12-18); diagnosis (7-12); and baseline behavior (12-18).</td>
</tr>
<tr>
<td>Coping</td>
<td>Avoidant vs. vigilant (6, 12, 18).</td>
</tr>
<tr>
<td>Previous healthcare experiences (procedures and previous hospitalizations)</td>
<td>(6, 12, 18).</td>
</tr>
<tr>
<td>Temperament - responsiveness, adaptability, mood, distractability, predictability (6, 12).</td>
<td></td>
</tr>
<tr>
<td>Anxiety - (tendency to be anxious) (6, 12, 18), state (anxiety as result of specific experiences) (6, 12, 18).</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>Comprehension (6, 12, 18).</td>
</tr>
<tr>
<td>Anxiety (especially maternal anxiety) - (tendency to be anxious), state (anxiety as result of specific experiences) (6, 12, 18).</td>
<td></td>
</tr>
<tr>
<td>Parental presence and involvement (6, 12, 18).</td>
<td></td>
</tr>
<tr>
<td>Preparation for Medical Procedures</td>
<td>Provide clear, developmentally appropriate, accurate information – what and why procedure will happen, sequence of events, sensory explanation, demonstration materials (6, 12, 18).</td>
</tr>
<tr>
<td>Self Evaluate</td>
<td>Provide coping plus modeling techniques – audio/visual distraction, tactile stimulation, counting, and verbal interaction (6, 12, 18).</td>
</tr>
<tr>
<td>Instruct patient/family on comfort positioning (6, 12, 18).</td>
<td></td>
</tr>
<tr>
<td>Documentation of child/family assessment/response to preparation in medical chart (6, 12, 18).</td>
<td></td>
</tr>
<tr>
<td>Integrate Feedback</td>
<td>Conducted on April 1, 2009.</td>
</tr>
</tbody>
</table>

**Columns with asterisks refer to the competencies identified by the University of Akron’s Child Life Council Evidence-Based Practice Statements (2007, 2008a, 2008b).**

*Based on:*


Students will work in a team of 3 and assume the role of a child, parent or child life specialist. Each student will assume each role. Use a different scenario when you change roles.

First Child Life Class: Basic skills

1. John, 2 year old, admitted for dehydration, needs an IV, no previous hospitalization, mother present, coping well in mother’s presence.
2. Mary, 6 year old, admitted for sepsis, needs IV antibiotics, first hospitalization, father present, fearful of new experiences.
3. Todd, 10 year old, admitted for post-T&A bleeding, needs IV fluids for hydration, outpatient surgery 2 days prior (coped well with surgery), tired and reluctant to drink fluids, mother present.
4. Sarah, 16 year old, admitted for new onset of diabetes, needs IV, first hospitalization, mother present, coping well.

Second Child Life Class: Intermediate skills

1. Peter, 5 month, admitted for RSV, fussy, not taking fluids well, needs an IV, first hospitalization, mother present (worried about her mother who is hospitalized with a heart attack in a local hospital).
2. Jane, 4 year old, seen in ER for flu, needs IV, relocated to the area with family 2 weeks ago, weary of staff, grandmother who watches Jane while parents work is present, received stitches in ER last year.
3. Michael, 8 year old, admitted for MRSA, needs IV, x-ray, pitcher on baseball team with championship game in 2 days, upset about missing game, parents present, first hospitalization.
4. Luanne, 14 year old, admitted for new onset of Crohn’s disease, very anxious, needs IV, x-rays and scans, has been symptomatic for 2 months and resistant to tell parents, honors student, counselor for first time at summer camp in 1 week, mother present.

Third Child Life Class – Advanced skills

1. Marcus, 18 month old, admitted for new diagnosis of cystic fibrosis, irritable, needs IV, mother is a single parent, has one sibling (Darnell) age 4 who was diagnosed with CF 3 years ago.
2. Shaniqau, 5 year old, in pain, seen in ER for fractured left femur following MVA in which mother was injured and taken to nearby hospital, needs an IV for pain medicine, father present and upset about Shaniqau and his wife.
3. Tyler, 9 year old, seen in ER for rule-out meningococcal, has petechia and is lethargic, needs IV and spinal tap, first hospitalization parents present, 4 and 7 year old siblings in waiting area with grandparents.
4. Mari, 17 year old, admitted to PICU for end stage renal disease, history of dialysis, diagnosed at age 8, non-compliant for last 2 years, depressed, parents not present. In previous hospitalizations parents unreliable and when present not supportive.

\[\text{Figure 2. Sample Simulated Case}\]

The course includes two fifty-minute labs per week. During each lab, students practice role-playing the child life specialist’s role with one or two peers who assume the role of a child and/or parent. Discussion among students occurs before and after the simulation. They comment on areas in which their peer performed well and appeared to be effective and offer suggestions for improvement. The student who played the role of the child life specialist also shares insight into her/his skills and what went well and identifies areas for improvement. During the next lab, the students videotape the scenario. Students review their own performance and complete a self-evaluation (Figure 3). The instructor also views the video and responds to the students’ comments, adding additional suggestions for improvement. Periodically, students share their best practice with the class. Twice during the semester, students complete three competencies in a row, with the idea that in actual child life practice, specialists are moving in and out of interactions and varied situations. These mock experiences allow students opportunities for success and for slipups in the safety of the learning environment. As a result, they have increased self-confidence when they enter an actual clinical setting (Yoder & Hochevar, 2005). Research has shown that students retain information better when it is complemented with situations that increase comprehension (Jenkins & Pepper, 1988). Additionally, implementing the competencies promotes cooperation and discussion among students. One student commented that she was quite nervous prior to the lab experience, but felt increased confidence and competence by the end of the semester. She also reported that during her internship, she was able to apply these skills directly. Research on group-oriented activities has shown that such activities encourage self-confidence, leadership, and cooperation (Perkins & Saris, 2001; Yoder & Hochevar, 2005). Competency-based assessment is a tool that may be used with interns or new employees as well.

**Conclusion**

The education of child life students/interns is a culmination of experiences and knowledge gleaned from the academic setting, clinical experiences, and the personal qualities of that student/intern. It is the combination of an astute instructor/clinical supervisor putting information into a context through which learners can understand and apply new concepts to a practical situation, and from the interest and drive of motivated students/interns willing to put time and effort into reading, self-reflection, questioning, problem solving, learning from mistakes, and evaluating their decisions. In *You’re the Game Changer in Next Generation Learning*, Milliron (2012) summarizes, “Understand that some learning takes time and the payoff comes in the future, not right away.”

**References**


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Figure 3. Sample Self-Evaluation

Name ___________________ Date ___________________

Child Life Skills Lab
IV Preparation

Student writes scenario, including age, diagnosis, coping with medical experience, current stressors and family support

Assessment/Coping Issues:

Student completes this section after reviewing the video.

Chart Note:

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<td>1.</td>
<td>2.</td>
<td>3.</td>
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Evaluation:

Prepared/Proficient
Introduction: self, CL role, goals
Assessment: ask questions, observation, plan
Intervention: type, tools used, coping techniques, questions
Therapeutic Relationship: develop and maintain
Allow for Questions

Self-Evaluation:

Strengths ____________________________

Areas for Improvement ____________________________
academic programs. The majority (83.3%) of academic sites reported that they require practicums to be in a hospital setting with 95% of those requiring supervision by a Certified Child Life Specialist (CCLS). Of the academic sites not requiring a hospital-based child life practicum, 20% still require supervision by a CCLS within an alternate setting. Other than hospitals, child life practicum facilities utilized by academic programs included grief or hospice centers, facilities that treat medically complex chronic conditions or medically fragile children, health departments, non-profit agencies, and rehab facilities.

Hour totals. In regards to the number of hours that practicum students must complete, results from both surveys ranged from 50 hours to 580 hours for practicum completion. Currently, there is no CLC recommendation for practicum hour totals; however, 48% of clinical programs and 52% of academic programs require students to complete 100 to 150 clinical hours. Again, it should be noted that the academic survey did not specify whether the required hours were to be completed in a hospital environment. This comparison offers valuable information as the Practicum Task Force moves forward in defining a child life practicum and developing a philosophy of practice.

Practicum student opportunities and involvement. The clinical site survey asked respondents to define the level of involvement of students in specific interventions, ranking student involvement as observing, participating, or leading. The results are presented in Figure 1.

Clinical sites reported requiring students to complete assignments such as journal entries, developmental assessments, and activities at a rate of 97%. Academic sites also reported a variety of assignments for practicums; the top five most common assignments were journaling, shadowing child life specialists, playroom activities, special projects, and bedside activities.

Defining practicum. A common disparity did appear in both surveys in regards to a “definition” or “philosophy” of a child life practicum. Responses from both surveys varied in their interpretation of the practicum experience from being hands-off/observation-only, to being “volunteers,” to being able to manage playrooms without supervisor involvement. Despite these variations, the survey respondents did report common themes in relation to practicum experiences, such as:

· Become familiar with the role of a child life specialist
· Increase comfort in the hospital environment
· Prepare for child life internship
· Opportunity for observation of a child life specialist
· Increase knowledge of therapeutic play
· Develop skills to build rapport with children and families
· Introduce child life services

Next Steps
It is evident from surveying both academic and clinical practicum programs that universally-defined guidelines for the child life practicum experience are needed to establish consistency within the field. Additionally, the Practicum Task Force is analyzing the results of a recent survey sent to child life internship coordinators to examine the relationship between practicum completion and internship acceptance among child life internship applicants. An early finding is that 79% of respondents require internship applicants to have completed a child life practicum or child life-related clinical learning or shadowing experience. The Practicum Task Force is actively reviewing the information gathered through the surveys as well as information gathered by conducting benchmarking of similar professions in an effort to inform the structure of an introduction into the field. As the Practicum Task Force continues with its analysis of current practicum programming, its focus is to create a definition of child life practicum and develop a philosophy of practice for child life practicum experiences. These recommendations will be provided to the CLC Board this fall.

Milestones
Pat Manning, MEd, CCLS recently retired as Director of Child Life and Family Education at University of Chicago Medicine Comer Children’s Hospital. Pat began her career working with children as a teacher, and came to child life and the University of Chicago Hospitals as an intern in 1986. After being hired as the infant/toddler specialist, Pat was selected as Director and has served in that capacity since. We wish Pat a happy retirement.

Jennie Geartz-Ott, MS, CCLS has been appointed as the Director of Child Life and Family Education at University of Chicago Medicine Comer Children’s Hospital, where she has spent her 13-year child life career supporting children and families.
Child Life Alphabet  

continued from page 1

al., 1990), and possibly even earlier. At Children’s Hospital of Pittsburgh of University of Pittsburgh Medical Center (CHP of UPMC), there is a unique program in place for medical residents. All second year residents complete a rotation with the child development unit, and as part of this requirement, they must spend three hours directly shadowing a child life specialist. This is our opportunity to demonstrate our involvement with patients and families and follow up with explanations of why we do what we do. With a shadowing resident, I have had the opportunity to demonstrate medical play, guided imagery, procedural preparation, distraction, One Voice, and comfort positioning, as well as provide information that pertains to the resident’s specific area of interest. I have never had a resident seem indifferent during the experience; in fact, I have received genuine interest and gratitude as many of the residents have recognized that they are furthering their own knowledge of and skills in developmentally appropriate and therapeutic interventions.

It is the professional responsibility of all child life specialists to effectively teach those child life students who are the future of the profession. At CHP of UPMC, up to four interns and four practicum students each semester are provided the opportunity to partake in in-services that address a comprehensive variety of topics (e.g., charting, special needs, sibling support, professional boundaries, death and dying) to enrich their overall foundation and knowledge. Child life students are able to participate not only in case studies and brainstorm possible solutions and interventions, but they also participate in journal club to discuss current and professional literature on various topics related to the field. Additionally, students are given the chance to shadow other child life specialists outside of their chosen rotations/disease populations as well as other multidisciplinary staff (IV team, palliative care, interventional radiology, etc.) to provide the most well-rounded experience possible.

From my professional perspective, hands-on demonstration is the most crucial teaching method, in that while we are teaching children and families in creative ways, we are also teaching the medical staff and students who witness these techniques. We are the child development experts within our settings of practice. We are charged as we maintain the child life competencies set forth by the Child Life Council (2010) to provide education in all of these ways. As a counterpart to teaching, we strive to learn new and creative ways in which to teach children, families, students, and staff. We have the advantage of sharing our ideas and learning from each other through the CLC Forum and the Bulletin. Therefore, we are not only teachers and educators; we are also constant learners.

“He who dares to teach must never cease to learn” (Richard Henry Dann).

References


Personal Perspective  

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allow me to continue fulfilling my developmental needs as an academic instructor. I believe this developmental fulfillment is why my transition from clinician to academician has gone so smoothly.

The reward I value most is students’ gratitude for having an instructor with extensive clinical experience who can share the personal stories of child life work. My biggest success occurred on October 27, 2011, when my university’s Curriculum Committee officially approved my five new child life-specific courses. I remember sitting in this large meeting with representatives from departments across the university thinking, “I’m just a girl who wanted to be a child life specialist,” as they unanimously approved my curriculum. It was a huge compliment to have the university endorse my hard work!

References


NEW Anaphylaxis Adapter Set

Program helps you explain anaphylaxis and show all aspects of severe allergic reactions. Facial adapter illustrates hives, swollen lips and inflammation around eyes and nose. Chest adapter shows extensive hives and oxygen depletion in fingertips. Adapter set may also be used on Radical Randy Medikin to demonstrate airway swelling.

For details call 1-800-238-7951 or visit www.LegacyProductsInc.com
approaches to continuous quality improvement through critical thinking, inquiry, and evaluation. She embodies the determination, drive, and love for learning that makes a child life specialist outstanding. When faced with new or unfamiliar situations, she observes, asks critical questions, conducts research, and engages in formal collegial conversations with other child life professionals to learn, focus, and strengthen her practices. Furthermore, Stephanie commits to over 200 hours a year of public service in developing countries through Operation Smile, to contribute to the lives of others and in the effort to develop a deeper understanding of self and diversity, both cognitively and experientially. Because of her commitment to ongoing evaluation, she is able to turn difficult situations into meaningful interpretations for improving professional practice. Her commitment to life-long learning and reflective practices make her a shining example as one of the brightest and most effective child life specialists within the Child Life Council.

**Stephanie Hopkinson**

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Stephanie demonstrates unparalleled competence and effectiveness in providing exceptional interventions firmly rooted in evidence-based practices and profound care. Undeniably, her approach to intervention has helped forge relationships with families resulting in new hopes, new strengths, and new possibilities. In 2010, Stephanie participated in her first Operation Smile mission in Kisumu, Kenya. Stephanie was able to utilize simple tools, crayons and paper, balls, and a deck of UNO cards to gain trust of patients and families she could not otherwise communicate with. During one incident, two little girls from a remote village had traveled very far, and had probably never been in a city, at a hospital, or in the company of any foreigners, much less in numbers of the mission team. Both were five years old, one the daughter of the woman who had brought them to the screening site and another little girl from the same area whose parents couldn’t, or wouldn’t, make the trip. They were extremely timid, watching everything in wonderment, but never choosing to participate. Slowly, with smiles and gentle gestures, Stephanie brought crayons and paper to where they were sitting away from the rest of the children. Just intuitively knowing that they had never even seen such things, she took time to demonstrate the basics, gently placed a crayon in one girl’s little hand, then wrapped her own hand around the girl’s. For a few moments they drew together, the other girl watching intently. Stephanie then removed her hand, passed some crayons to the second girl, and stepped back. Within minutes, two budding artists were at work, exploring the magic held within those wax sticks, and the potential within themselves. Throughout the process, Stephanie demonstrated compassion, awareness, and contextual support.

**Models child life practice and team behaviors that acknowledge and respect the diversity of patients/families and members of the health care team**

Stephanie respects, values, and considers the opinions, circumstances, feelings, and views of patients/families and her colleagues, in ways that authentically take into account their diverse backgrounds. Stephanie’s compassion and effectiveness can be seen in her ability to quickly recognize an individual’s unspoken needs and then respond accordingly. She understands the power of words and that language drives attitudes and actions. She helps families to understand that their child’s diagnosis is a part of them, but does not have to define the “soul” of them. Her philosophy of practice has helped families, nurses, physicians, and volunteers change the way they “see” patients by putting the child before the diagnosis. She actively describes what the child has versus who the child is. For instance, she has shared with teens, “You have cancer; you are not cancerous,” helping them to understand and articulate the difference in peer situations. This approach goes beyond the premise of being politically correct, but embraces a paradigm of value and respect for patients including how they cope and view their life circumstances.

**Exercises sensitivity to the individual circumstances of patients/families…and embraces and models the core concepts of family-centered care**

Stephanie is a passionate worker and at the heart of her professional practice is family-centered care. When trauma, fear, and worry are commonly at the forefront of a family’s
hospital experience, Stephanie has a gift for creating the calm in the midst of a storm. A striking example of her commitment to the principles and practice of family-centered care involves an 18-month-old named Annabelle, who was diagnosed with histiocytosis and facing end-of-life care. Annabelle's parents were teens and consistently treated like children by the nursing staff because of their age and signs of cognitive immaturity. As Annabelle showed signs of end of life, the nursing staff began to remove the baby from the mom. The mom seemed confused and upset by what was happening. Stephanie gently stepped in and advocated for mom’s wishes. Because of her advocacy, the medical care team was able to respect and honor the mom's request to play music and hold her baby. As the mom said her goodbyes, Stephanie shared with her the next steps and provided vital information to help the parents’ understanding of the hospital's policies and procedures. Moreover, she was able to give the parents the opportunity to be informed and actively involved in the final stages of their child's life.

**Participates in the development and incorporation of evidenced-based practice**

Stephanie is a creative thinker and plans the future with unconventional thoughts and wisdom. She has made significant contributions to the body of child life as a writer, board member, committee chairperson, mentor, panelist, and presenter. She co-authored a chapter of the CLC publication *Child Life Beyond the Hospital* (2008) and delivered the closing keynote address for the CLC 25th Annual Conference and Anniversary Celebration. Each of these experiences has afforded Stephanie the opportunity to strengthen her professional practices, develop her leadership skills, and nurture the wisdom of others.

**Mentors new child life specialists and students in developing child life competencies and supporting the effective transition to professional practice**

One of Stephanie's greatest strengths is her ability to mentor new child life specialists, students, and emerging leaders. She has been inspiring and mentoring students for over a decade. Early in her career, Stephanie realized how precious and unique the child life community was and quickly understood the importance of challenging and fostering thoughtful, well-rounded, and motivated child life specialists. Consequently, she became actively involved in academia, state and national child life conferences, and task forces by assuming positions as faculty, internship coordinator, and committee chairperson. She was responsible for the co-development and implementation of the child life internship program at Children's Hospital Los Angeles. The program she developed was comprehensive and strongly evidence-based, which has led to the effective training of valued, effective, and critical-thinking child life specialists. As a result of the success of the internship program, a similar practicum model was developed for junior and senior students enrolled in child development and educational psychology at California State University Northridge to provide them with experiences in the medical environment.

**Actively participates as a member of the Child Life Council**

Stephanie is a visionary and has provided professional service to the Child Life Council since 2000 through her active participation in the design, development, and delivery of professional development intensives for annual conferences on topics that include leadership, reflective supervision, and systems thinking. Stephanie has gained respect for her professional opinions, leadership, and expertise by those who have worked with her on committees leading to her election as a Member-at-Large on the CLC Executive Board (2006-08) and appointments as chair of the Education Committee, a leader within the Child Life Certification Committee, and her current role as co-chair of the Public Policy Task Force.

The Child Life Council congratulates Stephanie on her selection as the recipient of the 2013 Mary Barkey Clinical Excellence Award! If you are interested in submitting the name of a colleague for the 2013 award, the call for nominations was recently issued online, and initial nominations will be accepted through August 2, 2013. Complete nomination packets with supporting materials are due September 5, 2013.

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**Giving it Your All**

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- Monitoring and recommending approaches to the increasing global interest in child life
- Researching and upgrading the office’s Association Management System (AMS) and—coming in 2014—updates to the website.

It also takes a dedicated group of board members to move a strategic plan forward, and what a privilege it has been to serve with the current CLC Board of Directors. As with any team, it takes time to form, storm, norm, and perform, but I can honestly say this is one of the highest functioning teams I have been on. The giving of time, experience, perspective, and energy is something I admire in every one of the board members.

To summarize what has been the most rewarding part of being CLC President this past year, I would have to say it is being surrounded by people who give it their all, and who do so tirelessly, selflessly, and seemingly effortlessly.

Which leaves me with the other half of the question, what has been the most challenging part of being CLC President? In taking on this type of leadership position, I did not fully anticipate the time commitment required, the types of inquiries or issues that would come up, the preparation needed for board meetings or conference calls, and the myriad of “other related duties.”

Do the rewards outweigh the challenges? Without question! I could never have anticipated the lasting friendships I would form, the deeper commitment to my profession I would develop, the even greater admiration of the volunteer members, board, and staff I would take away – and how much personal and professional growth I would experience.

As my year comes to an end, I have the greatest confidence in welcoming Amy Bullock Morse into her role as President of the Child Life Council. I have worked closely with Amy on the Leadership Development Committee and in this past year, in her capacity as President-Elect. As President, there is no doubt that Amy will also give it her all as she continues to move the association forward.
CLC Calendar

JULY
1   Deadline to submit articles for consideration for Fall 2013 issue of Bulletin and Focus
31  Call for Abstracts deadline for 2014 Annual Conference

AUGUST
15-30 Child Life Professional Certification Exam Administration Testing Window
14  CLC Webinar - Critical Conversations: Discussing End of Life with Children and Families
21  CLC Webinar - Play and Wellness: Two Mutually Complementary or Exclusive Concepts

SEPTEMBER
18  CLC Webinar - Managing Communication and Conflict
20  Deadline for applications for the November 2013 computer-based Certification Exam Administration

OCTOBER
1   Deadline to submit articles for consideration for Winter 2014 issue of Bulletin and Focus
15  Deadline to withdraw from November Administration of the Child Life Professional Certification Exam
23  CLC Webinar - Effectively using Pain Management and Palliative Care in Children’s Cancer Treatment
31  Late Deadline to recertify with Professional Development Hours (late fee and additional paperwork required)

NOVEMBER
1-15 Child Life Professional Certification Exam Administration Testing Window

Upcoming Events
October 26, 2013
8th Annual Great Lakes Association of Child Life Professionals Regional Conference
Cleveland Clinic, Cleveland, OH
Contact: Channel Pack, cpack@dmc.org or 616-293-9768