CHILD LIFE COUNCIL
Bulletin

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Reflections from the CLC International Scholarship Recipients

Jaime Bruce Holliman, MA, CCLS

International scholarship recipients Nana Chavchanidze and Khatuna Dolidze of Georgia compare notes between sessions.

The Child Life Council remains committed to supporting our colleagues who practice abroad. At the 31st Annual Conference on Professional Issues in Denver, Colorado, this past May, nine professionals involved in the care and support of hospitalized and medically challenged children around the globe were awarded conference scholarships supported by the Advancing the Field of Play for Hospitalized Children Initiative.

Recipients of this award included Blondi Kwok of Hong Kong, who is a manager for the Hospital Play Service at Playwright Children's Play Association, and Joanne Cross of the United Kingdom, who is a Hospital Play Specialist at Plymouth Hospitals NHS Trust. Lubna Mohammad Aamir, a child life specialist practicing in Kuwait, and Lorraine Pratt, a Research Hospital Play Specialist in the United Kingdom, also received scholarship support. Charlotte Rosline Soans of India, as well as Nana Chavchanidze and Khatuna Dolidze of Georgia represented their countries and institutions as award recipients. Dr. Lucia Celesti of Italy, a practicing pediatrician, accepted her award with the hope that she will be able to introduce child life as a formally recognized profession in her home country. Jane Kamau of Kenya, a child life health worker at Sally Test Paediatric Centre at Moi Teaching Referral

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INSIDE

Child Life Alphabet

U IS FOR UTILIZATION OF CHILD LIFE SKILLS IN SUPPORTING FAMILIES OF ORGAN, TISSUE, AND EYE DONORS

Kim McClain, MS, CCLS, CEIM
Indiana Organ Procurement Organization

In the United States, there are nearly 120,000 individuals awaiting lifesaving transplants. Every day, 10 people are added to the transplant waiting list, with 18 individuals dying each day while waiting (Donate Life America, 2013). It is the selfless acts of organ, tissue, and eye donors and their families that make a second chance at life possible for so many of those waiting.

The clinical complexities of donation evoke human complications, a wide range of emotions, and often expose the limits of understanding in regard to death and dying. Part of the role of a Family Services Coordinator is to ensure that children and families are well prepared for the process of donation, understand brain death, and feel supported emotionally. My background as a child life specialist has provided me with the skills and tools necessary to work in this unique role.

When describing the process of organ, tissue, and eye donation, our department works to include information about the who, what, when, where, and why of donation to ensure that families feel empowered and informed throughout the process. Beyond giving concrete

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PRESIDENT'S PERSPECTIVE

Moving Forward with an Eye Toward the Past

Amy Bullock Morse, MSEd, CCLS

I'm excited about entering the Presidency during a period of innovation within our profession. I feel fortunate to have the wisdom and guidance of our Executive Director, Dennis Reynolds, nudging me along as I build upon the strong foundation of leadership that our Past President, Diane Hart, laid. Diane is a tough act to follow with her attention to detail and discipline. Her commitment to high standards truly set the stage for success. I have a great leadership partner in Carla Oliver, President-Elect. Carla's zest and motivation will be great assets as we dive into the year ahead. I'm thrilled to be working alongside a skilled Board of Directors with unique perspectives and expertise focused on advancing our profession and exploring the needs of our membership. I'm grateful to have dedicated Child Life Council staff members who work diligently to support child life specialists each day. Can you imagine how many hours it takes to manage certification, prepare for a conference, organize webinars, address student inquiries, publicize our services, engage in social media, manage a website, support our committees and task forces, and identify donors who will support our programs? I'm so glad we have the best of the best working to advance our programs and services each day.

Our profession has exciting opportunities ahead that necessitate bold tactics to maintain relevance in the fast-paced health care environments within a global community. While working tirelessly to support emotional resiliency in children through procedural support, medical play, education, and normalizing play, child life specialists continually seize opportunities to advocate for children and families, communicating age-appropriate information in a way that teaches self-empowerment and the value of care partnerships.

We see these skills echoed on the global stage as our international colleagues explore opportunities to share empirical evidence about the efficacy of child life interventions and the need for institutional support to promote the profession. While the programs and services that children and families receive vary across regions, we are all working together as agents of change to advance quality psychosocial care for children and families and maintain relevance in dynamic health care environments. I feel honored to support our international members and friends in their efforts.

I am fortunate to enter the Presidency surrounded by a talented and dedicated group of volunteer leaders who continue to work tirelessly to explore the opportunities and challenges around the expansion of child life services. The 2012-2014 Strategic Plan provides a framework from which we may facilitate several overarching goals: (1) promote credibility of the child life profession, (2) provide timely, innovative, and high quality programs, products, services, and networking opportunities to members, (3) promote the presence and expansion of child life services in all health care and related settings serving infants, children, and youth, and (4) attain the financial and human resources necessary to carry out the strategic plan.

While an incredible amount of work has been done over the past two years to move strategic initiatives forward, I am most passionate about those that lie ahead. Supporting the development of clinical research that uses empirical and theoretical data to promote the efficacy of child life interventions is a high priority to me. Expansion of our body of research has positive implications for quality of care, and relevance in ever-changing health systems. Since my tenure as Chair of the Leadership Development Committee, I have had a keen interest in leadership development initiatives. I look forward to working alongside the Board of Directors to create a leadership development strategy and identify sustainable training resources for our membership. Lastly, I look forward to continuing our dialogue with global constituents around opportunities to advance psychosocial services. I was inspired by the innovative work our international scholarship recipients presented at the national conference, and I look forward to learning more about the clinical progress of our colleagues abroad.

This is a dynamic time in which our profession has an opportunity to advance quality services and maintain relevance in the current health care climate. It is a distinct honor to serve as your President and advance the Child Life Council's strategic priorities. I look forward to the opportunity to engage with many of you over the next year and encourage you to email me with questions, suggestions, or constructive feedback. I look forward to an exciting year ahead!

Child Life Council *Bulletin/FOCUS*
11821 Parklawn Drive, Suite 310, Rockville, MD 20852-2539
(800) CLC-4515 • (301) 881-7090 • Fax (301) 881-7092
www.childlife.org • Email: bulletin@childlife.org

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FROM THE EXECUTIVE DIRECTOR

Child Life—Global Perspectives

Dennis Reynolds, MA, CAE, CLC Executive Director

Over the past year, there has been a notable increase in the number of inquiries we have received from health practitioners all over the world expressing an interest in child life. At the same time, in those places where child life has even a small inroad, we have also seen activity expand. As I write this column, we are halfway through the summer and progressing nicely on a grant-supported international outreach project, identifying key leaders in pediatric psychosocial care, informing them about the child life profession, and learning what is happening in their countries in pediatric psychosocial care. CLC completed its fourth year of international Conference scholarships in May, and we are now accepting applications for international scholarships to be awarded next year for CLC's Annual Conference in New Orleans. I am especially pleased to point out the article in this issue of the *Bulletin* highlighting the experiences of our 2013 Annual Conference scholarship recipients. It is absolutely heartwarming to read of their experiences.

In some cases where child life is established, it has been growing organically, such as in Japan. There are more than two dozen Certified Child Life Specialists in Japan, mostly in one-person programs. Most of our Japanese colleagues are members of CLC, and in addition they have formed the Japanese Association of Certified Child Life Specialists.

In a few countries, there are organized plans for spreading child life nationally, in some cases through a public hospital system, in other cases through leading private entities. Three examples of where we are seeing planning and efforts unfold to spread child life nationally include Georgia, Romania, and the Philippines. There is prevalent child life planning and activity in at least two countries in the Middle East, Kuwait and Qatar. Growing child life interest and action in Asia extends from Hong Kong to Singapore to India. Interest in child life specifically has been a little slower to unfold in Western Europe, with Switzerland and more recently Italy showing the greatest signs of child life activity. In Africa, movement toward developing a child life profession is prevalent in both Kenya and South Africa. We have a strong advocate or two in Central America, but of all major areas of the world, it is interesting that there has perhaps been the least specific child life activity in South America, at least to our awareness.

In several English-speaking countries outside of North America, the leading pediatric psychosocial care profession is called Hospital Play or Health Play. It is prevalent in Great Britain, Australia, and New Zealand, and is represented in several other countries of the world. In many ways the work of Hospital/Health Play Specialists mirrors the work of child life specialists, although the amount and types of academic and clinical preparation vary, as does the overall scope of activities. We definitely consider Hospital/Health Play Specialists kindred spirits. There have been some Hospital Play Specialists who have earned the Certified Child Life Specialist credential, and this interweaves our common interests even more closely.

These are just a few representative examples of locations where child life, and more broadly pediatric psychosocial care, are becoming more visible within the fabric of health care all over the world. It is by no means a comprehensive list, and as we are finding out more all the time about developments in countries outside North America and are being contacted regularly by interested parties from all over the world, no doubt we will have added several others by the time this article is published.

At the same time, one of the most interesting challenges we are facing is to learn how CLC as an organization can best facilitate the global growth of child life and pediatric psychosocial care in general. Amid such widely varying academic and clinical training preparation requirements and backgrounds of those interested in instituting child life, as well as the enormous differences in health care systems and conditions among nations, the question of how to support this international development is quite complex. We must find a suitable answer in order to ensure that child life and the practices and principles it represents can be truly global in scope.

In the end, it is most important to remember that those who will benefit most from this increased activity are children and their families. The developments we see are very exciting, with the potential to reach an unprecedented number of children in need. We look forward to meeting the challenge of determining how we can best support and promote the growth of pediatric psychosocial care around the world.

Child Life Council

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POINT/COUNTERPOINT

POINT:

Billing for Child Life Services: The Time Has Come

Genevieve Lowry, Med, CCLS, Practical Parenting Solutions, New York, NY

The American Academy of Pediatrics (AAP) reports that "the child life specialist focuses on the strengths and sense of well-being of children while promoting their optimal development and minimizing the adverse effects of children's experiences in health care or other potentially stressful settings" (Child Life Council & Committee on Hospital Care, 2006; p. 1757). By using the phrase, "other potentially stressful settings," the AAP acknowledges that children live and develop in a variety of settings, and that the expertise of a Certified Child Life Specialist (CCLS) can and should extend beyond traditional healthcare environments. From the child life specialist's perspective, this seems like an obvious next step in the continuation of care, but the crucial question remains: Who will pay for it?

Child life specialists working in the hospital see patients with a variety of illnesses, conditions, and needs. We may offer play and preparation, education, and sibling support during that time. But once the family returns home, child life services end, and we move on to the next patient. Consider the child recently discharged home with a new diabetes diagnosis. The family is knowledgeable about her insulin injections, but the child becomes withdrawn since her parents began attending every birthday and school party to ensure she doesn't eat the wrong thing or get teased because she needs a special dessert. Consider also the parents of a premature infant, who are now home after two months in the hospital and are confronted by a five-year-old sibling who is now wetting the bed at night, or the child who once underwent multiple blood tests and IV insertions during a routine hospital admission and now kicks and screams during every doctor's visit. To whom can parents turn for help and support in these scenarios?

A child life specialist in the community continues the work of the hospital specialist by supporting the family through issues that arise after discharge, including chronic illnesses that can be primarily managed at home, or fears and anxieties that arise after hospitalization. According to the Child Life Certifying Committee Code of Professional Practice, we have an obligation to improve service and practice while providing child life interventions and care in medical settings and in the community (Child Life Council, 2012). Can establishing billable, specific child life interventions become a way to expand the profession, educate others about the role of child life, and improve care provided to children and families?

Historically, hospital child life programs have been supported by "operating budgets of the hospital, with the remainder coming from other sources such as grants, endowments, donations, auxiliary organizations, and telethons" (Wilson & Cross, 2009, p. 215). Child life service in the hospital is often part of the "bed charge." Therefore, insurance companies or Medicaid are already paying for children to have access to play and preparation.

However, another possibility may exist: "reimbursement of child life services, for example by requesting payment for services provided in non-hospital settings or by billing adult hospitals for interventions provided to children of adult patients" (Wilson & Cross, 2009, p. 215). Essentially, child life specialists would need to identify the procedures and services they routinely provide to patients to determine what potentially could be reimbursable ("Correctly bill," 2012).

This has been an issue and direction for growth in child life since at least 1999, when Jeriann Wilson, Director of Child Life at Johns Hopkins Hospital at the time, asserted that "child life services should be valued and reimbursed by insurers, both public and private" (DePasquale, 1999). Furthermore, the Child Life Council has suggested that "as third party payment and health care systems change, exploration of new ways to serve children and families become more important" (Child Life Council, 2006, p.42). The time has come to reassess the issue of reimbursement and consider the changing needs of children and families and their access to child life interventions.

Most healthcare salaries are derived from billable services, as physicians, physical and occupational therapists, and nurse practitioners in turn generate revenue streams for the medical center by billing insurance companies. Outside of the hospital, in clinics, community centers, and in private practice, other professionals such as social workers bill for the services they provide. As child life specialists offering a similarly valuable service, we need to explore new strategies for creating the financial freedom to expand the profession in increasingly relevant ways with new job opportunities and needed services for families.

Potentially, a child life specialist working as a private practitioner in the community or contracted through an agency could extend the work of the hospital-based child life specialist. Currently, however, there are limited systems for reimbursement. Agencies may have limited funds from which multiple services draw. The family who sees a private practitioner may have to pay out of pocket. This system then forces agencies to determine who gets what service or the child life specialist in private practice to limit care to only those who can pay. According to the Child Life Council, when there are "scarce financial resources, services must be targeted to treatment areas with a concentration of families who need support the most" (2006, p.13). If insurance companies reimbursed for child life interventions, then the child life specialist could target treatment for families in a variety of settings, not just those within the hospital or those who can afford the hourly rate. Since child life is not presently a reimbursable profession in or out of the hospital, it forces child life specialists to work within the confines of an established medical center, leaving families discharged home without a viable option for psychosocial support. By addressing the issue of billing and potential streams of revenue, the doors open for other opportunities outside of the hospital, which in the long run can only benefit both families and the profession. Child life specialists should find a way to bill for services so that we are able to continue to see those most in need, not just those who can afford it.

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COUNTERPOINT:
Billing for Child Life Services: Not Now

Maryanne Verzosa, MS, CCLS, New York-Presbyterian Morgan Stanley Children's Hospital

For almost a century now, child life specialists have worked arduously to validate and promote our role in the health care industry. The creation of the Child Life Council, as well as the development of required academic coursework, clinical internships, and the certification examination have been vital in strengthening the integrity of individuals within the field nationwide.

With the growth and evolution of the profession, there has been a yearning for legitimization in the eyes of the medical community. When faced with the revenue-generating business model of U.S. hospitals, it is inevitable that child life would encounter the question of whether its viability is contingent upon being a billable service. Some argue that child life services need to be billable, since, as child life does not bring concrete revenue to a hospital, our work can sometimes be seen as dispensable to hospital administration. Although my personal immediate reaction was, "Yes, of course!" child life services should be reimbursable, there are other factors to consider.

First, given the economic climate of the health care industry and child life's professional growth curve, it can be difficult to defend the notion that the field is currently ready to become a billable service. U.S. hospitals have recently suffered widespread criticism for their "inconsistent," "chaotic," and "secretive" billing systems (Brill, 2013; Reinhardt, 2009). Are child life services ready to be thrown into a hospital's "chargemaster" list of procedures, medicines, and services in this climate of close supervision and dispute from policy makers, patients, insurance companies, and hospital administrators? I argue that child life may not be quite ready to tackle this economic hurdle and see several important issues that must be addressed if the profession eventually decides to go this "billable" route.

Currently, child life in the hospital setting provides a broad array of services, arguably too broad to place a price on any given component. To make the argument that child life services should be reimbursable, we first need a comprehensive breakdown of the "services" in question, and outcome-based research supporting the economic value of each.

Recognizing this need for evidence-based research, the Child Life Council has identified as a primary focus for its strategic plan "ensuring and promoting research that advances the theory and practice of child life services, and which substantiates the profession's therapeutic and economic value" (Child Life Council, 2011). In February of this year, The Walt Disney Company awarded the Child Life Council a $250,000 grant to initiate such research on the therapeutic role of play on hospitalized children, which may influence the economic model of child life services (Child Life Council, 2013).

If certain child life services prove to be billable, while others stay non-reimbursable, will this cause a major division in services that make up current child life programs? Greene and Hopkinson suggest that a fee-for-service private consultation practice can be developed based on the traditional child life role within the hospital, as "the moment you share an idea or strategy, you are acting as a consultant because you are planning, advising, assisting, and/or recommending. You are not directly controlling the situation, but you are influencing a favorable outcome based on your role in the organization as well as your knowledge, methods, and techniques." (2008, p. 33). Since these consultative-like services have had some success as fee-for-service, it may be suggested that such services will be deemed as billable within the hospital. For example, traumatic experiences such as the diagnosis of a chronic illness or unexpected death of a loved one often require child life consultation. Assessments and specialized interventions (i.e. developmentally appropriate explanation and communication, self-expressive activities, etc.) are used to promote positive coping. By providing specific technical assistance using the training, expertise, and skill set of a child life specialist, it may be assumed such services are considered billable.

At the same time, we must keep in mind that child life specialists are still the main promoters of play within the hospital. If we begin billing for "consult-like" clinical services, how will this division in services affect opportunities for play and/or playroom time within the hospital? This becomes a major concern for child life specialists, as the core concepts of our profession are grounded in play. Many of these concerns call to mind Principle 11 in the Child Life Certifying Committee Code of Professional Practice: "Individuals shall recognize that financial gain should never take precedence over the delivery of services" (Child Life Council, 2012, p. 2). In going this billable route, will we be sacrificing the foundation our profession was built on—the importance of play?

Child life specialists also educate healthcare professionals and members of the community on the developmental needs of children and our role in supporting them. We continue to need to explain the purposes of our services, and often re-explain them to reassure that appropriate referrals are made. Within this hypothetical structure of billable child life services, will specialists be forced to provide services based only on referrals and written orders at the discretion of physicians and other medical team members? With such constraints, will we be at risk of missing children who are in need of support?

Another major concern is the current state of our nation's hospital billing system. Uwe E. Reinhart (2009) explains, "The pricing of hospital services is best described as 'Chaos Behind a Veil of Secrecy' . . . No one really understands the determinants of the wide variations in prices paid hospitals by a given insurer for basically the same medical episode." Brill (2013) explains how it is not only until this year that some "chargemaster" lists (itemized breakdown of prices) have been revealed to the public due to major inequities in hospital billing systems and asserts that most hospital prices seem to have no rationale.

As U.S. hospitals receive negative press about this controversial financial model, we

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Child Life in a Rehabilitation Setting

Christina Dellibovi, MS, CCLS, CBIS, Children's Specialized Hospital, New Brunswick, NJ

Child life specialists working in rehabilitation have many roles to play. The interventions offered are unique to the specialty models in this environment (Davitt & Munn, 2008). While many acute care child life skills can be transferred, rehabilitation comes with its own challenges and requires child life specialists to further hone their abilities. Knowledge of child development, coping, and family systems are still paramount, but the rehabilitation setting stretches those skills in a new way. Just as the various units of a large acute care setting may be different, so too can each rehabilitation experience differ dramatically.

Rehabilitation is a process that starts the moment a family undergoes a medical change. It is not only a medical process, but also a growing process that involves renegotiating life patterns and creating new meanings of self. The focus shifts from nursing care and medical updates to an emphasis on function and independence, with overall care driven by a team of therapists. During this particular phase of recovery, the magnitude of potential stressful events, and thus the need for child life services, should not be underestimated.

Children and their families are exposed to many new stressors when transitioning to a rehabilitation facility. A parent may be trying to balance an increasingly complex myriad of responsibilities while also returning to work. For the patient, the intensity of rehabilitation activities can produce added anxiety and pain along with an expectation of increasing responsibility for personal care and mobility. Furthermore, most therapies are hands-on, intensive, and sometimes invasive. Exposure to new terms and equipment is frequent, as is the potential for blurred boundaries. On top of all this, some patients are truly facing new realities. It may be an overnight transformation from being "typical" to being permanently disabled via trauma or catastrophic illness (Hicks & Davitt, 2009).

A child life specialist can help the patient and family adapt to the rehab setting by advocating for family-centered care practices within the institution and providing specific interventions that focus on normalization, play, and adjustment. For instance, a calendar with key dates, daily successes, and special events can help the child visualize their progress while also communicating daily changes to the rest of the family. A child life specialist can facilitate the transition to rehab by collaborating with the child life team from the patient's previous facility to create a sense of continuity and trust. Additionally, the rehab child life specialist can provide support and education in the form of self-care guides, communication tools, trusted websites, and other local resources designed to help families during the rehab period. Like child life programs in acute care settings, programs in rehabilitation settings also "strive to promote optimum development, maintain normal living patterns, and minimize psychological trauma" (Child Life Council, 2002, p. 57).

When children are admitted to a rehab facility, the overall care and mobility responsibilities quickly shift from the nursing and medical staff to the child and/or families in preparation for going home. It is a crucial time for children to realize the importance of their own participation in their care. A fun, child-friendly, and motivating environment can help promote independence and autonomy. In addition to preparation and support for this expectation, personalized interventions based on individual child life assessment can facilitate adjustment to not only the new setting and routines, but also to potential new realities.

Whether a child's condition is temporary or permanent, community and school reintegration are paramount to a child's future success. While child life can help accomplish this by physically taking patients from the hospital into the community or school, engaging the family and child in psychosocial preparation is also essential. Rich opportunities exist during extended intensive rehabilitation stays for child life specialists to facilitate adjustment to injury, illness, and disability using individualized plans of care.

Given the many stressors that children and families face during a rehabilitation stay, child life specialists have a unique professional skillset to support coping and development in this population. Davitt and Munn (2008) have noted that many rehabilitation programs have begun to expand their multi-disciplinary teams to include child life specialists. Since there is only a small, but growing, population of child life specialists working in rehabilitation, there may be variation in the roles and responsibilities that each of these individuals plays within their interdisciplinary healthcare teams. Regardless of the facility, child life specialists are an essential element of a comprehensive care plan that integrates psychosocial well-being into physical and cognitive goals. Indeed, a skilled child life specialist has the potential to positively alter the patient's rehabilitative outcome using the professional skills inherent to the field.

To learn more about the typical day of a child life specialist working in a rehabilitation setting, see the Bulletin *blog on CLC Community.*

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CHILD LIFE Focus

VOLUME 31 • NUMBER 4 FALL 2013

Effective Use of Praise or Reward for Children Undergoing Stressful Medical Experiences

Cheryl Murray-Miyamasu, MA, CCLS
Jeevan Aadhar, Mumbai, India

Introduction to the Clinical Problem

In many pediatric medical settings, child life specialists lead the way in modeling appropriate support for children undergoing stressful medical procedures, utilizing their specialized education and training in child development (Child Life Council, 2010). Child life specialists aim to promote coping and mastery of healthcare experiences for children (Child Life Council, 2002), as these experiences may impact children's perception of future procedures (Dahlquist et al., 1986).

Child life specialists and other medical professionals regularly use incentives with children undergoing stressful healthcare experiences. However, it is unclear whether the use of incentives promotes coping skills and mastery in children (Cameron, Banko, & Pierce, 2001). Furthermore, there are noted variations in individual clinical use of incentives in healthcare environments. Therefore, the purpose of this project was to utilize the Evidence-Based Practice (EBP) framework to examine the most effective use of praise or reward for children undergoing stressful medical experiences in order to promote positive coping and behavior.

Evidence-based Framework

The Child Life Council's (CLC) model for evidence-based practice was used as a guide for this project. A graphic of the model can be viewed at https://www.childlife.org/files/EBPModelChildLife.pdf.

The first step in the model is to assess the practice need. A child life specialist may identify this need through direct observation or insight from children and families. A practice question is formed using the following format:

P – Population – what is the specific group being looked at?

I – Intervention – what is the intervention being examined?

C – Comparison – to what will the intervention be compared?

O – Outcome –what outcome is being measured?

Search terms are derived from the practice question and entered into appropriate databases to obtain relevant evidence. Studies are then critically appraised, leveled, and graded to evaluate the strength of the evidence. The evidence is evaluated in the context of the healthcare provider's clinical expertise as well as patient and family preferences. With sufficient evidence for synthesis, a recommendation for practice can be made. At this point, providers must consider the most effective implementation strategies to disseminate the recommendations and integrate them into practice. Then the clinician can implement the EBP recommendations into practice and disseminate the information found through the EBP process. The final step is to evaluate the EBP project and examine outcomes.

The Clinical Question

The clinical PICO question asked for this EBP project was: *Among pediatric patients, does the use of praise versus reward improve behavior and coping during a stressful medical experience?*

For the purpose of this project, the following terms were defined:

- Praise – a verbal statement or tangible item which positively recognizes or affirms a child's intrinsic qualities or exemplified behaviors, such as a certificate of bravery, a trophy, or a medal.
- Reward – a tangible item that serves as an extrinsic motivator or prize, such as a Matchbox® car or small toy.
- Incentive – any item, whether praise or reward in nature, which is used to motivate children or enhance coping.

Searching the Evidence

Key search terms included: children, pediatric, praise, reward, incentive, behavior, coping, distress, anxiety, motivation, healthcare, medical patients, and prize. Databases searched were PubMed, PsychoINFO, Cinahl, Medline, and Google Scholar. The date range was limited to articles published between 1980 and 2011.

The search produced eight studies that yielded evidence related to the use of praise or reward for children undergoing stressful medical experiences. These articles were appraised using LEGEND grading tools (Clark, Burkett, & Stanko-Lopp, 2009) to determine the validity and reliability of the studies.

In addition to the literature search, queries were posted to the CLC's general and academic email forums to gather expert opinion and clinical consensus. Nine responses were received and varied based on how incentives were used by clinicians. Clinicians questioned these noted inconsistencies and the potential harm of

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This project was implemented at Cincinnati Children's Hospital, Cincinnati, OH

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such inconsistent practice among healthcare professionals with statements such as, “The misuse, confusion, and abuse of incentives can have negative results,” and, “Often it appears as if gifts/prizes/rewards are given to meet the needs of the adults involved.”

One child life department reported a decision to no longer partake in using incentives, as “The underlying question regarding the giving of gifts, prizes and rewards by child life staff to patients and family members is, what is the goal being met?”

Another theme identified from responses addressed using incentives to promote intrinsic motivation to increase positive coping. Many mentioned using medals or certificates in their clinical settings in order to help promote intrinsic motivation.

PRESENTATION OF THE EVIDENCE

SYSTEMATIC APPROACH

While there was not sufficient evidence to directly answer the PICO question, themes were identified throughout the literature. One valuable theme was that the use of an incentive, whether praise or reward, was shown to be most effective when provided systematically. In a descriptive study of a behavioral training approach to teach cooperation and control to children undergoing radiation, Slifer, Bucholtz, and Cataldo (1994) found that 8 of 10 participants were able to successfully complete radiation without sedation. The behavioral training included specifically designed reinforcers, such as a sticker chart for each step of the procedure and a reward at the end.

In 1990, Manne et al. conducted a controlled clinical group study of a behavioral intervention that incorporated parent coaching, distraction, and positive reinforcement to control child distress during an invasive treatment. The patient could “win” a sticker by holding still and “win” another if they used a party blower. The group using the behavioral intervention displayed decreased distress and increased cooperation during the procedure.

In 1994, Manne, Bakeman, Jacobsen, Gorfinkle, and Redd conducted a randomized controlled trial examining a behavioral intervention for children undergoing venipuncture. The intervention included the patient earning one sticker by holding still and another by using a party blower during the procedure. Less crying was exhibited by children who used the behavioral intervention during the procedure.

Jay, Elliott, Katz, and Siegel (1987) used a randomized controlled trial to examine the efficacy of a cognitive-behavioral intervention and Valium for reducing children’s distress during bone marrow aspirations. The intervention included filmed modeling, breathing exercises, imagery/distraction, positive incentive, and behavioral rehearsal. The positive incentive used was a trophy, symbolizing mastery and courage, which children could win if they were able to lie still and utilize the breathing exercises. The researchers found that the intervention, including systematic use of incentive, was more effective in reducing child distress than Valium or no intervention. Similarly, in a descriptive study by Allen and Stokes (1987), a systematic use of practice, escape, stickers, and praise was found to be effective in decreasing children’s uncooperative behavior during dental treatment.

SPECIFICITY AND CONTINGENCY

Another theme cited repeatedly throughout the literature regarded the importance of using praise in specific, contingent ways. Gelfand and Dahlquist (2003) found that criticism from both the nurse and mother had a positive correlation with child distress and recommended that non-specific praise be replaced by specific praise, in which the adult clarifies the explicit behavior worthy of praise.

Manne et al. (1992) conducted a descriptive study examining relations between adult behaviors and child distress, crying, and coping during venipuncture. They found praise from adults and child coping were positively correlated after the procedure was complete and recommended training parents in the use of contingent praise to improve effectiveness. Manne et al. (1994) reported a randomized control trial examining a behavioral intervention for children undergoing venipuncture. One reported finding stated that praise moderately affected children’s behavior and that specific parent coaching was associated with influencing children’s behavior more than general encouragement.

Finally, Pringle and collagues (2001) examined the effectiveness of an intervention for reducing distress in children during needle sticks. The intervention included teaching parents how to use specific praise statements to validate their child’s behavior. Five out of eight participants exhibited significantly less distress when using the intervention.

VERBAL CONTRACT

The evidence also revealed a common theme across studies: when a reward was used in a systematic way, the children were informed of the protocol in advance. In these studies, a verbal contract was made prior to the procedure so that the children understood what behavior was expected from them in order to receive the reward. In a randomized controlled trial by Jay et al. (1987), children in the study were told what the reward would be and how it could be earned prior to the procedure. In their descriptive study, Allen and Stokes (1987) rewarded children with small prizes for cooperation during dental treatments. The children

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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were told in advance what behavior they needed to demonstrate in order to earn the prize. Slifer, Bucholtz, and Cataldo (1994) developed a protocol to increase cooperation during radiation treatment. Each step of the treatment and expected behaviors were clearly explained to children beforehand, and the children had an opportunity to earn a sticker on a chart for cooperation at each step. They were told in advance how many stickers they needed to collect to earn a prize.

It was interesting to note that across studies, the behavioral intervention plans, which included praise or reward, were found to be effective with patients who had a history of being uncooperative in the past. In the study by Manne et al. (1990), children included in the sample had been identified as previously needing to be restrained during procedures. The restraints required in the group receiving the behavioral intervention were significantly less than those needed in the control group. Allen and Stokes (1987) included in their study children who had failed to cooperate in the past. They found that the children rewarded with escape, stickers, and praise for cooperative behavior during dental treatments exhibited a significant reduction in disruptive behaviors, from 90% to less than 15%.

Another point of interest was found in the study by Jay et al. (1987). In this study, the group that received the behavioral intervention plan, which included a trophy incentive, had lower levels of distress than those who had received Valium or who were in the control group. The behavioral intervention included filmed modeling, breathing exercises, imagery/distraction, prize, and behavioral rehearsal. Children in the behavioral intervention group were asked which of these elements "helped the most" and which they "liked the most." In reference to the prize, the children rated it as helping the least, but they liked it the most.

The literature reviewed in this body of evidence included an age range of patients from 3 years old to 15 years old. While a systemic approach to praise or reward may also be effective in promoting positive behavior and coping among older children and patients with developmental challenges, there is a lack of sufficient evidence to determine this.

EVIDENCE SYNTHESIS AND RECOMMENDATIONS FOR PRACTICE

Based on synthesis of the evidence, the following recommendation was developed:

> It is recommended that the use of an incentive, whether praise or reward, be approached in a systematic and planned manner in order to positively affect behavior and coping in children undergoing a stressful medical experience.
>
> **Note:** Using praise as part of a systematic approach during a healthcare experience is most effective in affecting behavior when given to children in specific, contingent ways (e.g. "You are doing a great job at holding your arm still") rather than nonspecific, unlabeled praise (e.g. "You are doing a good job").
>
> **Note:** Using praise or reward is most effective when a healthcare professional has a conversation with the child prior to the stressful healthcare experience to communicate: 1) the praise or reward system being used, and 2) the desired and expected behaviors of the child during the healthcare encounter (Murray-Miyamasu, 2012).

DISSEMINATION OF EVIDENCE INTO PRACTICE

Evidence was disseminated through a Best Evidence Practice Statement, a poster presentation, and an educational presentation of findings to healthcare professionals, including a discussion of how to integrate the information into clinical practice as follows:

1. Systematic approach

It is recommended that the use of an incentive, whether praise or reward, be approached in a systematic and planned manner in order to positively affect behavior and coping in children undergoing a stressful medical experience (Murray-Miyamasu 2012).

- Plan ahead of time: Have a system in place in advance for the praise or reward system being used.
- Consistency among staff members: Be sure the healthcare team is in agreement about the goals of using incentives and collaborate together to use them in an effective manner.
- Follow through on the plan: Examples of plans include earning stickers for holding still, attempting the procedure, or using a coping technique; receiving a "prize" for earning a certain number of stickers for each step of a test or procedure; and displaying a linear photo poster or banner with pictures of expected behaviors during steps to guide the child to the prize.

Examples were discussed to highlight these practical applications in a variety of settings and disciplines.

2. Praise

Using praise in a systematic approach during a healthcare experience is most effective in affecting behavior when given to children in specific, contingent ways (Murray-Miyamasu, 2012).

- Specific – Address specific aspects of the child in focused statements. Avoid general statements.
- Contingent – Dependent on what the child is doing. Have a purpose or goal behind the statement, such as encouraging positive behaviors to continue, encouraging a sense of mastery, or encouraging intrinsic motivation.
- Examples of specific contingent praise include: "Johnny, you are doing a great job at holding your arm still," "I like the way you are blowing that pinwheel nice and easy, Sally," or "Isaac, thank you for helping the doctor by letting him look in your mouth."

3. Verbal contract

A systematic approach to praise or rewards is most effective when the healthcare professional provides a child with an explanation of the desired or expected behaviors prior to the stressful healthcare experience (Murray-Miyamasu, 2012).

Key elements of a verbal contract include: 1) The system is discussed with the child prior to the stressful healthcare experience. 2) The clinician defines expected behaviors, such as, "Your job is to help hold your arm still." 3) The adult sets the child up for success. For example, if giving the child a job such as holding his or her arm still, tell the child, "Some kids say it is really hard to hold their arm still. I will be here to remind you just in case you forget." Give clear boundaries with options of other appropriate behaviors, such as, "You can yell or squeeze my hand, but you can't hit the doctor." Remind the child of what he or she can do to make the procedure easier or better, such as relaxing and taking deep breaths. 4) The clinician assesses the child's understanding. Does the child understand the system in place?

continued on Focus *page 4*

continued from Focus *page 3*

As a closing for the presentation, clinicians were challenged to resist "urges" in practice that include giving a prize to a patient because "they're so cute!" or "his little brother needs one!", or making general praise statements like, "you're doing so well."

The presentation was videotaped and posted as an online learning module for clinicians to view at their convenience for continuing education units.

EVALUATION

At the conclusion of the presentation, surveys were given to attendees to evaluate the new knowledge gained and assess intentions of integrating the material into practice. The Kirpatrick Model (Kirkpatrick, 2006) was used to guide the formulation of the survey.

In total, 47 surveys of semi-structured questions were completed. Results are presented in Table 1.

TABLE 1. POST-PRESENTATION SURVEY RESULTS

1. My initial reaction to the content as related to my practice is:
   positive n=47 undecided n=0 negative n=0
2. Did this presentation provide you with new information?
   YES n=44 NO n=1
3. The top two things I learned today are: (top four responses)
   - Importance of giving specific praise with a purpose
   - Value of having a plan and system in place for either praise or reward
   - Recognition of the need to talk with the child about the plan and expected behaviors prior to the stressful experience
   - Necessity/value of having a therapeutic goal or intention behind using praise or reward
4. Will this information effect your practice?
   YES n=46 NO n=0
5. Please share how you intend to transfer your learning into practice: (top four responses)
   - Share knowledge gained with teams/other healthcare staff
   - Implement a plan/system for using praise and rewards
   - Use a verbal contract with children prior to stressful experience
   - Reflection on current practice and how to implement
6. I perceive the following barriers would hinder applying this content into practice: (top two responses)
   - Educating other staff and having buy-in to a different process
   - Consistency or lack thereof among all disciplines
7. I think that if I applied my learning that I would anticipate:
   improved results n=42 same results n=3 not as good results n=0

CONCLUSION

This EBP project revealed evidence that can guide clinicians in their use of praise and reward for children undergoing stressful medical experiences in order to promote positive coping and behavior. These guidelines include using a systematic approach, giving praise in specific and contingent ways, and establishing a verbal contract with children prior to the stressful medical experience. However, there is a need for future research regarding the use of praise versus the use of reward in children undergoing stressful medical experiences. The information found in this EBP project can be used to guide clinical practice for child life specialists and other healthcare professionals in order to facilitate positive coping for children facing stressful medical experiences.

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Child Life in a STAR Role

Missy Stover, BS, CCLS, Children's Mercy STAR Power Program Coordinator, Children's Mercy Hospitals and Clinics

Being a kid in the hospital isn't always easy. Being a kid *outside* of the hospital isn't always easy either. For many children, the day-to-day challenges of bullying, test anxiety, screen time, junk food, and other hurdles can make the average day seem like an uphill battle. The Child Life Department at Children's Mercy Hospitals and Clinics in Kansas City, Missouri, has developed a school-based program to help children face such challenges and provide the tools to withstand battle.

The Kohl's and Children's Mercy S.T.A.R. Power program (**S**trong, **T**alented, **A**uthentic, and **R**esilient), was developed in 2010 through a partnership with Kohl's Cares. The STAR Power program reaches over 5,000 elementary students per year through classroom education and activities related to the topics of relaxation, self-esteem, healthy eating, and movement. Coordinated by a Certified Child Life Specialist, the program includes student-led discussions and expressive activities, as well as tips and resources to help kids be the best they can be.

The program targets third- and fourth-grade students with a goal of influencing their behaviors and attitudes toward health at a pivotal time in their development. Over 80 elementary schools in the Kansas City area have welcomed the program with open arms. School nurses, counselors, and classroom teachers understand the importance of educating the "whole child" and appreciate the additional resources brought to the school at no cost.

The classroom sessions are playful and fun and aim to meet the students on their level, on their turf. Students are given opportunities to share their life experiences and also to offer advice and suggestions to their fellow students. For example, after exploring the challenge of eating the recommended amount of vegetables and getting enough physical activity, students might share recipe ideas for making veggies taste better or video games they play that get them up and moving. The child life specialist encourages these discussions and empowers the students to brainstorm ideas and develop solutions that make sense to them.

Measuring sugar content by funneling sugar into an empty soda bottle and watching heart rate increase while jogging in place are just a couple of the hands-on activities that enhance the student's learning experience. Activities such as journaling, breathing exercises, and muscle relaxation are concepts that might be new to some students and being able to practice and master these coping techniques in a "normal" setting promotes resilience when the situation is *not-so* normal.

During the relaxation session, students are given the opportunity to share experiences that were frustrating, hurtful, or worrisome. Students are eager to share tales of sibling rivalry, spelling bee jitters, and relationship troubles. By creating a supportive environment, students will sometimes share

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CLC Board Approves Recommendation for Advanced Degree Requirement Effective in 2022

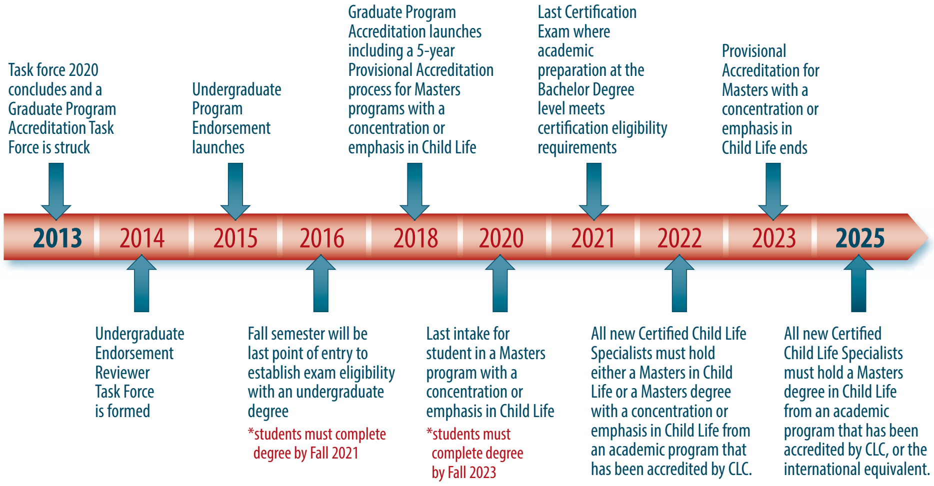
At its May 2013 meeting, the CLC Board of Directors approved a series of important recommendations defining a progression of steps whereby, effective in 2022, all newly credentialed Certified Child Life Specialists would be required to hold an advanced degree from an academic program that has been accredited by CLC.

- Effective in 2022, to establish eligibility for certification, candidates will be required to hold either a master's degree* in child life OR a master's degree* with a concentration or emphasis in child life from an academic program accredited by CLC.
- Effective in 2025, this requirement will be amended to require that all certification candidates hold a master's degree* in child life from an academic program accredited by CLC.
- Certified Child Life Specialists who hold the credential prior to 2022 will not be required to obtain a master's degree to remain certified provided they maintain their credential and recertify as appropriate.

*Master's degree or international equivalent

An overview of the timetable developed by the Academic Preparation: Task Force 2022 is provided at left, and more information on the advanced degree requirement is available on the CLC website at http://www.childlife.org/Certification/AdvancedDegree2022/index.cfm.

Recommended Progression of Steps to all new certified child life specialists holding an advanced degree from an academic program accredited by CLC in 2022



Reflections

continued from page 1

Hospital, was also awarded a scholarship but was unfortunately unable to attend.

Most of these award recipients attended conference as "first-timers," not knowing exactly what to expect or anticipate from the experience. "In the run up to the conference, my excitement and expectations grew and grew, so by the time I landed in Denver they were certainly a mile high! My expectations were not only met but they were exceeded," stated award recipient Lorraine Pratt. "The enthusiasm and warmth from everyone attending the conference radiated throughout the venue. I spent five days submersed in amazing educational and networking experiences."

To kick off their conference experience, these award recipients were honored at the International Scholars Reception, where they had the opportunity to meet their assigned CLC mentors and network with each other as well as other CLC colleagues. About this reception, Blondi Kwok stated, "It was great to meet people from all over the world from the same profession. It just gave me a sense of feeling to join a big family with people speaking the same 'language' regarding what we are doing for children at hospitals or in the community." The opportunity to network was also appreciated by Charlotte Rosline Soans, who said, "Interacting with various child life specialists from all over the world has given me a wide perspective of child life. On the whole it was very informative and pleasant experience during the conference and I am keen on attending future conferences."

Scholarship recipients were able to fully participate in all aspects of conference. Joanne Cross expressed her gratitude for these learning opportunities saying, "The content of the conference was brilliant. I learnt so much and it will take me a long time to go back through all the information I gathered before I can begin to introduce it to my own practice and share with my own colleagues, and with members of my own organisation."

Each recipient worked with her CLC-member mentor to identify workshops and sessions that would be beneficial for her individual needs. Each of the recipients shared favorite sessions, including Blondi Kwok who says, "it was inspiring to attend the intensive session by 'Life is good Playmakers' to have an interactive session to learn some therapeutic games and activities to promote healing and growth of children." Charlotte Rosline Soans attended a session on resilience and says, "The three R's of resilience –Relax, Reflect, and Respond - has given me a different perspective of working as child life practitioner."

Lubna Mohammed Aamir reflected on another presentation saying, "I was very impressed with the closing session with Professor Corey Ciocchetti. During his session I kept on asking myself am I doing that. It made me change the way I take things and what I miss in my day-to-day life. This can be some of the ways to help in not getting burnout at work in team members and handling situations with a positive approach."

The opportunity to attend conference was appreciated by all of the award recipients, but Nana Chavchanidze and Khatuna Dolidze expressed it saying, "We have seen the world with the glasses that has broader view. You gave us a chance to get deep into important details of working as a child life specialist, and to look at the important thing—child life in people's lives, relations between people, globally." Dr. Lucia Celesti echoed the sentiment saying that she "truly left a little piece of my heart in Colorado and this experience was a wonderful occasion for me to fulfill my education and expertise."

If you or someone you know is interested in applying for an international scholarship for the 2014 Conference, please visit http://www.childlife.org/Annual%20Conference/ConferenceScholarship.cfm for more information. Applications are due October 30, 2013.

Acknowledgements: This article is composed from excerpts from the individual reflections submitted by these international scholarship award recipients. The full text of each submission is available in the new *Global Perspectives in Child Life* blog in CLC Community. We encourage you to read each submission to learn more about the recipients and their conference experiences.

Billing: The Time Has Come

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This conversation is by no means complete; the hope is that we can start a dialogue about billable services in child life. Other professionals have successfully been able to define their billable services and methods for where and how those services are provided. The idea is not to limit services, but to expand beyond the acute care setting. By embracing this paradigm shift, child life can continue to grow and advocate for both the developmental and financial value of our work. Most in this field did not choose child life for the financial gains, but because we love what we do and believe in its value. Together, child life specialists in traditional settings and those within the community can support each other through referrals, education, and expansion into a variety of venues, including non-medical settings, leading to increased services for families and financial support for the work of the child life professional.

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Child Life in STAR Role

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experiences that others were unaware of such as illness/disability, divorce, or death. This can be an eye-opening experience for the other students and school professionals who might be hearing this information for the first time. By gaining this insight, fellow students (and teachers) have a better understanding of that classmate's behaviors. Research shows that children who experience loss or trauma are vulnerable to depression that may slow down cognitive functions and lead to loss of motivation, difficulty distinguishing between relevant and irrelevant information, and difficulty concentrating on school subjects (Dyregrov, 2004).

The child life specialist must develop a quick rapport with each class, as the topics are presented in 45-minute sessions. Schools may choose as many as three of the four topics to be presented to the students, which are spread over multiple visits to the school. School professionals might also invite the child life specialist to facilitate a session that is specific to some circumstance or event such as practicing relaxation exercises in preparation for state testing.

Teachers and other school professionals are invited to provide feedback on the program through an on-line survey at the completion of each classroom session. Of 161 responses:

- 98.75% reported that students have demonstrated a better understanding of the topics,
- 96.25% reported that they have observed students discussing the topic with their peers, and
- 98.75% reported noticing positive changes in the students' behavior related to the topics.

The STAR Power program recognizes that parents and caregivers also play a significant role in the habits and behaviors of their children. A large portion of the funding received by Kohl's Cares is dedicated to public service announcements that encourage healthy role-modeling. These messages are aired on local cable networks and radio stations. To view the PSA videos and check out other resources for parents, visit the STAR Power website at www.childrensmercy.org/starpower or visit the STAR Power Facebook page at www.facebook.com/starpowerprogram for more tips and ideas.

The STAR Power program creates a unique opportunity for the child life specialist. Spending time with children outside of the hospital is significantly different from the usual role of a child life specialist; however, the goals are largely the same: providing emotional support and exploring coping strategies through play, preparation, and self-expression activities. The program also introduces students to a hospital professional who is fun, friendly, and supportive, and for those students who have never been hospitalized, this encounter may create a more positive image of hospitals and the staff who work there.

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Billing: Not Now

continued from page 5

must consider whether child life is ready to be involved in this complex conversation. According to the Medical Billing Advocates of America, "As many as 8 out of 10 bills for health care services contain errors" (cited in Park, 2013). American hospitals are under close scrutiny for claims of deceiving their patients and manipulating prices. If child life chooses to go forth with this battle to become a reimbursable service, we will need to form task forces to tackle these issues and legitimize services with state and federal policy makers, negotiate prices that vary across hospitals, and convince insurance companies and Medicaid of the need for payment.

With advancements in child life research, as well as changes to our evolving healthcare system, we may have new and helpful material to work with in years to come. For now, this conversation is full of unknowns and what-ifs, but it is sure to be continued.

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BOOK REVIEW

Building Resilience in Children and Teens

A REVIEW OF GINSBURG, K. R., & JABLOW, M. M. (2011). *BUILDING RESILIENCE IN CHILDREN AND TEENS: GIVING KIDS ROOTS AND WINGS*. ELK GROVE VILLAGE, IL: AMERICAN ACADEMY OF PEDIATRICS.

Christa Peterson, CCLS, Seattle Children's Hospital

Most parents wish that they could raise their children in environments free of pain and sorrow, where children know only happiness and do not have to encounter disappointment, sadness, adversity, and failure. Parents understand that this wish can never become a reality, however, and therefore they are faced with the task of nurturing their children while preparing them to encounter and recover from setbacks. The ability to recover or bounce back from setbacks is known as resilience, and cultivating this quality in children enables them to deal more effectively with difficult situations and experiences.

In the second edition of *Building Resilience in Children and Teens: Giving Kids Roots and Wings*, Dr. Kenneth Ginsberg and Martha Jablow (2011) write extensively about how to facilitate healthy physical and emotional development in children and adolescents and, more specifically, how to help children and their caregivers successfully navigate life's inevitable challenges. Ginsberg contends that building resilience in children takes time, energy, and practice and includes seven interrelated components, also referred to as the "the *7 Crucial Cs*"— *competence*, *confidence*, *connection*, *character*, *contribution*, *coping*, and *control*. Ginsberg discusses each of these factors in detail and from a developmental perspective, incorporating real-life examples in an effort to show how to promote these qualities in youth of all ages. Ginsberg's primary message is that children and teens are unique individuals who possess inherent valuable qualities, one of which is resilience. Ginsberg maintains that resilience is "built in" rather than acquired through the course of life and should therefore be fostered by connection, communication, and opportunities to demonstrate competence. This display of competence then leads to greater confidence, which enables children to develop character and encourages them to contribute to their world. Ginsberg also reminds parents and caregivers of the power of unconditional love with appropriate limits and reiterates that children usually behave in a manner that meets adults' expectations—whether those expectations are low or high. Moreover, Ginsberg emphasizes the importance of being consistent with children and points out that kids and teens pay far more attention to caregivers' actions as opposed to their words.

The book itself is organized into seven sections and includes 39 easy-to-read chapters in which Ginsberg covers a wide range of topics, including the effects of stress on children and families, developmental considerations when communicating with children, how to support children in their schoolwork and academic achievement, the impact of multimedia on children's emotional and social development, parenting styles and discipline, the importance of nutrition and physical exercise, strategies for promoting emotional health, and much more. Ginsberg also devotes several chapters to addressing how to support military families during deployment and times of war and how to help families cope with difficult situations like divorce, chronic illness, disaster, terrorism, and death.

Ginsberg covers numerous different topics, and although the topics are diverse, each subject is appropriately related to fostering healthy development and resilience. He makes it clear that the chapters are not meant to be a "how to" manual on raising children but rather to be used as a reference—and to support and encourage genuine connection with children. Ginsberg presents information in a way that is easy to understand, yet he does not overly simplify the material or make it too anecdotal, and his claims are well supported by research. Furthermore, he provides readers with resources for further exploration so that they can build their own knowledge base. *Building Resilience in Children and Teens* is a truly informative work that takes a common-sense approach to parenting, supporting, and interacting with youth, and within its pages, Ginsberg draws on his own expertise as a pediatrician who has worked with diverse groups of children and teens for more than 20 years. Such a resource is likely beneficial to any individual or group (parent or professional) who desires to know more about how to connect and build meaningful relationships with children and adolescents.

Save the Date!

Child Life Council
32nd Annual
Conference on
Professional Issues

May 22-25, 2014
Hilton New Orleans Riverside, New Orleans, LA

On the banks of the Mississippi River and within walking distance of the French Quarter and the New Orleans Streetcar lines, the Hilton New Orleans Riverside is the ideal location for exploring the city and enjoying its many dining, shopping, and sightseeing options.

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U is for Utilization

continued from page 1

preparatory information, we also focus on acknowledging the cognitive and emotional complexity of organ transplants.

Traditionally, when we contemplate death, we envision someone dying because their heart has stopped beating. Alternatively, many organ donors are declared brain dead, which poses confusion for many families. When an individual has been declared brain dead, the swelling in the brain is so extensive that blood supply ceases, leading to irreversible damage to the point that the individual will never regain function. Organ donors who have experienced brain death are maintained medically and still possess a heartbeat, which makes brain death a complicated topic for many children and teens. To help educate and support children during this time, we encourage families to be open and honest with their children throughout the donation process. We have found that providing children with honest and accurate information pertaining to brain death and donation, as well as allowing the children the opportunity to become a part of the process, helps children to cope much more effectively.

Throughout my career, I have witnessed the impact that therapeutic interventions and legacy building pieces have on the families of a loved one who has died. I have created a program at the Indiana Organ Procurement Organization (IOPO) called "Healing Hearts Through Art," which focuses on meeting the therapeutic, expressive, and bereavement needs of donor families. IOPO has a well-established bereavement program and the "Healing Hearts Through Art" program is geared towards serving the emotional needs of children.

"Healing Hearts Through Art" has three components. The first is for families of pediatric donors. Our program uses Model Magic to create hand molds to help memorialize the legacy of the organ donor. Many family members find it therapeutic to assist in the creation of the hand mold.

The second component is creating an ink handprint for all donor families. We use a variety of colors so that families are able to select the color that they feel best describes their loved one's personality and preferences. The ink handprint is pressed onto cardstock alongside a poem entitled "Afterglow," an inspirational poem about life, death, and remembrance. We encourage families to be involved in the creation of the prints as they are comfortable doing so.

Finally, we help families to create a legacy bead jewelry item or key chain. Each Family Services Coordinator carries a variety of beading supplies to use with teenage and school age children, allowing them to express feelings about their loved one by sharing memories and stories of their loved one's life through the use of beads.

AFTER GLOW

I'd like the memory of me
To be a happy one.
I'd like to leave an afterglow
Of smiles when day is done.

I'd like to leave an echo
Whispering softly down the ways,
Of happy times and laughing times
And bright and summer days.

I'd like the tears of those who grieve
To dry before the sun
Of happy memories I leave
Behind - when day is done.

— Helen Lowrie Marshall
Close to the Heart (1958)

With all of the clinical complexities that go along with donation, the "Healing Hearts Through Art" program provides a component of humanity, compassion, and legacy building to the donation process. As one family member shared, "Whenever I feel sad or miss my baby, I pick up the hand mold that you created for us and I touch the place where her hand was. I can see the creases that were in her tiny hands and can almost feel the way her sweet hands felt."

Organ, tissue, and eye donation has the ability to change lives in a very unique way, for both donor and recipient families. As a child life specialist in the organ donation services setting, I hope to continue to enhance the lives of children and donor families through educational interventions regarding the benefits and process of donation, therapeutic and expressive play and legacy interventions, and psychosocial support for family members.

REFERENCES

Donate Life America. (2013, June 19). Statistics. Retrieved from http://donatelife.net/understanding-donation/statistics/


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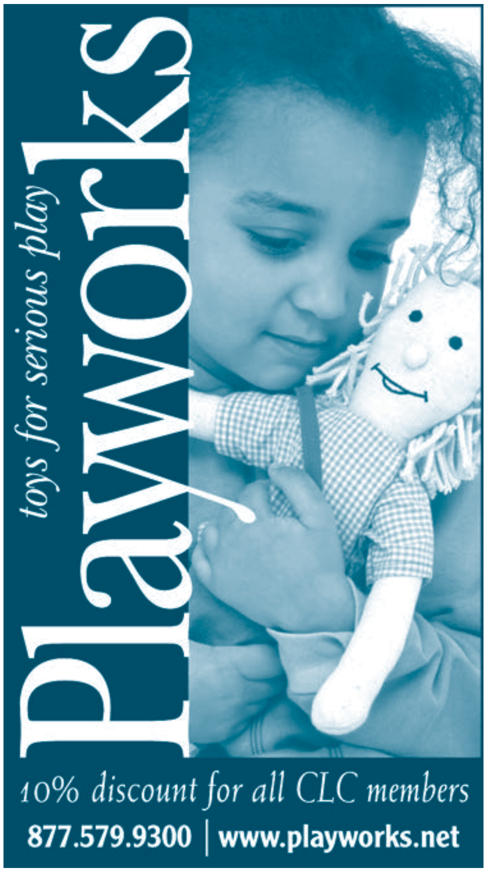
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VOLUME 31 • NUMBER 4 FALL 2013

CLC Calendar

OCTOBER

1	Deadline for *Bulletin* and *Focus* articles for consideration for the Winter 2014 issue
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	CLC 32nd Annual Conference Sponsorship Deadline for inclusion in the Conference Program
1-15	Child Life Professional Certification Exam administration testing window
7-10	CLC Board of Directors meeting

DECEMBER

31	Last day to reinstate lapsed CCLS credential

JANUARY 2014

1-31	Start planning your *Child Life Month* events and activities for March!
1	Deadline for *Bulletin* and *Focus* articles for consideration for the Spring 2014 issue
31	Deadline for applications for the March 2014 computer-based Certification Exam administration (January 15 for those educated outside of the US or Canada)

Upcoming Events

October 7, 2013
NECLP, Inc. Annual Conference
Hosted by the New England Child Life Professionals, Inc.
Hole in the Wall Gang Camp, Ashford, CT
Contact: Rachel Alley, Rachel.alley@bhs.org
or 413.210.5609

October 12, 2013
Child Life Conference: Work Hard Play Harder
Children's Hospital of The King's Daughters, Norfolk, VA
Contact: Chelsea Shepherd, chelsea.shepherd@chkd.org
or 757.668.7994

October 14-16, 2013
11th Annual Child Life Directors Networking Retreat and Conference
Camelback Inn Marriott Resort and Spa, Scottsdale, AZ
Contact: Chris Brown, brownchristina951@gmail.com
or 512-466-1174

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

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