You know, sometimes I think the motto of this hospital should be ‘hurry up and wait’!” The patient’s comment came as we moved into our second hour of waiting in the ultrasound holding room. I wasn’t compelled to argue with her assessment. Hospitals require patience—ask anyone who has ever spent time in a health care facility.

For patients and families, hospital stays are characterized by long periods of downtime between doctors’ visits, procedures, tests, and most importantly, results. As they wait for answers, tension and anxiety can foster uncertainty, leaving families feeling helpless. Research has indicated that periods of wait before procedures, particularly procedures that are painful or invasive, provide opportunities for patients to obsess over every possible complication they may face (Cohen, Fiske, & Newton, 2000). If the imagination is left to run wild during these high-stress times, eventually even the worst case scenario seems not only possible, but inevitable.

Luckily, the presence of social support during waiting periods can decrease fear and anxiety (Lien, Lin, Kuo, & Chen, 2009). While long intervals waiting for answers are predictably stressful for patients, these times often present opportunities for child life specialists to develop rapport and provide meaningful interventions.

Instead of staring down the clock, participation in guided imagery, expressive activities, and open play sessions, beyond simply filling time, can empower families to take back control of their circumstances (Kaminski, Pellino, & Wish, 2010). When we accept these periods of wait as unavoidable and focus our attentions instead on using the time productively, we work to remove the element of helplessness, and build something stronger instead: resiliency.

The criteria for the Distinguished Service Award include professional experience, integrity, leadership, vision, and overall contributions to the child life profession and CLC. Dr. Jessee’s career accomplishments in each of these areas have been outstanding.

Peggy’s introduction to child life began in 1978 with a short item she read in Parade Magazine, which described the concept of child life and mentioned a conference in Toronto. Her interest was piqued, and she attended the meeting. Although she has few specific memories of the conference, she says, “I know I went to all of the sessions and loved each one.” She discovered that child life connected several of her interests: hands-on learning, child development, and the health care of children.

The old joke goes, “What does love mean to a tennis player?” The answer is … nothing. Though “love” may mean zero in a tennis score, if the tennis player is Dr. Peggy Jessee, love means a long and distinguished career in child life. The Child Life Council (CLC) Board of Directors has selected Peggy Jessee, MS, PhD, CCLS, to receive the 2014 Distinguished Service Award at the 32nd Annual Conference on Professional Issues in New Orleans, Louisiana.

The Child Life Alphabet

W is for Waiting

Bethany L. Fisackerly, MS, CCLS, Baptist Children’s Hospital, Miami, FL

Book Review: Children’s Bereavement Resources: Ideas for a Small Collection

Teaching Infant Massage Beyond the NICU

CLC to Host International Summit

Research Corner: Reflecting on the Past to Cultivate the Future of Research in Child Life

In Focus: Japanese Parents’ Perceptions About Children’s Medical Play

Is a PhD Right for Me? A Conversation with Child Life Specialists in Doctoral Programs

2014 Distinguished Service Award Honors Peggy Jessee’s Illustrious Career

Randall McKeeman, MSEd, CCLS, Mayo Eugenio Litta Children’s Hospital, Rochester, MN

“...
Staying on the Front End of Change

Amy Bullock Morse, MSEd, CCLS

I was recently speaking with a colleague about the changing paradigm in health care and the ways that varied medical models across the globe have influenced one another. Suggesting that mental health was in a precocious position given the Affordable Care Act, he asked, “How will child life adjust to the changes in health care?” My response was simple: Stay on the front end of change. Child life specialists have been advocating for children and families for years. We’re now presented with an opportunity to translate our services into language consistent with emerging health care trends.

Our profession was built on the pioneering efforts of individuals who observed the way children were treated in medical settings and identified ways to provide higher quality care. Our challenges today parallel those of our founders. Historically, child life challenged organizational perspectives on pediatric care, making a strong case for the positive and long-term implications of visitation with family and access to developmentally appropriate play opportunities. By supporting parent-child attachment and crafting developmentally appropriate strategies to empower children to manage stressful medical encounters, child life specialists contributed to a patient-centered philosophy in support of the whole child and family. Today, child life specialists work to advance quality care delivery and build a body of research that reflects the efficacy of family engagement and play-based interventions.

Psychosocial models of care are a welcomed resource if they can be linked to measurable outcomes. Anyone working in health care today understands the value that organizations place on quality and efficiency. This begs the question of how to measure services impacted by so many contextual factors in health care systems. How do we prove that age-appropriate preparation reduces pre-procedural anxiety and therefore leads to fewer pharmacological interventions and reduced cost? In what way do factors such as temperament, development, previous medical experiences, or caregiver responses interact with psychosocial methods? As clinicians, we understand the weight of varied contextual factors. We observe positive behavioral outcomes associated with procedural preparation and therapeutic play. We continually seek opportunities to empower patients and families to express their values and engage as partners in care. While we know clinically that child life interventions contribute to self-efficacy, emotional resilience, compliance, and health, we are faced with a growing demand for measurable outcomes that directly influence quality, productivity, and cost savings.

How do we stay on the front end of change? I’d suggest that by identifying emerging trends in health care and thinking progressively about the ways that child life services are characterized, we may position ourselves not only as essential providers of psychosocial care, but also as agents of change in health care delivery. Take the emerging discipline of health care advocacy, for example. The discipline includes professionals such as patient advocates, patient liaisons, and patient representatives and encompasses services ranging from complaints with legal ramifications to advocacy around end-of-life issues. As child life specialists, advocacy is a part of our daily treatment planning. We collaborate to provide treatment delivery that is consistent with a child’s developmental needs and familial values. I believe child life has an opportunity to demonstrate the ways in which our advocacy strategies positively impact global health outcomes.

While I’ve focused on broad themes for the profession, you may now be wondering what all of this means for a child life specialist. Staying on the front end of change requires participation and engagement from each member of the child life community. As professionals, when we want to succeed, we thoughtfully develop our strategy and prepare ourselves for divergent perspectives. Staying on the front end of change means collaborating with interdisciplinary colleagues to submit a case study for publication, presenting performance improvement outcomes, contributing to empirical research, and familiarizing yourself with local and national policies that impact the psychosocial care of children. Collectively, child life specialists have hundreds of years of experience advocating for children and families in ways that are consistent with developmental, familial, and cultural priorities. We are talented experts on therapeutic play, consistently seeking innovative opportunities to promote coping, attachment, and emotional resilience. Let’s harness these talents and demonstrate how child life specialists progressively deliver high quality care for children and families. Let’s demonstrate how child life remains on the front end of change.
FROM THE EXECUTIVE EDITOR

Providing and Documenting Professional Growth Opportunities
Jaime Bruce Holliman, MA, CCLS

During my tenure as a member of the Focus Review Board (FRB) and Bulletin editorial team, I have had a front row seat to our growth and development as a publication and CLC as an organization. One of our most exceptional aspects has been the recognition, growth, and contributions of our members abroad. In this issue you will find information about CLC’s upcoming International Summit, just one of the many exciting opportunities to share in the triumphs and challenges of advocating for children in hospitals across the globe. To further highlight international contributions to CLC, the FRB editorial team is pleased to feature the work of a child life specialist from Japan, Toshiko Nonaka. Her work on the care of children and families in her native country is presented as the Focus Focus Review.

Children’s Bereavement Resources: Ideas for a Small Collection
Carrie Potter, MS, CCLS, Kosair Children’s Hospital, Louisville, KY; Member, CLC Professional Resources Committee

Some child life specialists consistently work with children and families who are experiencing the death of a loved one, and, as a result, have collected a wide range of therapeutic and educational books that they use to help explain concepts or explore emotions. For other child life specialists, books related to death and dying may be an infrequent—although still important—need. Books can provide a tool to begin a discussion with a child who is dying or experiencing the death of a loved one. Since it is important to choose a book that meets the individual needs of the intended reader, a child life specialist’s book collection must include books appropriate for a variety of developmental and coping needs. For a child life specialist looking to keep a small selection of books on hand, the six reviewed here provide enough variety to help almost any child or family start the process of coping with their grief.

The Next Place, by Warren Hanson (1997), is an illustrated poem that explores the possibilities of where a person goes after they die. Without specifying heaven, the book discusses leaving earth behind and going where there are no more hurts and where the only things carried are the love and memories of loved ones. This book is beneficial to adults and children of all ages and could be used with children who are dying or with siblings or children of patients who have experienced the death of a loved one. For other child life specialists, they use to help explain concepts or explore possibilities of where a person goes after they die. Without specifying heaven, the book discusses leaving earth behind and going where there are no more hurts and where the only things carried are the love and memories of loved ones. This book is beneficial to adults and children of all ages and could be used with children who are dying or with siblings or children of patients who have experienced the death of a loved one.

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To contact a Board member, please visit the CLC Member Directory at http://www.childlife.org/Membership/MemberDirectory.cfm.
FROM THE EXECUTIVE DIRECTOR

CLC Member Survey: Listening to You
Dennis Reynolds, MA, CAE

Last fall, CLC conducted a general membership survey, asking all members about your use of CLC programs and services and the issues you saw as of foremost importance for the child life profession. Full results of this survey can be found in the CLC Official Documents & Resources section of the File Library in CLC Community. I would like to review some of those results here.

Why Be a Member … and Who Pays?

Members were asked about factors in their decision to join CLC or renew their membership. Based on a rating scale where 5.00 was the highest attainable rating, the following were rated as the most important:

- Professional development and educational opportunities: 4.47
- Staying informed about issues facing the child life profession: 4.39
- Access to CLC programs, products, and services: 4.24
- Membership is a professional responsibility: 4.18
- Interaction/networking with other child life professionals: 4.01

When asked who paid members’ annual membership fees, a huge 87% reported that they paid their own dues; 12% reported that their workplace paid their dues.

CLC Programs and Services

A key question on the survey asked members to rate the usefulness of each of CLC’s 16 programs and services, again using a 5-point scale. The two top-rated features were online certification management (4.55) and online membership management (4.42). After these two, the other most highly rated services were as follows:

- Annual Conference: 4.18
- Webinars: 4.13
- Bulletin: 4.10
- Forums: 4.08
- Child Life News Monthly: 3.92
- Online Resource Library: 3.78
- Online Directory of CL Programs: 3.74
- CLC Notes/News Flashes: 3.72

Members reported similar patterns when asked about their use of the CLC website, with 84% reporting using it to track their certification, and 74% using it for membership management. The next highest member uses of the website were for CLC Annual Conference information (64%), webinars (63%), and for access to CLC Community (60%).

A relatively low number of CLC members reported using CLC social media sites for information or networking. The most-often visited CLC social media site was our Pinterest site (30%), which is the newest among our various social media outlets. Next highest was the CLC Facebook page (25%), followed by YouTube (15%), LinkedIn (13%), and Twitter (8%).

CLC Bulletin

The Bulletin was the focus of a number of questions; following are some of the results:

- 19% of members read the Bulletin cover-to-cover; 29% read most articles; and 40% scan and read articles of the greatest interest to them; only 8% indicated that they only read a single article or two occasionally, and only 4% indicate that they never or rarely read anything in the Bulletin.
- When asked about the possibility of CLC publishing the Bulletin only in electronic format, 20% indicated being strongly in favor, 44% indicated it would be fine with them, 27% indicated they would still prefer to receive a print copy, and the remainder indicated no preference.
- If Bulletin was to publish online bonus content to supplement the printed version, 22% of members indicated they would routinely go online to read the online-only material; 50% said they would go online depending on the specific articles; and 28% said they would not likely go online to read additional content.
- When asked what kind of content they would like to see more of in the Bulletin, 74% indicated they would like to see more pieces by child life specialists who use their skills in innovative settings; 67% would like to see more research articles; 55% would like to see more updates on CLC programs and services; and 53% would like to see more progress reports on CLC strategic initiatives affecting the child life profession.

Issues Most Affecting Child Life Specialists and the Profession

The survey asked members to indicate the three professional issues most important to them as individual child life specialists, and the three issues most important to the child life profession as a whole. This was an open-ended question; CLC staff looked through the answers and categorized them, and the most prevalent answers are reported below. (Percentages add up to greater than 100%, since members could specify up to three responses.)

The most important professional issues affecting individual respondents were:

- Enhancing personal skills/professional development and growth: 22%
- Salary and compensation: 19%
- Lack of respect and awareness of the child life profession: 17%
- Job opportunities and job security: 15%
- Funding for their child life department: 15%
- Lack of EBP/research resources: 15%

Many of the same issues dominated the responses to the question asking about major issues facing the profession as a whole:

continued on page 11
like many others, I came to learn about providing infant massage instruction while exploring additional skill-building opportunities for child life specialists. Discovering some of the benefits of infant massage was enough of a catalyst for me to seek certification, both to enhance my skills, and to provide our child life department with a unique way to provide services in our neonatal intensive care unit. After becoming certified in infant massage instruction, I started implementing it in monthly group workshops and individual sessions in the NICU. Soon, however, when my position at the hospital changed and I became an outpatient child life specialist, I struggled to find ways to implement massage education into the different clinics from which I received referrals. Twelve months later, I’ve been able to incorporate infant massage education in some unique ways in every clinical area I’ve served.

In August 2012, I began providing services in a pediatric primary care clinic serving children from birth to 18 years for well- and urgent-care visits. It was important for me to find a way to engage with new and seasoned parents even if the family was not experiencing a traumatic life event. I realized that caregivers and their infants often had a long wait time in the clinic, and I wanted to make that time useful for building rapport and providing some infant development education in a non-threatening way. Based on my previous experiences, I strongly felt that infant massage instruction would be a great way to do just that. I made copies of my infant massage materials, created a basic handout on infant massage, and obtained a donation for a continuous supply of knitted infant items. As most infants are scheduled in the earlier hours of the clinic, I set aside an hour a week to sit in the waiting room with my plastic baby dolls and teach infant massage to caregivers. At the end of each 10 to 15 minute intervention, I supplied caregivers with a copy of the massage strokes they had learned, the handout on infant massage, and a knitted item. I kept careful statistics on which caregivers I saw and which strokes they liked the best. Many of the mothers from the clinic lived together in an adolescent maternity residence, which reached out to our clinic to see if we could lead educational workshops for the mothers. Since the mothers were responsive to infant massage education in the clinic, I proposed making site visits to the home and leading infant massage groups. Every other week for approximately four months, I visited the mothers at their home, where we spent time practicing infant massage as a group on their babies and also conversing on other topics such as parenting styles, support systems, and developmentally appropriate toys and games for infants.

I also became involved in the pediatric neurological surgery clinic and really wasn’t expecting to incorporate infant massage into my services there. However, one day I was speaking with a caregiver whose infant had plagiocephaly (flat head syndrome), the incidence of which has risen partly due to the American Academy of Pediatrics’ recommendation that infants sleep on their backs (Turk, McCarthy, Thorne, & Wisoff, 1996). The doctor had recommended that the caregivers try to increase the amount of “tummy time” so the baby’s head wouldn’t always be touching a surface. The caregivers mentioned that this may be a hard feat for their infant because she did not respond well to tummy time. So it was logical for me to suggest infant massage as a way to help the baby move around.

Teaching Infant Massage Beyond the NICU
Laura Romeo Sobel, MS, CCLS, CIMI, NewYork-Presbyterian Hospital/Weill Cornell Medical Center

continued on page 8
died. Reading *The Next Place* can provide an opportunity to discuss personal beliefs or be employed as a legacy item by placing the handprints of a loved one on the vellum page at the front prior to their death. This book does not offer concrete explanations of death and dying and can be used after a death occurs, in anticipation of someone close to a child dying, or with a child who is dying. Death and funeral rites are explained using simple and direct explanations and language, and emotions that a child might experience are normalized throughout. The book contains prompts, separated from the text, for the adult reading the book to use in conversations in order to enhance the application of the book to the child’s experiences. The text of the book is only twenty-one pages and there are few words on each page, making it a reasonable length to read all the way through with a young child. Even so, the book is organized in such a way that reading smaller snippets and then putting it away could easily be done.

*When Dinosaurs Die: A Guide to Understanding Death*, by Laurie Krasny Brown (1998), is a picture book designed for young school-aged children who have experienced or are preparing for a loved one’s death. This book explores how death is different for each person. The author explores different causes, feelings, and ways of grieving, using clear and easily understood language. In addition to the basic text, the dinosaurs have thought bubble conversations to provide clarity and answer additional questions. The book has suggestions for coping with feelings and also discusses funeral and religious customs surrounding death, continuing the book’s theme that people do things differently.

*When Someone Very Special Dies: Children Can Learn to Cope with Grief*, by Marge Heegaard (1988,) is a guided journal geared towards children ages 6 to 12 who have experienced a death. The instructions in the beginning of the book suggest that it be used once a week for six weeks, but it can be used more or less often depending on an individual’s grief process. This book blends the exploration and validation of feelings of grief with explanations of basic concepts of death and the variety of beliefs about death that exist in different cultures and religions. The open-ended nature of this book makes it flexible for use with people of many different belief systems, as they can personalize it through their writing and illustrating. There are a wide variety of feelings explored, including sadness, anger, happiness, and fear, followed up with pages to encourage additional outlets for coping with those feelings, as well as suggestions for additional reading. It is important in using this book to make sure that an adult is engaged in the process of completing this book with the child.

*Fire in My Heart, Ice in My Veins*, by Enid Samuel-Trainisman (1992), is a guided journal for teenagers experiencing a loss. The introduction encourages the reader to use the book on their own terms: as frequently or infrequently as the teenager likes, and with or without parameters on the amount they have to write. The introduction also establishes that it is okay for the journal to be private and that there is no right way to feel. Throughout the prompts are quotes from teens who have experienced a loss. In addition to exploring feelings, this journal encourages activities that promote emotional expression like music, art, and poetry. There are places to write memories about the life of the person who died and their funeral or memorial service. One of the most unique parts of this book is the section on unfinished business, which contains a variety of prompts about wishes and things left unresolved that might assist a teen in finding closure after someone has died.

*Tear Soup: A Recipe for Healing After Loss*, by Pat Schwiebert and Chuck DeKlyen (1999), creates a metaphor for the bereavement process, comparing grief to making soup. A description of the ways different people grieve and what might be involved are represented by the recipes and soup-making process. The metaphor is too complex for younger children but would be appropriate for adults and adolescents, as well as some older school-aged children. Although this book is meant for someone who has already experienced a loss, it is also appropriate for someone who is close to a grieving person, as it provides insight into how different people might experience grief. This book portrays grief and loss as highly individual processes, which makes it useful to a wide audience. There is an excellent compilation of tips and resources at the end of the book for those who need additional support and help.

While these books are not the only ones that a child life specialist might find useful, they are resources that can meet a variety of developmental and coping needs and would be a welcome addition to most child life specialists’ bookshelves.

**References**


Opinions expressed about the books reviewed in Bulletin are those of the individual reviewer, and do not reflect endorsement by the Child Life Council.
Japanese Parents’ Perceptions About Children’s Medical Play

Toshiko Nonaka, MS, CCLS, The Mount Sinai Kravis Children’s Hospital, New York, NY

Child life programs have developed in health care settings in North America to meet the psychosocial needs of children and teens during medical experiences. In recent years, child life programs have been rapidly expanding to countries such as Kuwait, Japan, Singapore, and the Philippines (Child Life Council, 2012). One of the countries that is embracing child life is Japan. The first Japanese child life program started in 1999, and currently 25 programs are in operation (M. Ohashi, personal communication, February 10, 2012).

The growing number of child life programs in Japan may indicate the acceptance of play-based support programming for children in health care settings. Medical play, which relates to children’s health care experience, is often used as an intervention. There is a limited field of research indicating how parents feel about medical play with their hospitalized children. Child life specialists in this growing field may find it useful to know more about Japanese parents’ beliefs regarding the role of play in influencing children’s development and well-being in healthcare settings. Knowledge about parent beliefs may help health care practitioners adapt their practices in culturally-specific ways. Parents’ beliefs about play have been found to vary across cultures and to influence their involvement in their children’s play (Damast, Tamis-LeMonda & Bornstein, 1996; Parmar, Harkness & Super, 2004). The current study examined Japanese parents’ views and opinions regarding the effects of medical play on child development.

Research indicates that adults’ assumptions and beliefs about children’s development are culture-bound (Parmar et al., 2004). Moreover, adults’ assumptions are related to the ways they manage play and children’s play behaviors (Parmar et al., 2004; Parham, 2004). After reanalyzing children’s play data from the Six Cultures study, Edwards (2000) argued that cultural norms and opportunities influenced children’s play through their influence on parents’ beliefs about whether play is a good use of children’s time and whether adults should encourage work versus play. Parents’ perspectives about children’s play in Japan have not been frequently explored in research (Imaizumi, 2012). However, one toy company’s survey about parents’ beliefs demonstrated that many Japanese parents of young children thought play was “very important” for children’s development (BorneLund, 2012).

Research on the childrearing ideas of professional caregivers in Japan is also instructive. Tobin, Hsueh, and Karasawa (2009) demonstrated through a cross-cultural ethnographic study of preschools in China, Japan, and the U.S. how adults’ beliefs about child development and human nature dictate preschool routines, including how and when play occurs. Interviews with early childhood educators and other informants in Japan indicated that they prioritized social and emotional development over academic preparation in preschool programming, and that they believed that play opportunities in groups are more valuable than individual activities. In order to promote children’s social problem-solving skills, teachers were less involved in children’s conflicts and class sizes were larger than in the U.S. Unstructured play was greatly encouraged. Although the study has its limitations in that it did not include all the variations of preschool programming in Japan, it suggests that professional caregivers’ beliefs about children’s play have an important role in determining how they set up environments to facilitate certain types of play.

Past research has thus revealed that parents’ and professionals’ beliefs about play reflect their culture and experiences. The present study was designed to explore beliefs about children’s medical play among parents in Japan. Child life programming is still new in Japan and Japanese parents’ views about medical play in health care settings have not been examined. The results of this study may suggest ways to support parents’ understanding of the benefits of play opportunities in health care settings.

Abstract

Japanese parents’ beliefs about medical play, one form of therapeutic play in healthcare settings, were examined. Mothers of 2- to 5-year-old children were recruited and asked to answer yes/no and open-ended questions about two medical play scenarios as well as questions regarding normative play among young children. Qualitative content analysis was used in analyzing the data. The results revealed that mothers thought normative play is helpful for young children’s learning and development. It was common for parents to believe that medical play is not helpful because it reminds children of negative feelings such as pain and fear related to immunization. Cultural implications regarding mothers’ answers and the limitations of the study are discussed.
Adults’ Understanding of and Participation in Children’s Play in Health Care Settings

Child life professionals emphasize the use of activities and therapeutic play that help children master developmental milestones and cope with critical life events such as hospitalizations (Koller, 2008; Oremland & Oremland, 2000). Nevertheless, Jesse and Gaynard (2009) observed that adults in North America “often view children’s play in traumatic situations as inappropriate or unnecessary” (p.136). Lane and Mistrett (2004) similarly note that some parents and caregivers may unconsciously create barriers to play due to their concerns about safety; their perceptions of their child’s disabilities, illnesses, or injuries; or their lack of experience in playing with children with disabilities or health care needs. Kielhofner, Barris, Bauer, Schoestock, and Walker (1983) observed that when engaging in play with their children in the hospital, parents were less comfortable and not as spontaneous as they were at home. This phenomenon might also be common in Japan.

Despite the fact that many parents seem uncomfortable with their children’s play in the hospital, it has been suggested that parental involvement in children’s play in medical settings may have a positive effect on children. Tisza, Hurwitz, and Angoff (1970) found that adults’ presence helped to change children’s affect and increase the complexity of their play during the first three days of hospitalization. In another study in the hospital setting, the developmental level of children’s play was greater when adult caregivers were participating than when they were present but passive (Kielhofner et al., 1983). However, the effects of parental involvement specifically during medical play have not been explored. Though it is usually recommended that trained professionals facilitate this type of play so that they can react to children’s needs, professionals are encouraged to have parents’ approval about engaging children in medical play, which helps children to participate comfortably (Petrillo & Sanger, 1980).

In a rare study exploring Japanese parents’ points of view on children’s general play opportunities in health care settings, Murata and Fujiwara (2009) asked Japanese parents whose preschool-age children have experienced hospitalization about their impressions about children’s general play and experience in the hospitals. They did not ask about medical play. Responses revealed parents’ strong support for normative play and activities during hospitalization. Parents expressed concerns regarding the lack of opportunities for young hospitalized children to interact with their peers and play like healthy children. They also voiced their needs for psychosocial support for both children’s and parents’ emotional wellness (Murata & Fujiwara, 2009).

The increasing use of play and medical play might have an influence on parents’ opinions. So that Japanese professionals can support parents’ understanding and involvement in play and care for children in healthcare settings, it would be helpful for medical professionals to know more about Japanese parents’ overall beliefs about the effects of play on child emotional well-being in health care settings. The current study explored such ideas among Japanese parents.

Method Participants

Japanese parents of 2 to 5-year-old children were recruited through five online social network parent support groups and through flyers distributed to parents of children in two child care centers. A Japanese social networking site, mixi, hosts many parent community groups. Five of them were randomly chosen: 1) Kosodate wo toushite seichosuru oya no kai (the group of parents who learn through childrearing, 18,129 members), 2) Funabashi de kosodate (the group of parents in Funabashi city, 1,876 members), 3) Yashiro de kosodate (the group of parents in Yashiro city, 289 members), 4) Kobe, Higashinada, Hyogo ku, Kosodate no kai (In Kobe, Higashinada, & Hyogo area, a group of parents, 1577 members), and 5) Wako de kosodate (the group of parents in Wako city, 797 members). The social networking site company, mixi, Inc. was contacted regarding the study, and they did not object as long as their rules and guidelines were followed. The permission of the five groups’ organizers were also obtained. A link to the survey and the purpose of the study were posted on these five parent support groups’ bulletin boards to introduce the study.

Flyers about the study were distributed to parents of children who were enrolled in Notre Dame Seishin Daigaku Yochien (Notre Dame Seishin University-affiliated preschool) and Kosui Hoikuen (Kosui childcare center). The number of children age three to five at Notre Dame Seishin Yochien was approximately 160. The number of children age two to five at Kosui Hoikuen was about 100.

A total of thirty-four parents responded to the survey. Twenty-six Japanese mothers who had at least one child aged 2 to 5 years old (M = 3.6, SD = 1.12) answered the questions completely or partially. Six mothers’ and two fathers’ answers were excluded from the data analysis because they did not answer key questions (scenario 1, 2 and question 3). The mothers’ ages ranged from 27 to 42 (M = 32.84, SD = 3.74). The majority of participants (n = 21; 80.8%) graduated...
from a college or university. Three mothers graduated from high school, one graduated from middle school, and another did not specify educational background. Half of the children of participating mothers attended part-day preschool programs (Yochien), whereas 34.6% of children attended full-day child care programs (Hoikuen). Six children of participating mothers had experienced hospitalization in the past. Most of the mothers ($n = 21; 80.8\%$) learned about the survey through the social networking site mixi, and 5 mothers were recruited through preschool and child care programs.

**Procedures**

When participants went to the survey website on SurveyMonkey, they first saw the purpose of the study. This statement explained that their answers would be collected in order to better understand parents’ thoughts on play in healthcare settings. The survey was open for four weeks. Parents of children aged 2 to 5 who decided to participate in the study accessed the questions by clicking a link on this page. They answered the questions by checking off survey boxes and writing their answers to open-ended questions. All information for parents, including all questions, was translated to Japanese and then back-translated to English to see the consistency of content across the two languages. The back-translator was a Japanese certified child life specialist who is fluent in both Japanese and English and lives in the United States. Japanese translation was corrected until no difference was found by back-translation.

Respondents’ ages, their children’s ages, their relationship to the child, their education, child care arrangements, the child’s experience of hospitalization, and how they learned about the study were collected. Following the demographic questions, two specific scenarios, each describing a medical play idea for children with health care needs, were presented. Two questions about the value of play in those scenarios, as well as one about the value of play in general, followed. Respondents were encouraged to express all of their thoughts.

The first medical-play-related scenario and questions were as follows: “Shiho is a 4-year-old girl who fell and broke her leg yesterday. She got a cast on her left leg and needs to be in the hospital for another 3 days. She is scared, but her pain is under control. One of her nurses would like to help her by creating a cast on her doll with small casting materials and then letting her play with the doll. What do you think about this idea? Do you think it is a good idea for Shiho to play with the doll that has a cast and why?” Participants were asked to choose either “yes,” “no,” or “I don’t know.” They were also encouraged to provide their reason for thinking so.

The second scenario involved immunization. The scenario and the question were as follows: “Kenji is a 5-year-old boy. Today, he will get an immunization shot at his doctor’s office. About a couple months ago, he had a flu shot and he remembers that it hurt and he cried. The nursing staff at the doctor’s office is planning to play with him with a doll and a needleless syringe before the next immunization so that he will be more comfortable with it. What do you think about this idea? Do you think it would be helpful for him?” The participants again were able to choose their answers from “yes,” “no,” or “I don’t know.” There was a space for respondents to explain their reasoning.

The final question targeted parents’ general beliefs about play. It posed a question, “Does play contribute to young children’s development? Why?” For the first of these questions, participants chose from “yes,” “no,” or “I don’t know.” The question “why?” asked parents to provide their reasons for their answers.

**Analysis**

The responses of parents were analyzed using a qualitative content analysis process.
created, which was called “the reversed role, taking care of the doll, helps child understand the situation better.”

Finally, such overarching categories within the same answer were compared with each other to see if they made sense together as a theme. One group of mothers mentioned that “the doll in the same situation as the girl would help her understand,” which became a category. When combined with the other category mentioned above, a theme, “playing with the doll will facilitate children’s understanding of their own situation and treatment,” was formed. Some categories didn’t create larger categories, such as mothers’ answers supporting medical play with the doll and reasoning that “the doll can make the girl feel she is not alone.” All the responses from Japanese mothers, codes, subcategories, and categories were read and checked by a Japanese certified child life specialist to see whether these items were appropriately sorted and made sense as categories. Disagreements were resolved by discussion.

**Results**

**Question 1: Scenario 1**

The mothers expressed mixed opinions regarding the case of the girl with a cast. Twelve mothers (46.2%) checked “Yes, it is a good idea,” thus showing support for the idea of using a doll with a cast (see Figure 1). These mothers wrote that they thought the doll would help children problem-solve to understand the possible causes of their stress. Their responses fell into three categories: (a) the reversed role, taking care of the doll, helps the girl to understand better (n = 5, 19.2%), (b) creating the same situation helps her to understand it better (n = 3, 11.5%), and (c) the doll as a companion (n = 2, 7.7%). The first two categories have in common a theme. One group of mothers mentioned either (a) the possibility that the child would recall the pain and fear associated with the injury (n = 2, 7.7%), or (b) the child would feel uncomfortable about injuring the doll or having a doll with an injury (n = 4, 15.4%). For instance, one mother answered that the girl would not want to heal if she had a doll with the same problem. The other category that emerged was in regard to the appropriateness of using medical equipment for play: A cast is not a toy (n = 2, 7.7%). Another mother didn’t provide her reason.

Five mothers (19.2%) answered that they did not know if it was a good idea for a child to play with a doll with a cast (see Figure 1).

**Question 2: Scenario 2**

In response to Scenario 2, in which medical play related to immunization, two mothers (7.7%) checked “yes, it will be helpful” to the question asking whether or not the medical play with a needleless syringe and a doll would be helpful (see Figure 2). One thought that the play would be helpful for the boy to understand the situation better. Another mother answered based on her own experience when her child was encouraged to use a syringe with her drink; her child has shown less fear after that.

Fourteen mothers answered that this type of play would not be helpful. Nine mothers checked “I don’t know.” Among the mothers who answered either “no” or “I don’t know,” the majority voiced doubts about the effectiveness of medical play with a syringe. These two groups of mothers accounted for 53.8% and 34.6% of the sample, respectively (see Figure 2). Their written responses were analyzed together due to the similar tone of their answers. The responses fell into three categories: (a) not helpful to increase his understanding (n = 4, 15.4%), (b) the play experience would make children know or recall feelings related to the injections (n = 7, 26.9%), and (c) having a doll get a shot would be useless because it would not diminish the pain of the shot (n = 3, 11.5%). Parents who answered that this type of play would not help the boy to further understand the situation reasoned that there is too big a difference between a child’s real experience with shots and a doll’s. Many responses in the second category (about discomfort) highlighted that this type of play might provoke uncomfortable memories or feelings such as fear and pain. Others stated that the pain level of the actual shot would stay the same even if children observed and played with the doll that got a shot.

Seven mothers (26.9%) across the answers added their own ideas about what works to decrease children’s fear and anxiety. This became an additional category: own ideas work better. Two mothers stated the medical play...
might work when facilitated at other times. Four mothers thought explaining to the child the reason to have immunization injections is more effective. For example, a mother wrote “it is rather helpful for a 5-year-old to know why a shot is necessary although it hurts.” Using a book, explaining verbally multiple times, and using a doll that has the illness that the immunization targets were examples of methods mentioned by these mothers.

The issue of appropriateness of medical equipment use in a play session was also brought up in response to this scenario (n = 3, 11.5%). One of three mothers who thought that a syringe was not appropriate for play also commented that using an index finger as a pretend syringe would be a better way to show the child how the doll gets an injection. One mother did not answer at all.

**Question 3: Play**

All 25 mothers answered this question and responded “yes” to the question, “Does play contribute to young children’s development?” The reasons for their positive responses fell into two categories. The first one is observation of learning, and the second is awareness of play’s contribution to one or more developmental domains. In the first category, five mothers (19.2%) emphasized how much children learn from different types of play, but no elaboration was given on what children learn or how the learning helps their development.

The other 20 mothers (76.9%) mentioned one or more developmental domains when discussing how play helps children grow. These can be divided into four subcategories: (a) play promotes cognitive development, (b) play promotes/involve social skills, (c) play promotes physical development, and (d) play promotes emotional development and psychological wellness. Seven mothers mentioned multiple developmental domains within the above subcategories, whereas six responses were limited to a single area of development. Eight mothers mentioned children’s learning and skill related to cognitive development. Seven mothers wrote that social skills are needed for play and will be maximized through play activities. Five mothers commented that play benefits physical growth. Five mothers wrote that play has effects on psychological wellness or emotional development. Among them, three respondents mainly wrote that children’s motivation was increased by play opportunities. One mother who had an experience in health care settings with her child indicated that play had helped her child to sort out feelings brought up through the child’s medical experiences.

The other mothers responded with a variety of beliefs that did not belong to any of the above categories. They conceptualized play as opportunities for children to adapt their previous learning, or to gain stimuli (for development). Another mother did not provide a comment.

**Answers Across Scenarios 1 and 2**

The mothers’ answers across the first and second scenarios were explored to identify whether or not answers were consistent across situations. Mothers who did not support medical play in the first scenario were consistent in that they also did not support it in the second. In contrast, mothers who did support medical play with the first case tended to be inconsistent in that they did not feel this way about medical play regarding an inoculation, as in the second case (see Table 1).

**Children’s Hospitalization and Mothers’ Responses**

Table 2 divides the yes/no responses to Scenarios 1 and 2 by whether or not their children had ever had a hospitalization experience. Mothers with and without experience taking care of their children in the hospital in the past had varied opinions toward medical play. Most mothers were likely to have been present and supportive with their children when they were receiving immunization injections, but it is apparent that most parents did not seem to support the idea of playing with a doll and a syringe regardless of past medical encounters.

**Discussion**

The aim of this study was to gain knowledge about Japanese parents’ opinions regarding medical play in healthcare settings. The mothers who participated in the study expressed various opinions about medical play. Their beliefs are valuable to know because they may be used in the design of

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**Table 1. Consistency of Mother’s Responses to Scenarios 1 and 2**

<table>
<thead>
<tr>
<th>Scenario 2 Immunization</th>
<th>“Yes, it is helpful.”</th>
<th>“No, it is not helpful.”</th>
<th>“I do not know.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes, it is a good idea.”</td>
<td>1 (3.8%)</td>
<td>1 (3.8%)</td>
<td>0</td>
</tr>
<tr>
<td>“No, it is not a good idea.”</td>
<td>5 (19.1%)</td>
<td>5 (19.1%)</td>
<td>4 (15.3%)</td>
</tr>
<tr>
<td>“I do not know.”</td>
<td>6 (22.9%)</td>
<td>2 (7.6%)</td>
<td>1 (3.8%)</td>
</tr>
</tbody>
</table>

**Table 2. Mother’s Responses to Scenarios 1 and 2 by Hospitalization**

<table>
<thead>
<tr>
<th>Scenario 1 Girl with a cast</th>
<th>Mother whose children have been hospitalized (N=6)</th>
<th>Mothers whose children have not been hospitalized (N=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes, it is a good idea.”</td>
<td>2 (33.3%)</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>“No, it is not a good idea.”</td>
<td>4 (66.6%)</td>
<td>5 (25%)</td>
</tr>
<tr>
<td>“I do not know.”</td>
<td>0 (0%)</td>
<td>5 (25%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scenario 2 Immunization</th>
<th>Mother whose children have been hospitalized (N=6)</th>
<th>Mothers whose children have not been hospitalized (N=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Yes, it is helpful.”</td>
<td>1 (16.6%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>“No, it is not helpful.”</td>
<td>1 (16.6%)</td>
<td>13 (65%)</td>
</tr>
<tr>
<td>“I do not know.”</td>
<td>3 (50%)</td>
<td>6 (30%)</td>
</tr>
</tbody>
</table>

**NOTE:** One mother who had a child with hospitalization experience didn’t answer the questions pertaining to Scenario 2.
future research measuring parents’ beliefs regarding the effects of medical play. One of the purposes of this study is to simply learn parents’ current beliefs as a phenomenon. This process will help us in the next step of figuring out trends of their beliefs.

Among the answers from parents, some similarities were found in responses across the two vignettes. Responses to the first medical play scenario, in which a child with a broken leg is offered a doll and casting materials, generally indicated that parents were supportive of the idea that medical play allows children to learn about health care situations. In regards to normative play activities, mothers considered play as opportunities for children to grow and develop their skills as many mothers described benefits for children’s understanding.

The results may indicate many parents seemed to be reluctant or afraid to engage children in medical play when children remember difficult experiences and emotions such as pain and fear. Petrillo and Sanger (1980) pointed out that many parents fear that medical play will stir up children’s feelings. This fear was manifested in some Japanese parents’ responses in the current study. Petrillo and Sanger (1980) proposed that professionals can decrease this fear by explaining clearly that this type of play is a way of helping children lessen fears; for example, explaining how medical play familiarizes children with medical tools and provides children with appropriate ways to cope with their feelings.

Cultural practices and values might also have affected how the mothers responded to these scenarios. Tobin et al. (2009) explained that in Japanese everyday theories of interpersonal communication, it is the listeners’ responsibility to intuit the unexpressed feelings and thoughts of others. They also suggested that children are not particularly encouraged to express feelings at childcare or in preschools. It follows that the mothers in this study might have felt uncomfortable sensing the fear of the children in these stories and showed empathy by saying that they want to avoid children’s reactions to the situations. Secondly, parents might not have thought about emotional expressions through medical play as necessary because emotional expression is not particularly encouraged in Japanese society. The ways Japanese children and adults express and communicate their feelings differ from those in the United States and need to be carefully explored further.

Interestingly, a few parents pointed out that engaging their children in medical play will not be helpful because the physical pain from the injection will remain the same. Their focus may be more on physical pain rather than psychological fear that the injections may cause. Their concerns are valid and both physical and psychological pains need to be addressed for better coping. As a therapeutic intervention, medical play is designed to address psychological coping related to medical experiences. Professionals may need to specifically explain about psychological effects of medical procedures and benefits of play for children’s current and later coping. It is important to note that often child life professionals are able to provide tools to minimize physical pain or perception of pain-related procedures with procedural support, which should be explained to parents as well. Parents could, for example, be informed about comfort positioning or pharmacological pain management options that are available.

Some parents thought medical equipment was not appropriate for children’s play. This was commonly found in the responses to both scenarios, but especially the case regarding the needleless syringe. Parents were concerned that children might misunderstand or misuse the tools, or that the tools cost too much to be used as children’s play materials. The word “play” may have affected their answers. They may have felt medical “play” cannot be a serious session and these medical items are not something to “play” with. Another possible explanation for this response is related to cultural value. Japanese culture embraces a concept of “mottainai,” which is a “sense of regret concerning waste when the intrinsic value of an object or resource is not properly utilized” (Daijirin Japanese Dictionary, 2006). Japanese mothers may have thought medical items have to be used for their original purpose only, and not for children’s play. This opinion is interesting to further investigate. Utilizing toy medical equipment as a substitute may ease their concerns. Furthermore, explaining the safety rules and procedures to which child life programs adhere may reassure parents that medical play with real or toy tools will allow children to manipulate them safely.

Parents’ comments and alternative ideas to help children cope with medical procedures suggest that some parents are willing to support young children who are dealing with health care experiences. Although mothers expressed reluctance about engaging children in medical play, they did recognize that play benefits children’s learning. As mentioned in the literature review, Japanese parents whose preschool-age children have experienced hospitalization revealed their strong support for normative play in health care settings and expressed their needs for emotional support (Murata & Fujiwara, 2009). Parents’ awareness of children’s emotional needs related to health care experience is likely to make them open to explanations about the positive effects of medical play.

**Limitations and Directions for Future Research**

One of the reasons that mothers were not supportive of medical play might be connected to the content of the scenarios. For this study, two short stories were used as examples of health care play; no extensive reading materials were provided. The described health care situations and the types of medical play in the vignettes (utilizing a doll and medical equipment to engage children in pretend play) were relatively specific, but not detailed enough to explain possible variations in types of medical play, the ways they are facilitated, the different timings of play, or the ways professionals respond to children’s play and feelings.

Along the same lines, the storylines or wordings of the scenarios could have affected some responses. For example, some emotional expressions, such as “sad” and “cried,” were mentioned in the stories; however, the ways these feelings and responses will be taken care of by a facilitator were not mentioned. Medical play is usually carefully facilitated by trained professionals who can respond to children’s feelings in appropriate ways, encourage children to find effective coping strategies, and support the process of understanding. In the second scenario, health care play occurs right before the procedure, but in reality, it could have occurred after the procedure based on the child’s needs and responses. It could also have been combined with other procedural support. The stories did not indicate these important factors. It is important to point out, however, that these short stories might have encouraged mothers to express their own impressions without being influenced by others. Explaining clearly the purpose of medical play and how it will be
facilitated may be the key for parents.

One other limitation of this study is the small number of participants. It is possible that accessing the survey online discouraged many parents from taking part in the study. In 2010, more than 95% of Japanese who are in their 20s and 30s reported that they were able to access the internet in some way (Japanese Ministry of Internal Affairs and Communications, 2010). Since the current study targeted mothers in this age range, it appears that internet access is not one of the obstacles. However, their actual usage of internet was not examined in the above statistic. Many people might have access to the internet; however, an online survey may not have been feasible for busy parents with young children. Though they may sign up on the online support groups and the message boards, it is possible that most rarely check them. It is also possible that a common understanding today that some internet website links are misleading and link to unwanted sites or record personal preferences for marketing reasons might have affected parents’ participation. Parents might have thought the link would be lead to an advertisement and that therefore it was best to avoid such risks by not participating in the study. Finally, there was no incentive offered to participate in the current study.

Mothers’ educational background is also important to note. Eighty percent of the participants mentioned that they are either two- or four-year college graduates, which is higher than average for Japan. About 57% of the population aged between 25 and 34 are graduates of higher education institutions (Organisation for Economic Co-operation and Development, 2012). The mothers with higher education may have been more willing to contribute their opinions on the topic presented or interested in participating in a study. For these reasons, the results should not be overgeneralized.

Many parents did not have children who have been hospitalized in the past, but children’s hospitalization did not seem to impact the responses of mothers in a way that would make them think that medical play would be helpful for the psychosocial needs of children. Most mothers must have experienced helping children cope with immunization injections; however, the responses mainly indicated disagreement with the play opportunity in Scenario 2. This result might have been due to the small sample size; this is something to further examine in the future. One of the mothers whose child had been hospitalized described her observation of her child trying to cope with feelings related to health care experience through play. Parents who have experienced their children’s hospitalization or other stressful life events may be more aware of play’s effects on emotional wellness and development. On the other hand, they may have reasons why they do not believe health care-related play is effective. It would be important to investigate these reasons further.

Parental beliefs are important to study. Damast et al. (1996) found that the more knowledge mothers have about play and development, the more appropriate their interactions during play. The results of the current study showed that Japanese mothers with 2- to 5-year-old children may or may not support medical play depending on the context. When they think that reenacting a medical situation is emotionally upsetting for children, they are less likely to support this activity. On the other hand, the mothers also considered normative play to be a very important part of children’s lives and beneficial for children’s learning. The results illustrate the importance of professionals clearly explaining to parents the purposes of medical play and the ways it will be facilitated with careful attention and support for feelings that might appear in the sessions.

More research is needed to learn further about parents’ perspectives on their children’s medical experiences and medical play. This study is a step forward to better understand parents’ beliefs. The mothers’ responses in the current study are a rich resource to design a new survey to measure parents’ beliefs about medical play, which may convey insight to help us understand parents’ behaviors and wishes. Japanese mothers’ concerns regarding emotional upset during medical play and their ideas about socially appropriate ways to communicate and express feelings may be important to consider in future studies.

REFERENCES


Is a PhD Right for Me? A Conversation with Child Life Specialists in Doctoral Programs

Contributors:
Korie Leigh, MA, CCLS, CT (KL)
Amy Bullock Morse, MSEd, CCLS (AM)
Kathryn A. Cantrell, MA, CCLS (KC)
Cara Sisk, MA, CCLS (CS)
Alison J. Chrisler, MA, CCLS (AC)

Increasing numbers of child life specialists are expressing interest in pursuing advanced degrees at the doctoral level. The Bulletin editorial team was able to connect with five child life specialists who are currently pursuing doctoral degrees in a variety of programs; we have compiled their insights here in hopes that they may be helpful for those contemplating enrolling in a doctoral program.

Q: What inspired you to apply to a doctoral level program?

KL: Having worked as a child life specialist and bereavement counselor for nearly ten years, I was looking to expand my clinical skills as well as contribute to meaningful research on topics that child life professionals often encounter.

KC: My first clinical position was in an HIV clinic at a research hospital, and luckily, research was integrated into our child life program. My supervisor gave me free creative research time to develop my methodological skills (both quantitatively and qualitatively), but also expand my theoretical knowledge. Therefore, obtaining a PhD was the logical choice.

Q: What type of program did you select and why?

AM: I selected a PsyD program so that I could develop an integrated approach to clinical care, while getting some exposure to research. I’m not a statistician by any means!

KL: I chose a clinical psychology (PsyD) program at a transpersonal/spiritual psychology school. The program is student-focused with an emphasis on person-centered, experiential learning. Each class starts with several minutes of mindfulness, and spirituality is integrated into every course. It was incredibly important that I find a school that was aligned with my belief system and allowed for personal growth as well as academic growth.

KC: My doctorate will be in counseling psychology. While I applied to other programs, I noted the clinical piece was missing; this program sets students up with practicums and internships as a psychologist counseling individuals and families, which translates perfectly to child life. Likewise, I felt that my clinical background wouldn’t be sacrificed for my affinity for research. The counseling program is strengths-based and client-centered, not as diagnostic or medical as other segments of psychology. Within this philosophy, expressive therapies are more accepted and my program has embraced my intervention background.

Q: How have you been able to integrate your clinical background into your current coursework and program?

KL: Despite the program being adult-focused, I specialize all my work in adolescents and young adults so that there’s constantly a developmental focus. I look at each assignment as an opportunity to advocate for the field I love.

CS: In many of my courses, I draw upon my knowledge of family-centered care, developmental psychology, and expressive arts when relating to the course material. I have found that even in a class setting I continue to be an advocate for working with children. The lens with which I view children and families is influenced by my child life practice and thus, I have been able to introduce concepts such as preparation, medical play, advocacy, and family-centered care to core faculty and my classmates.

Q: How has your pursuit of a doctoral degree influenced your practice or philosophy of child life?

AM: It has helped me develop a more critical eye for assessment measures that capture children’s cognitive skills and temperament to better understand how these and other contextual factors influence coping strategies and intervention outcomes.

KL: Find out what your research passions are and find the best program that will align with your topic. Having a grounded understanding—continued on page 11
In 1980, Peggy completed her master’s degree in the Department of Human Development and Family Life at the University of Alabama, and was then hired as a research associate and accepted into the doctoral program. Her perspective on the needs of children and families was further honed through her dissertation work in rural Alabama, where she envisioned child life contributing to the well-being of children and families in many different settings.

In her long association with the University of Alabama, Dr. Jessee transitioned from student to teacher. She began her teaching career as an assistant professor, followed by promotions to associate professor, Director of the Child Development Laboratory, and professor. She continues her association with the university as professor emeritus. Peggy was instrumental in developing the University of Alabama’s Child Life Program, beginning her advocacy as a doctoral student, and finding that she had even more leverage once she had completed her degree. “I was lucky enough to have colleagues and department chairs who were willing to listen and to learn,” she says. “The Department of Human Development and Family Studies at The University of Alabama has never been ‘territorial.’ If something seems appropriate for the students, the faculty will support it.”

Through her many years of teaching, advising, and supervising, Peggy has touched the lives of hundreds of students, but teaching was only part of Peggy’s work at Alabama. She conducted research and wrote scores of articles and papers on topics pertaining to child development, play, ethics, and family involvement, and has been published in a variety of journals; her curriculum vita has several pages dedicated to publications alone. Peggy’s work at Alabama also included serving on dissertation committees, master’s committees, and doctoral program planning committees, as well as numerous departmental and university-wide committees.

Dr. Jessee has been a presenter at dozens of conferences from Kyoto to Orlando, from Aukland to Montreal, from Quebec to Krakow. Since 1986, she has made nearly 70 presentations on a variety of topics too numerous to list here. Her soft, but strong voice has shared the message of child life around the globe.

Peggy’s contributions to professional organizations go back to the days of the Association for the Care of Children’s Health when she served as a board member-at-large from 1993 to 1996. She was CLC Certification Chair from 2000 to 2003. She applied her writing and editing skills on the CLC Bulletin Editorial Board from 2003 to 2005, and served in an advisory role with the CLC Bulletin from 2006 to 2008. Peggy served on the CLC Board of Directors as a member-at-large from 2000 to 2004, and says that one of her proudest accomplishments as a CLC volunteer was helping to lead the transition of child life certification from an application process to certification by exam. This was accomplished, she says, through careful planning and preparation – “getting all of our ducks in a row.” She still remembers the hard work and initial resistance to the change.

In December 2000, Dr. Jessee and a colleague published the initial salary survey of child life specialists, making this data available to CLC members for the first time. The survey has been repeated, most recently in 2012, and is now available through a child life salary calculator at www.childlife.org.

Reflecting on her child life mentors and role models, Peggy mentions Dr. Dick Thompson. He “wrote the book,” she says, adding that he was an influential presence at conferences and helped her in her academic career with guidance about tenure and promotion. She appreciated Dick’s academic and practical approaches. Joy Goldberger was another influential colleague, noted for her foundational work on play as it relates to child life and infant and toddler development.

When asked about the challenges facing the child life profession as we move forward, Dr. Jessee speaks at length about the need to have agreement about a standard curriculum for academic programs in child life. “Institutions of higher learning need to move to implement standards as we move toward accreditation,” she says, adding that progress in this effort requires strong advocates for the profession within institutions to push this change.

For future child life leaders, Dr. Jessee recommends that we be clear about our goals and know where we want to go. Then “…go slow, think it through, and educate your champions along the way to make it happen.”

Since her retirement in 2005, Peggy has remained active in academics and as a consultant. She served as an adjunct professor at Appalachian State University in Boone, NC, in 2009 and currently is a member of the adjunct faculty at Western Governors University in Salt Lake City. Internationally, she consults with Kuwait University on their degree program in child life.

When asked about her favorite way to include play in her own life, Peggy reports that she hits the tennis courts approximately four times a week and that her United States Tennis Association team was the runner-up at the state level! She also enjoys gardening and, of course, family time.

To Peggy Jessee, tennis player and child life leader, love is what she has earned for her years of contribution and dedication to the profession of child life. Please celebrate Dr. Peggy Jessee’s contributions at the Distinguished Service Award presentation on Friday, May 23, at the Opening General Session of the 32nd Annual Conference on Professional Issues in New Orleans.

**Milestones**

After more than 32 years of dedication to the profession, Linda L. Jones, Med, CCLS, has recently retired. She was hired as a child life specialist in 1981 at what was then known as the Orlando Regional Medical Center, and has served in various child life capacities (specialist and leader) within the same medical center, now The Arnold Palmer Hospital for Children, for her entire career.

Sandra C. Oberman, M.Ed., CCLS, recently retired as Manager of the Child Life Department at the Medical University of South Carolina Children’s Hospital in Charleston, SC. Sandra established the Child Life program in 1985. She intends to continue to support the hospital through the development board and to promote the new M.S. program in Child Life at the College of Charleston, set to begin this year.
The importance of patience and rapport with families cannot be understated. As child life specialists, we are often the first point of contact for families when they arrive at the hospital. It is our role to provide a warm and inviting environment that fosters respect and trust. By doing so, we can help families feel more comfortable and at ease, which can ultimately lead to better health outcomes for their children.

Child life specialists can also be instrumental in ensuring that families have safe spaces in which to spend delays by advocating for the design of “healing environments” in areas such as waiting rooms and clinics. These environments support the use of warm and inviting colors, comfortable chairs, natural materials such as fish tanks and plants, and appropriate play materials for pediatric patients. These elements help create environments that foster peace and stability (Schweitzer, Gilpin, & Frampton, 2004; Thompson, 2009).

In a practical example, at Baptist Children’s Hospital, we saw a significant improvement in patient satisfaction scores for our emergency department after installing mounted video game systems in the waiting room and providing hourly rounding with families who have had long delays. Designated employees (including child life specialists) answer questions, offer updates on care when appropriate, and provide hospitality items (e.g. food, water, activities) if needed. We have found that sometimes all it takes is having a staff member acknowledge and validate the frustration associated with long hours of waiting to earn a caregiver’s trust and, subsequently, cooperation for the rest of the stay.

On a final note, it is advantageous for all health care professionals to remember that the task of learning patience is not solely the domain of families. As child life specialists, we may find ourselves in periods of “waiting” as well: waiting for patients to feel comfortable participating in the activities we have spent so much time planning; waiting for families to decide we can be trusted with their honest feelings; or waiting for other medical staff to recognize the knowledge and experience we can bring to the table, and thus respect our opinions as colleagues.

No matter how confident one may be with the “tricks of the trade,” there is simply no substitute for time. Knowing when to press forward and when to take a step back, to wait, is a skill that can only be mastered with experience. There are no short cuts. Taking the time to truly assess and identify the needs of those around us (even if it takes longer or requires throwing the “textbook” approach out the window and going with our gut) will ultimately lead to the best outcomes for all involved.

References


Teaching Infant Massage

I used that as an opportunity to teach the caregivers back massage strokes so that they could help soothe their infant while they were on their tummy, hopefully prolonging the time she tolerates it.

And it didn’t stop there. I provide monthly services in a neuro-modulation clinic and have taught infant massage to caregivers of children of all ages and developmental levels who want to help their children relax tight muscles. When covering for the inpatient and pediatric intensive care units, I’ve taught the strokes to caregivers who are feeling helpless and need a way to feel as though they can do something to help their children feel comfortable. Recently, I’ve begun working in our sleep clinic where I plan to teach some caregivers strokes to incorporate into a bedtime routine to help their children fall asleep.

When I was first certified in infant massage, I never thought I would be applying it in so many different ways. However, I’ve learned that teaching it is a wonderful way to introduce myself and the other services I can provide as a child life specialist, build rapport with families, and also really empower caregivers to take an active role in their children’s comfort and development. I used to always carry around my baby doll just in case I needed to do a “spur of the moment” medical play session. Now, I carry it around because I never know when I’m going to need it for infant massage instruction!

References

As a major part of a broad and generous grant from Disney, the Child Life Council is pleased to be able to host an Invitational International Summit on Pediatric Psychosocial Services to be held following the CLC Annual Conference on Professional Issues in New Orleans. Delegates from more than 40 countries worldwide will constitute the summit, and a majority of the delegates will also be attending the Annual Conference.

Delegates will come from six continents, both large countries and small, highly developed and developing. Some are child life specialists, others are hospital play specialists, and still others come from a wide range of backgrounds, including pediatric medicine, psychology, social work, nursing, and others. Delegates will come from health care institutions, universities, foundations, associations, and government agencies. The objectives of the Summit are to initiate a dialogue on the state of pediatric psychosocial care worldwide, create a global network of individuals and organizations dedicated to advancing pediatric psychosocial care, and discuss ways in which knowledge about clinical practices and strategies for promoting pediatric psychosocial care within countries can best be organized and shared.

In addition to keynote presentations, participants will engage in panel presentations and small group discussions on topics such as the role of play and comparative play practices; the relative role of government, higher education, and health care facilities in recognizing and promulgating pediatric psychosocial care; the financing of pediatric psychosocial care; the role of various professions in developing pediatric psychosocial care; the working relationship between those who provide pediatric psychosocial care and medical and other staff in hospitals; and insights into establishing administrative support of pediatric psychosocial services and spreading awareness. As this article was being written, delegates were engaged in an iterative process to identify additional topics to be included over the course of the summit.

Before the Summit, each of the delegates will provide information about the state of pediatric psychosocial care in his or her country. CLC staff will use this information to create a series of small posters, which will be displayed during the Annual Conference as well as at the Summit itself, so that conference attendees with an interest in the state of pediatric psychosocial care internationally can view and compare information from each of the delegates’ countries. After the Summit, CLC will publish a monograph to share each of the posters, along with reports on panels and discussions. The Summit keynote and panel presentations will be recorded, and the videos will be made widely available as well.

Beyond the stated goals of the Summit, it is hoped that the knowledge base generated, the sharing of resources and information, and the relationships formed will build a foundation for future innovations in the psychosocial services provided to children and families throughout the world.
Reflecting on the Past to Cultivate the Future of Research in Child Life

Laura M. Ianni, MA, LPC, CCLS, NorthShore University HealthSystem, Evanston, IL

Most of us are familiar with the Association for the Care of Children’s Health (ACCH) Child Life Research Project completed at Phoenix Children’s Hospital in the late 1980s (Gaynard et al., 1998); however, there are many research studies from the early days of pediatric play and education programs that are still relevant, but largely unknown. I had the pleasure of interviewing Dr. Joan Turner, a child life specialist, academician, and researcher who has committed her professional work to child life scholarship. She joined the Child Life Department at Health Sciences Centre, Children’s Hospital Winnipeg in 1987 and has been at Mount Saint Vincent University in the Department of Child and Youth Study since 2002. Dr. Turner is a Certified Child Life Specialist and member of the Child Life Council and the Canadian Association of Child Life Leaders.

Q: Your scholarly work with the CLC Archives Management Group involves materials dating back to the early 1900s. Please describe some of the research and how it may have contributed to child life practice.

A: From 1932 to 1937, Anne Smith made observations and systematically collected data in what she referred to as an experiment with play at Children’s Memorial Hospital in Chicago. As the play director, Smith introduced group play to decrease the fears and anxieties which children experienced while hospitalized. She trained nurses, hospital play staff, and volunteers to use traditional play techniques such as songs, puppets, plays, and storytelling to provide play opportunities for children throughout the day. The belief then was that an expert was important to the provision of play as well as the training of play techniques so that most hospital staff could form positive relationships with children who were admitted for longer stays for convalescence. Smith documented the growing diversity of opportunities for play including pre- and post-surgery, in waiting rooms, and on inpatient units.

Later, two studies sponsored by the American Toy Institute examined the use of toys with children in the hospital ward at the New York Infirmary in New York City. Grace Langdon (1948) observed how toys were used and noted benefits that the toys appeared to have for children. For example, toys facilitated the expression of feelings, allowed for imaginary play and constructive play, and helped children with separation and transitions. Claudia Gips (1950) systematically observed the use of 20 toys in an attempt to identify specific benefits. She noted what we now refer to as medical or health care play, as children played doctor and nurse, acted out medical experiences, and expressed feelings of fear, loneliness, and anxiety around hospitalization, separation, and operations.

In 1953, “A Study of the Emotional Reactions of Children and Families to Hospitalization and Illness” was published from research completed by Dane Prugh and colleagues at the Children’s Medical Center in Boston. This controlled experiment was designed to examine the effect of increased parental visitation on children in hospitals. According to Prugh, Sally Staub, one of the authors and an early play specialist, made contributions that supported the preventive and therapeutic benefits of daily parental visitation over weekly visitation.

Q: What are some of the barriers that may result in a limited interest in research production for current child life professionals?

A: I think a major barrier is that people who go into child life choose it because they want to be clinicians and don’t go into it for the academic or scholarship opportunities. They have an interest in helping people—it’s no different that people who go into counseling or social work—and they don’t feel the need to step out of that zone because they feel that somebody else can do it, but for child life to keep going in the future, we may need to start addressing those research questions. Another consideration may be that most child life specialists in North America haven’t experienced the impact that research can have in terms of moving a program forward. That, paired with the fact that child life work has a mostly positive impact on patient and family satisfaction scores, keeps programs afloat without the need for scholarly research. Since there’s no apparent need for research, programs don't establish research as a priority. Program leaders need to establish a culture of positive attitudes toward research as a component of developing an overall research culture for the field.

Q: How can research from the past inform and help develop current research initiatives?
A: When looking back at older work, positive relationships and using one’s self as a tool for traditional play were emphasized over using toys and materials. Additionally, many research advances that were made in the past were collaborative efforts, so it’s important to recognize that we do have to work in an interdisciplinary fashion and be open to collaborative efforts to get research done. If you’re going to get funding for research, you have to have a connection, and quite often, the connections that are the strongest are through physicians or leading researchers in other fields.

Q: As child life moves towards an advanced degree requirement, greater attention to graduate level curricula and preparation for future child life specialists must be developed. What are some curriculum suggestions that may increase both the research interest and the skills of students?

A: We need to develop a graduate curriculum that supports the development of research skills and capacity in our field. This may encourage people to say, “Child life researcher is a legitimate route that I can take.” We have to encourage program leaders and child life specialists to take on research roles and get others excited and passionate about research to create a culture of curiosity and inquisitive-ness as well as allowing the time, money, and interdisciplinary collaboration to create those opportunities. We must develop a body of current scholarly literature written by child life specialists for child life specialists. The day of a child life practitioner is very busy – adding child life researcher as a role in a clinical department may be a way to start building new attitudes in practitioners.

REFERENCES

Research Corner is a new Bulletin feature designed to highlight the process of research, as well as feature child life specialists involved in research projects. If you know of a person or project that could be featured in this space, let us know by emailing bulletin@childlife.org

Is a PhD Right for Me?

continued from Focus page 8

ing of what your intentions are and how a doctoral degree can assist you in accomplishing your goals is a necessary step to take before embarking on this journey.

AM: Go for it! Our field needs more empirical evidence to support the efficacy of clinical interventions. Advanced degree programs also open additional doors for individuals interested in pursuing private practice, policy, or advocacy work.

KC: Please do it. The rigor of medicine and health care isn’t going anywhere and if we desire to remain an integrated part of pediatrics, health care isn’t going anywhere and if we desire to remain an integrated part of pediatrics, policy, or advocacy work.

CS: Please do it. The rigor of medicine and health care isn’t going anywhere and if we desire to remain an integrated part of pediatrics, we need to prove why we deserve it. Research means longevity within the competitive health care climate; thus, we need more researchers. Find a researcher whose work you love and contact that person, asking their advice. Word of mouth is a powerful tool in academics and you might stumble on a perfect program because you simply asked.

Salary and compensation 15%
Lack of respect and awareness of the child life profession 29%
Lack of published EBP/research resources 20%
Job opportunities and job security 19%
Funding for child life departments 17%
Salary and compensation 15%

Some of these responses reflect the overall uncertainty in the health care environment, while most are longstanding issues for the child life profession and for child life professionals. The strategic priorities of the Child Life Council are designed to address many of these issues; though it will be a long road, along the journey we hope to see increasing awareness of this field, more solid research that clearly demonstrates the value of child life and the most effective clinical practices, and an elevation in the position of child life professionals within hospitals and the health care community at large.
CLC Calendar

APRIL
1 Deadline for Bulletin and Focus articles for consideration for the Summer 2014 issue
9 CLC Webinar — The Grants Game for Child Life Programs
7 Standard Registration deadline for CLC 32nd Annual Conference on Professional Issues
23 CLC Webinar — Playing to Your Strengths in Private Practice
30 Deadline for CLC Office to receive Course Work Review submissions

MAY
1 Course Work Review Service suspended
7 CLC Webinar — Improving your Presentation and Facilitation Skills
22-25 CLC 32nd Annual Conference on Professional Issues, New Orleans, Louisiana
25-27 CLC International Summit: The State of International Pediatric Psychosocial Services, New Orleans, Louisiana

JUNE
4 CLC Webinar — Providing Family-Centered Care to LGBT Patients and Families
30 Deadline for recertifying by Professional Development Hours
30 Deadline for applications for the August 2014 computer-based Certification Exam administration (June 15 for those educated outside of the US or Canada)

JULY
1 Deadline for Bulletin and Focus articles for consideration for the Fall 2014 issue
15–31 Call for Papers for 2015 Annual Conference in Cincinnati, Ohio

UPCOMING EVENTS

APRIL 13 - 14, 2014
2014 ONCOLOGY NURSING CONFERENCE
The Ritz Carlton Hotel, Cleveland, OH
Contact: Viveca Kimble at kmblev@ccf.org or 216.448.0652
For information and registration, visit: www.ccfcmce.org/GoOncologyNursing

NOVEMBER 8 - 9, 2014
19TH ANNUAL MIDWEST CHILD LIFE CONFERENCE
Children’s Hospital of Wisconsin, Milwaukee, WI
Contact: Megan Massey at mmassey@chw.org or 414.266.8525