Missi Hicks to Receive CLC 2010 Distinguished Service Award

In 1985, Missi Hicks was an undergraduate student at the University of Delaware attending a class called “The Hospitalized Child.” Dreaming of becoming a physical therapist and helping children to walk, Missi found that, more and more, she was attracted to the psychological and emotional elements of healthcare. “Dr. Dene Klinzing, who taught the course, really helped to steer me in the right direction,” says Missi. Before the end of the semester, she had switched her major, and was soon on the lookout for a child life internship. At the time, the University of Delaware had a relationship with The Johns Hopkins Children’s Center for an internship placement. “I remember thinking, “I have got to get that spot,” she laughs.

Today, as a child life consultant based out of Raleigh, North Carolina, Missi reflects on a unique career trajectory that in many ways sets her apart from previous Distinguished Service Award winners, the majority of whom have been directors of well-established child life programs. Through her tireless efforts on behalf of the child life profession, Missi has demonstrated that there are many ways to be a great child life leader. While her path has been more varied—at several turns she pulled up roots, changing locations, work settings, and modes of service delivery—she has always relied on a core foundation of clinical skills and a healthy sense of adventure, which she has applied to great effect in both traditional and non-traditional settings. Her pioneering efforts in creating unique child life opportunities are reflected in her own career, and have also helped the larger child life community to embrace her vision of a future where child life extends beyond the hospital.

The Child Life Alphabet

G IS FOR GENDER ROLES
Heather Dubrule, MEd., CCLS, Special Education Teacher, Stonington Public Schools, Stonington, CT

Since the first book specifically written for children was published in 1658 (Epstein, 1991), children’s books on a variety of topics have been read in homes, schools, childcare centers, libraries, and even healthcare settings around the world. While parents, teachers, child life specialists, and other adults select books for children based on various criteria, they do not always look at these books with a critical eye towards the developmental needs and interests of children. Researchers have found that many books written for children contain evidence of gender bias, with greater attention given to male characters compared to female characters (Kortenhaus & Demarest, 1993). As educators of children in healthcare settings, child life specialists may benefit from learning about ways gender bias is presented in children’s books, as well as strategies for the selection of children’s books that balance male and female characters and roles.

Between the ages of four to six, children begin to make associations regarding information about their own gender, and by age eight, the opposite gender (Martin, cited in Lobel, 2000). Every society has a set of roles and behaviors that are interpreted as appropriate or not for men and women; many of these roles...
PRESIDENT’S PERSPECTIVE

Spring Growth for the Child Life Council
Ellen Good, MS Ed, CCLS
Yale-New Haven Children’s Hospital, New Haven, CT

As Winter makes way for Spring, our minds turn to fresh starts and new beginnings. This season is a natural time for rejuvenating our spirits and recommitting ourselves to our passions, whatever they may be.

At the Child Life Council, we are passionate about the progress and ongoing advancement of the child life profession, and to that end we have committed to several exciting new projects.

Based on the recommendations from the Child Life Academic Summit that took place last year at Wheelock College, three new task forces have been assembled, and each group has been actively working on their assigned charges. The Academic Task Force is in the early phase of reviewing core curricula for child life academic programs, and the Internship Task Force has begun work on proposing curriculum standards for clinical internship programs. Meanwhile, the Research Task Force has undertaken a survey to identify professional pathways of PhDs in the field.

One other group recently assembled, the Patient Ratio Committee, has been charged with creating a reliable and validated tool which will eventually assist them in categorizing patients, in order to help us to establish an updated patient/staff ratio that is better reflective of current and best practices.

Each of these groups is comprised of committed and talented professionals who are passionate about the work they have undertaken on behalf of CLC. This is exciting, new, and challenging work which will benefit the CLC membership as well as the patients and families we serve. I applaud the efforts of all of our committee and task force volunteers, and thank them for their hard work. Look for updates on their progress and achievements in future issues of the Bulletin and on the CLC Web site.

Another way that many of us reengaged in the child life profession was through our individual celebrations of Child Life Month (or Child Life Week) in March. Like many of you, I worked with my staff to plan activities for our hospital and community which highlighted the profession and our achievements as a department. We also took the opportunity to celebrate our patients and their families. I encourage all of you to share your success stories with CLC by sending an email to communications@childlife.org.

And finally, CLC has shifted into high gear with its preparation for the Annual Conference on Professional Issues, which will be held in Phoenix, Arizona, June 10-13, 2010. The program will offer a wealth of educational opportunities relating to clinical work, research, new programming, and much more. The conference title, Renew Your Spirit, Inspire Your Mind seems to say it all. This year we will be awarding the first ever Mary Barkey Award for Clinical Excellence, and we will also be presenting the Distinguished Service Award to Missi Hicks. More information is available in the Annual Conference section of the CLC Web site, and don’t forget to review the Top Ten Reasons for Attending the CLC Annual Conference on page 4 of this issue. Simply put, there is no other event in the world quite like the CLC Annual Conference. I hope to see many of you there.

I thank each of you for the important role that you play in helping us to advance our common passion for child life, and look forward to celebrating our many successes together!

Continued on page 6
Hitting My One Year Mark

With any luck on our end, by the time members receive this newsletter, winter will have finally subsided in our suburban DC home base of Rockville, Maryland. As you probably heard, our area got an unprecedented amount of snow this year, closing schools and businesses, and pretty much halting normal activity for a week.

The CLC staff had worked all last fall on updating our HR manual, including putting a lot of thought into our inclement weather policy, which we ultimately decided should follow the generally tough U.S. government protocol. So when in February—for the first time in its history—the federal government closed for four consecutive days, we were thrown for a bit of a loop. But we knew that our work wouldn’t stop, just because road conditions prevented us from making it to the office. Those of us with running electricity were able to continue monitoring email, as well as access files from the servers to work on documents from our snowbound homes. While technically the DC CLC office was “closed,” I was very proud of our staff for keeping a lot of things running while waiting for the plows to make it to their neighborhoods and dig them out.

Reflecting on My First Year

In the midst of all that snow, I celebrated my first anniversary at CLC. It has been truly wonderful getting to know child life specialists and be involved in this profession. I not only had the “opportunity” (read: was forced) to dance and belly laugh at an opening session at the Annual Conference (that was a first!), but I’ve also had the chance to visit 17 child life programs across the continent in the past year. Each one is unique, but they share many common bonds, practices, and outlooks.

At a recent staff meeting, I reflected on our accomplishments from the past year that have been made possible with the support of a dedicated staff, Board of Directors, committee volunteers, and members. While many of these have marked internal progress less visible to members, some of our more outwardly visible accomplishments have included:

- CLC moved into new offices (just a single last digit change in an address for those outside the office— but as much work inside the office as if we had moved 1,000 miles away!)
- We’ve held the Annual Conference and had two certification exams
- We’ve launched Child Life News Monthly, a new online newsletter citing research and news pertaining to child life, and have published four issues of the Bulletin
- CLC is in the midst of changing our certification testing agency; we’ve gone through a bylaws revision process, and we’ve instituted a new election process
- CLC has initiated three new committees and five new task forces, including three task forces arising out of the Academic Summit conducted last year at Wheelock College
- We’ve launched the Child Life Marketplace, a directory of companies and nonprofits supplying products and services relevant to child life programs
- We’ve held the first two CLC webinars and are planning for more throughout the year ahead
- We’ve introduced a new award—the Mary Barkey Clinical Excellence Award—and we’ve announced two International Scholarship opportunities to attend the 2010 Annual Conference
- We have had an active CLC bookstore, which introduced the eagerly anticipated Handbook of Child Life, and more recently—bumper stickers!
- CLC has selected, and will soon be implementing, a “social media” networking platform as part of the CLC web site

Toward Online Community

That last bullet above—implementing a new social media networking platform is one thing that has the CLC staff very busy right now. We are preparing to launch a new set of online components that have the potential to bring child life specialists into closer contact with one another, to share knowledge, ideas, and resources.

A common term for some of the features that will be available through this new capability is social networking. However familiar, we are eschewing that term a bit, preferring to refer to what is coming as a “professional networking” capability. In the initial launch of the system, we will not offer some of the networking functions that are characteristic of social media sites like Facebook—specifically “friending” and internal e-mail. Those will come later. Features that will be available from the start will include robust member profiles that let the child life community know who you are: where you work, your professional interests, and various other collegial information. The professional networking system will host the CLC forums offering enhanced search capabilities for members to locate relevant past communications. And it will allow members to upload...
Top 10 Reasons for Attending the CLC Conference!

CLC invites you to Renew Your Spirit and Inspire Your Mind at the Child Life Council’s 28th Annual Conference on Professional Issues, which will take place June 10-13, 2010 at the Sheraton Phoenix Downtown Hotel in Phoenix, Arizona. There are hundreds of reasons to attend this year’s event, but we have narrowed it down to the Top 10:

1. Learn from the experts, both in and outside the field of child life. With more than 60 different presentations to choose from, the conference offers something for everyone.

2. Make connections at a series of events that provide the opportunity to network with other child life specialists. Countless lasting friendships owe their beginnings to a chance meeting at the Annual Conference! First time attending? Be sure to get your “First-Timer” ribbon and attend the New Member/First Timer Orientation to meet other first-time attendees.

3. Earn up to 27 PDHs, the highest number of hours ever offered at an Annual Conference. Up to 16 PDHs are included with basic registration, and you’ll have the option to add anywhere from 3 to 11 additional PDHs by attending pre- and post-conference intensives (separate registration fees apply).

4. Explore the interactive Exhibit Hall, which will showcase more than 40 organizations which support the work of child life specialists, and allow you to talk one-on-one with the suppliers of the products and services you use every day.

5. Connect with prospective employers using the Job Board. Program directors post available positions, and job applicants post resumes, and many interviews are conducted right there at the conference. Be sure to check out CLC’s Job Placement Center prior to departing for the conference to get an idea of current job opportunities . . . you never know who you will find yourself sitting next to!

6. Browse the CLC Bookstore and save, with special conference discounts on the latest resources and CLC merchandise, plus no shipping fees! The CLC Book Store will be open during Exhibit Hall hours.

7. Meet the CLC Board and staff, all of whom will be on-site throughout the conference. Have questions on certification, membership, future conferences, volunteering and anything else related to the Child Life Council? This is your chance to get information straight from the source.

8. Enjoy the beauty of the Sonoran Desert during your visit to the “Valley of the Sun.” Phoenix boasts many natural attractions, including Camelback Mountain and the Desert Botanical Garden. The Sheraton Phoenix Downtown is located at the heart of Copper Square, surrounded by 90 blocks of shopping, restaurants, museums and entertainment venues. If you are interested in extending your stay, the CLC room rate will be honored three days prior to and following the conference, based on availability.

9. Bring the conference home. We know that not everyone in your department may be able to attend the conference every year, but you can bring the conference to them! Hold an in-service when you return and share what you’ve learned with the rest of your team.

10. Experience the power of Professional Community at the largest annual gathering of child life professionals in the world. The Annual Conference is truly a unique experience, offering unparalleled opportunities to meet and learn from your peers.

Register now to ensure entry into all of your first choice sessions and events. Registrants are encouraged to take advantage of the CLC discounted room rate of $145 per night plus tax (single or double occupancy). We are anticipating a sold-out room block, so make your reservations today!

For detailed information and to view the complete conference program, please visit the Annual Conference section of the CLC Web site at www.childlife.org/Annual Conference/.

Milestones

AWARDS

Jennifer Redfern, MS, CCLS, senior child life specialist at Medical University of South Carolina Hospital Authority, was selected as employee of the year for 2009. Jennifer works in ambulatory surgery at MUSC Children’s Hospital.

Amanda Eddington, CCLS, child life specialist at CoxHealth Systems, Springfield, Missouri, was recently awarded the Prestigious Partner Award for 2009/2010, an annual honor presented to an outstanding employee based on peer recommendations of exemplary work performance from throughout the year.

PUBLISHED

Creating and Using Games for Intervention:

Have You Ever Kissed a Purple-Spotted Frog?

Amy N. McGlory, MA, CCLS
Josh Cares Fellow, Cincinnati Children's Hospital Medical Center, Cincinnati, OH

Jaesook L. Gilbert, PhD
Early Childhood Education, Northern Kentucky University, Highland Heights, KY

Rita Hartke, BA, RPR, CMRS, CCLS
Cincinnati Children's Hospital Medical Center, Cincinnati, OH, is gratefully acknowledged for her contributions.

Play is a child’s work and is also the medium through which he or she communicates thoughts and feelings. The importance of play cannot be overstated, particularly when a child is sick, injured, or in the hospital (Brown, 2007; Wishon & Brown, 1991). Child life specialists can use their knowledge of child development and play to develop interventions that involve the use of play, including the use of games. Games with a medical theme, or indirect medical play (McCue, 1988), can be particularly appealing to children who are in the hospital.

Child life interns may also be in a position to develop interventions such as games to benefit children and families, as well as the child life department. The purpose of this article is to describe one such case where a child life intern, under the guidance of a Certified Child Life Specialist, developed a board game (with a medical theme) for a short stay unit at Cincinnati Children’s Hospital Medical Center. The significance of play and games for use as a child life intervention will also be discussed.

Play and Games with Rules

Children may prefer different types of play depending on their skills, abilities, interests, and developmental age. Board games become more interesting and challenging to children as they develop. Playing games helps children to practice their social skills and provides them with opportunities to try out new behaviors in a constructive social setting (Swank, 2008). The use of games can be an effective child life intervention before, during, and after a medical procedure or surgery.

Games with rules can be offered for a variety of purposes within pediatric settings. Games can help children with coping and also can be used to assist children and families as they prepare for discharge from the hospital. Pre-operative and educational programs often include play and medical play. Post-operative activities, including games, can help children to process their experiences and also encourage healing by creating a fun diversion for children.

Game Development, Purpose, Application

Have You Ever Kissed a Purple-Spotted Frog? (referred to as “Frog game” hereafter) is a game designed and constructed by the lead author while participating in a child life internship. The project idea was inspired by Rita Hartke, a Certified Child Life Specialist at Cincinnati Children’s Hospital Medical Center. Ms. Hartke had been using other board games as an intervention to encourage the intake of fluids. However, she was looking for a unique and specific “chug-a-lug” type of game to use with her post-tonsillectomy/adenoïdectomy patients. Thus, the Frog game was born. The development and utilization of the Frog game is described here.

The Frog game was designed for children who have had a tonsillectomy and/or adenoidectomy. The game encourages the intake of fluids post-surgically as drinking helps to keep the throat moist and minimizes bleeding. Encouraging the intake of fluids while having fun were the goals when designing the game board, game pieces and incentives. The basic idea of the game is that if the player answers “yes” to a “Have you ever…” question (e.g., Have you ever skinned your knee?), then the player takes a sip of his/her drink. If the player answers “no,” then it is the next player’s turn. Additionally, if the player selects particular questions (e.g., Have you ever had a tonsillectomy? or Have you ever kissed a purple-spotted frog?), he or she also rings a bell. Questions are culturally sensitive and represent a wide range of early childhood interests. In addition, questions can be altered, added and deleted as deemed appropriate by the child life specialist. In this way, the game can be customized to the population that is being served. In addition, if the child is not yet able to read, a parent or another adult can read the question. Finally, if a child has difficulty with sensory overload, then adaptations (such as removing the bell) can be made.

When creating a game to be used as a child life intervention, it is important to consider the purpose. In addition to the therapeutic goal (drinking fluids), the objective of the Frog game is to have fun and to build rapport. Simple games like the Frog game can also assist in facilitating natural communication by creating a relaxed atmosphere. With this in mind, the focus of the Frog game is more on the process rather than “who wins” and the rules of the game are flexible. It is most important that the play remains child directed and enjoyable.

The playful atmosphere is also maintained because the game includes developmentally appropriate humor and an element of fun. When creating the Frog game, humor was the pathway to fun. The game was designed for children between the ages of four and seven. At this stage, children are amused by things like silly songs, cartoons, playing with word rhymes and made up words, tongue twisters, and behavior that violates social norms, for instance, a father putting on a child’s hat (Frankenfield, 1996). Many of the questions in the Frog game fit this descrip-

Continued on page 8
Strengthening Partnerships

Continued from page 2

This document effectively describes and advocates for the inclusion of child life programs in health care and other settings (including home care, hospice and bereavement settings), for the financing of child life programs, for appropriate staff to patient ratios, and for additional research to validate the effects of child life services. With a primary recommendation that “child life services should be considered an essential component of quality pediatric healthcare and are integral to family-centered care and best-practice models of healthcare delivery for children,” the AAP policy statement serves as a valuable resource for child life professionals in their advocacy efforts and validation of our work.

The most recent version of the statement on Child Life Services can be found in the October 2006 issue of Pediatrics (Vol. 118:1757-1763) and online at http://aappolicy.aapublications.org/cgi/content/abstract/pediatrics;118/4/1757

Aside from the policy statement on Child Life Services, CLC members might be surprised to know that child life is mentioned in many AAP policy statements and clinical reports, for example:

- Family Centered Care and the Pediatrician’s Role (Pediatrics Sept. 2003 Vol. 112:691-696)
- Facilities and Equipment for the Care of Pediatric Patients in a Community Hospital (Pediatrics May 2003 Vol. 111:1120-1122)
- Physicians’ Role in Coordinating Care of Hospitalized Children (Pediatrics May 2003 Vol. 111:707-709)
- Guidelines for Pediatric Cancer Centers (Pediatrics June 2004 Vol. 113:1833-1835)
- Communicating with Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information (Pediatrics 2008:121:e1441-e1460)
- Patient and Family Centered Care in the Emergency Department (Pediatrics 2008:122:e511-e521)
- Patient and Family Centered Care and the Role of the Emergency Physician Providing Care to a Child in the Emergency Department (Pediatrics 2006:118:2242-2244)

These and other AAP policy statements and clinical reports are available in full text versions at www.aap.org or can be found in your hospital medical library.

Child life specialists collaborate with physicians on a daily basis and the effectiveness of this collaboration has been recognized not only by the frequent reference to child life in AAP publications and by the presence of a CLC representative on the Committee on Hospital Care, but also by the recent inclusion of Certified Child Life Specialists working in inpatient settings to become affiliate members of AAP’s Section on Hospital Medicine (SOHM). The Section on Hospital Medicine is “dedicated to the health of all children in the hospital setting through advocacy, education and service – incorporating the core principles of safety, effectiveness, timeliness, efficiency, and equitability in family-centered health care.” (2008, Hospital Pediatrics, Issue No. 2).

Now, in addition to the Section on Emergency Medicine for child life specialists working in emergency settings, Certified Child Life Specialists are invited to actively collaborate with AAP members through SOHM publications, meetings, lisserv communication and research. An article published in Hospital Pediatrics (Brown, C. “Child Life Specialists Join the Section on Hospital Medicine”, Issue No.2 2008) announced the new membership category and served to educate physician readers about the ways in which child life specialists can support care provided by medical staff.

A recent issue of Hospital Pediatrics (Issue No.1 2009) further affirms the role of the child life specialist working side-by-side with the medical team in an article by Dr. Rubén Nazario of Kentucky Children’s Hospital entitled “Participation of Child Life Specialists during Placement of Peripherally Inserted Central Catheters.”

Affiliate membership for Certified Child Life Specialists in either the Section on Emergency Medicine or the Section on Hospital Medicine is currently $60 with application information available at http://www.aap.org/member/SectionMbrreq.htm.

From our daily collaboration with physicians in our own settings, to the strong advocacy of child life provided by AAP’s policy statement on Child Life Services as well as other AAP publications, and the active involvement of child life specialists on AAP committees and sections, it is clear that the working relationships between physicians and child life specialists continue to strengthen. These are the relations we as a profession have worked hard to achieve since the earliest child life programs were established, many as a direct result of physician enlightenment, and a reminder to us all of how far we’ve come!

UPCOMING EVENTS

Great Lakes Association of Child Life Professionals Conference

October 16, 2010
Cincinnati Children’s Hospital and Medical Center
Contact: Lauren Wolfe, 513-636-8855 or lauren.wolfe@cchmc.org
Call for papers Ends April 30, 2010. Email submission at catherine.marshall@cchmc.org
Web site: www.cincinnatichildrens.org
Excerpt from a student’s reflective report on required service learning in a child life course:

I volunteered 23 hours at the Flu Shot Clinic and noticed emotions and needs changed during one short twenty-minute session with a child. Emotions ranged from fear and nervousness, to sadness and anger, and for some, excitement and a sense of accomplishment when the experience was over. Older children in the waiting room were more difficult to distract, while younger ones were eager to play. The treatment room is where emotions became more intense. They knew the shot was coming, so this is where a combination of distraction skills and the comforting skills of parents were needed to create a non-threatening environment. I discovered that it is important to prepare and inform them as much as is appropriate. Letting them know it may pinch a little, but it’ll just last a second, or telling them they’re going to have to be “as still as a mountain” (quote from a mother to her son) can really decrease stress and anxiety. For future students participating in this class, don’t be afraid to go up and invite children to play with new and cool toys. When you approach a child or family, bring a book (I found most success with I Spy and Spot 7). If they say no to toys, offer them a book; they often say yes to a book so they can stay next to Mom or Dad. I realized children responded well when they were given the job of making the pinwheel spin. If you run out of pinwheels (which happened one day!), tell the child it is their job to try and blow you over or blow you out the window! I thought this experience was very helpful because I have mostly worked with well children in home or school settings. I realized not only do I enjoy the clinic setting, I’m also kind of good at it. The hands on experience really put into practice what we learned in class. I learned a lot about creating a relationship with a child in a hospital waiting room, and it gave me the experience I needed to be confident that I can succeed in this career. (A. Lawinger, personal communication, December 12, 2009)

What can you discern about how this student learned from direct interaction with pediatric patients? What self-awareness did she bring to her experience? What aspects of this hands-on experience enlarged her understanding of promoting coping? How did she comprehend the power of play and learn to use play as distraction? One purpose of this article is to question and make visible how students learn to ‘think like a child life specialist’ as the aim of professional preparation. Another purpose is to foster more active learning by child life educators and supervisors who understand NetGeneration learners as students born in the 1980s and later (Oblinger & Oblinger, 2005). A final purpose is to share the excitement of one child life educator whose enlightenment as a teaching scholar helped re-make her courses into spaces of active learning.

**Learning To Think Like a Child Life Specialist: Teaching and Supervising the NetGeneration Learner**

Susan ‘BOON’ Murray, CCLS, CTRS, University of Wisconsin-La Crosse, WI

**Abstract**

A child life educator asks child life instructors and clinical supervisors to question how students learn to ‘think like a child life specialist’ as the aim of educational preparation. Suggestions are offered for understanding generational differences in learning based on the influence of technology. Examples are provided of how to intentionally foster active learning among child life students and interns. Initiatives and online resources are featured that promote a shift to enliven teaching by prioritizing learning.

Accountability for assessing learning and providing evidence of effective teaching has become a call for educational reform in the preparation of healthcare professionals by the Institutes of Medicine (IM) (Greiner & Knebel, 2003). Accordingly, the IM’s Committee on Health Professions proposed five core competencies that coincide with the Child Life Council’s (CLC) curriculum recommendations for applied areas of study: “All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics” (p. 45).

Child life educators and clinical supervisors invest considerable time and make decisions about what successful practice and competence look like. It is our duty to assess learning, verify successful clinical experience, and award related degrees. We are clear about what learners should know and the tasks of their job performance. But . . . do we understand how learners learn? Do we realize what makes learning...
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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ARE YOU A ‘DIGITAL NATIVE’ OR A ‘DIGITAL IMMIGRANT’?

If you are a student or beginning practitioner, you have probably grown up being connected to compelling graphic media through playing video games, breathing the internet like oxygen, and using devices like cell phones and laptops as “a digital native” (Oblinger & Oblinger, 2005). As a middle-aged professor and “digital immigrant”, I grew up riding my bike to the bookmobile and mainly conceiving images from text without graphics, using a landline phone, and writing letters in a slowed response time. Being a professor requires me to become technologically competent, which is an acquired skill, while activities like text messaging come naturally to you. Your expectation for immediate response overwhelms my email inbox so I have to set limits to free myself from the computer. You learn by doing rather than being told; as your supervisor or instructor, I may be habituated to my own socialized pattern of learning by being told. How does this digital divide affect our teaching and learning interaction?

It is not technology at stake but how we learn. Is it possible to transmit child life practice in new ways better suited to NetGeneration learners (also called Millennials)? These are college students born between 1982 and 1991, who are mostly hopeful and determined, and dislike anything slow (Oblinger & Oblinger, 2005). The majority expect instant access to friends, information, services, and answers to questions. Many shift quickly from one topic to the next and may ignore what does not interest them. For example, they are usually comfortable simultaneously completing homework, text messaging, and listening to iTunes, where the buzzword is ‘multitasking’. By contrast, I represent “Baby Boomers” born between 1946 and 1964, most of whom were raised to be responsible by concentrating on one activity at a time. Baby Boomers’ par-
In fall 2009, a pediatric intern for whom I was the academic supervisor proposed designing a Facebook Page for Shriners Twin Cities as her major project. Imagine the challenges she navigated across generations. Greatest Generation Shriners were financially struggling to support a limited technological infrastructure in her hospital so compromised by economic recession that there were staffing reductions in her department. Her Generation X clinical supervisor and Baby Boomer administrator approved her proposal and awarded her a grade of 5+/5 for her project. Her NetGeneration coworkers in the Public Relations Department assisted with technical issues and access. Her learning event succeeded in promoting Shriners Hospital to the world at the same time it corrected generations.

Can a Boomer Educator Accommodate NetGen Learners?

An opportunity for in-depth professional development as a 2003-04 Wisconsin Teaching Scholar re-enchanted me with professing. It enlightened me to shift my teaching practice to become more learner-centered (Weimer, 2002; Moon, 1999). It made me aware that I was so pre-occupied with making my own teaching performance entertaining that I was unknowingly suppressing students’ need to come to deep understanding by doing the heavy lifting of constructing knowledge from problem-solving. I was stuck unaware in recall and repetition; learners needed discovery, exploration, experimentation, and critical analysis that comes from learning by doing. I was so engrossed in child life professional issues that I neglected exploring outside my discipline about what really matters to the practice of teaching. A whole world of dramatic findings were coming to light about how people learn (Bransford, Brown, & Cocking, 1999) and how technology and the internet are transforming learning (Oblinger & Oblinger, 2005). Now I seek out research-based resources for teaching and learning (Nilson, 2003) and selectively cultivate professional development such as reading Journal of the Scholarship of Teaching and Learning online (see Online Resources at end of Focus). Reinventing my teaching parallels the CCLS striving to integrate evidence-based practice as life-long learning. The following examples make visible a more mindful effort to elicit learning by becoming knowledgeable about how NetGeneration students learn (Oblinger & Oblinger, 2005):

- They often learn better through discovery and doing than by being told. I use class time for active learning rather than lecturing. For example, students co-present interactive multimedia presentations by converting textbook chapters to visually stimulating PowerPoints featuring hyperlinks and YouTube videos related to child life. I construct group work during class time with applied exercises such as designing a playroom environment.
- Learners are connected hypercommunicators with fast response times who multitask and simultaneously move quickly. I utilize my campus online courseware DesireToLearn where students can access course information 24 hours a day instead of waiting until the next class session to clarify assignments. I connect students to co-create knowledge with myself and each other by sharing insights on a Discussion Board. I respect students’ activism to “go green” and cease destroying trees by posting their assignments electronically in a ‘dropbox,’ where I grade and return them by inserting electronic comments. I use this digital repository to publish a class CD-ROM of learners’ creative products including sibling support.

**Figure 2. A REFLECTIVE REPORT RUBRIC: SHADOWING A SPECIALIST IN DAY SURGERY**

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>NEEDS REVISION</th>
<th>GOOD</th>
<th>EXCELLENT</th>
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<tr>
<td>YOU write with clear focus</td>
<td>Focus seems is unclear without sufficient examples</td>
<td>Relates experience and provides solid examples to illustrate insights</td>
<td>Relates experience with exceptional detail; reinforces description with exceptionally clear examples</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td>YOU write with logical structure</td>
<td>The report appears to have no direction, with subtopics appearing disjointed.</td>
<td>There is a basic flow from one section to the next, but not all sections or paragraphs follow in a natural or logical order.</td>
<td>The report goes from general ideas to specific conclusions. Transitions tie sections together, as well as adjacent paragraphs.</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td>YOU communicate your particular point of view with mechanical accuracy</td>
<td>It is hard to know what the writer is trying to express. Writing is convoluted. Misspelled words, incorrect grammar, and improper punctuation are evident.</td>
<td>Writing is generally clear, but unnecessary words are occasionally used. Meaning is sometimes hidden. Paragraph or sentence structure is too repetitive.</td>
<td>Writing is crisp, clear, and succinct. The writer incorporates the active voice when appropriate. The use of pronouns, modifiers, parallel construction, and non-sexist language are appropriate.</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td>YOU articulate insight into the roles of a child life specialist</td>
<td>There is little application to the child life role.</td>
<td>Applies what was observed and experienced to key understandings about the child life role and whether the writer is suited to that role as a future career</td>
<td>Records application of the child life role with deep understanding and keen insight including personal projection of success in the child life career</td>
<td>Up to 10 points</td>
</tr>
<tr>
<td>YOU are timely</td>
<td>Material was submitted more than one class late.</td>
<td>Material was submitted on time within one week.</td>
<td>Material is submitted ahead of next week’s class so instructor can provide a graded copy.</td>
<td>Up to 10 points</td>
</tr>
</tbody>
</table>

YOUR TOTAL (possible 50)
resources or session outlines for playroom groups. Students use these later during internship and beyond for real world application.

- They are often social with a preference to work and learn in teams, most crave interactivity, and they may need to be encouraged to stop experiencing and spend time reflecting. I require written reflections of field experiences such as shadowing a child life specialist in outpatient surgery. Students complete 10 to 25 hours of service learning during a course, and connect experience to theory and course content in a summary report. I prompt learners' responses by posing questions like, “Imagine another student chose the setting you selected, for example, the Teddy Bear Clinic (see Figure 1). Offer three or four practical tips or advice that might be useful to future volunteers.” One student advised, “I would recommend you not to be shy in the flu shot clinic. You have to be fun and look excited! Clowring would be a great way to provide distraction. One little girl I was bouncing a ball with initially would only answer my questions with head nods and gestures. If I would act goofy when catching the ball or entusiastically compliment her for a catch or throw, she started to talk, smile, laugh, and become more comfortable with me.” (C. O'Toole, personal communication, December 19, 2009)

Current students' reports are posted electronically for future classes to help them choose a preferred setting to gain direct experience with children. The opportunity to be knowledgeable advice-giver excites learners.

- Most are very achievement-oriented and want parameters, rules, priorities, and procedures. They like to know what it will take to achieve a goal and prefer structure to ambiguity. I use rubrics extensively to structure and contain assignments and specify performance expectations. Stevens and Levi (2005) offer a classic guide to customizing rubrics as scoring tools used to specify acceptable and unacceptable levels of performance. Rubrics can be used to evaluate any task such as writing clinical documentation, facilitating a developmental assessment or a medical play session, or to give feedback to interns as they learn to provide procedural support. Developing rubrics to assess clinical skills is promising territory for clinical supervisors as well as educators. Supervisors who use existing checklists and observation forms save time. These feedback mechanisms can be made more effective, and impart expectations more clearly, when evaluators become more mindful and intentional about assessing performance by using rubrics (See Figure 2 for a reflective report rubric).

Child life specialists and students can become more self-aware of how technology is changing child life practice and affecting how professional caregivers learn to manage information. See Educating the NetGeneration (in the Online Resources at end of Focus), an online electronic book, especially the chapter on closing the gap between engagement and learning.

**How is Learning Problematic?**

The authors of How People Learn: Brain, Mind, Experience, and School (Bransford, Brown, & Cocking, 1999) may fascinate readers with new understandings in the psychology of cognition. The authors describe, for example, that learning is innately problematic because people forget what they learned. They learn without understanding. They hold preconceived ideas and socialized beliefs that impede new understanding (for example, disability is inability). They develop misconceptions as they learn a subject. And finally, they cannot apply what they learned previously to new situations.

These insights complicate the taken-for-granted academic tradition of building on prior knowledge with the layering of advanced coursework in a curriculum. For example, the use of pre-requisites assumes that learning occurs sequentially and that learning ‘takes’ and is definitive with a course grade. Brain research suggests that instructors and trainers need to uncover misperceptions, not assume learners are ready for new material, and assess learning lesson by lesson, or situation by situation, because:

Students come to every learning situation with prior knowledge, skills, beliefs, and concepts that significantly influence what they notice about the situation, how they organize and interpret it. This affects their ability to remember, reason, solve problems, and acquire new knowledge. (Bransford, Brown, & Cocking, 1999, p. 42).

As instructional designers Wiggins and McTighe (1998) note, “In even the most mature person, understanding is a mixture of insight and misconception, knowledge and ignorance, skill and awkwardness.” Consider nuances that affect the job task of providing support for procedures. We learn to think and act like a child life specialist through each event—each time it is the same, but different. Whether a child will cope or not remains unpredictable as a lived experience that is remarkably individual. Exchanges within the CLC Forum list serve attest that there can always be another possible response. Specialists learn from each other as they exchange posts to make sense of what happened and suggest how one might think like a child life specialist to solve a problem. See Online Resources section at end of Focus to access the podcast How People Learn: Bridging Research and Practice to explore the context of preparing for professions. Consider watching this podcast as a staff development inservice. Discuss the podcast.
to re-imagine supervising interns, volunteers, and new professionals, and how to sustain life-long learning for all levels of experience in a child life department.

**What Is the Difference Between Teaching and Learning?**

The teaching paradigm focuses on the quality and quantity of transmitting information (Wiggins & McTighe, 1998). This approach may represent how many child life educators experienced learning themselves and were trained to teach. Think back to your college experience. My generation's professors were sages on the stage rather than the guides on the side who typify today's experiential education. Their predominant mode was lecturing, which emphasized memorization and conceptualizing abstractions. Their syllabi predictably featured copious readings from definitive textbooks, quizzes and tests, and lengthy research papers where first-person writing was forbidden in deference to the authority of experts.

By contrast, today's learning paradigm focuses on the efficiency and effectiveness of the learning process in terms of: “What do students know and understand?” and “What can they do with this new information?” (Wiggins & McTighe, 1998, p. 15). My syllabi feature learning activities as group and individual projects where students make sense of core information in child life, for example, understanding what procedure support is and how it is facilitated. That is complex enough. But complexity is increasing in the healthcare environment, requiring applying what you know to new situations. For example, more children with autism are seen for clinic appointments. Students might create a photo preparation book or script for routine procedures as a beginning assignment. But a more complex assignment might be creating a social story to explain a medical procedure to a patient with autism. Many classroom professors are searching for effective ways to change from a transmission mode of instruction to a focus on improving the learning and mastery of content by students (Wiggins & McTighe, 1998). For example, learning to facilitate therapeutic play sessions is a foundational competence with a distinct knowledge base. Compare the following scenarios with the goal of teaching students facilitation skills for group play.

**Scenario A:** If the instructor's focus is on teaching, she may lecture students to understand the components of a play session. First, she engages them with a video example from a child life Web site. Next, she reviews a written play session outline from a course textbook where students realize that adhering to a template is important. She distributes brief descriptions of therapeutic play activities, asking each student to develop a customized play session outline as homework. Finally, she alone assesses each learner's product to see how closely it replicates the textbook example. These learners have a partial and possibly adequate comprehension of how to facilitate a medical play session. But their misperceptions may never be addressed because only the instructor corrected their outlines. Peers did not see other students’ outlines, just their own. Students did not self-remediate their outlines for accuracy, but respected the instructor's judgment and assessment. They did not spend class time experiencing live facilitation of their outlines because the instructor believed coverage of how to plan a session was the learning priority with application to come during internship. These learners may be accumulating endless strategies without the opportunity to understand what really matters about facilitating play sessions—the complexity of directly interacting with children.

**Scenario B:** If the instructor’s focus is on learning, she may frontload understanding by requiring a chapter reading from a course textbook. She may require completion of a take-home quiz before the class session. She uses class time to skillfully facilitate a hands-on medical play session making Blood Soup, using a session outline format required of local internship students in a child life department.

Many classroom professors are searching for effective ways to change from a transmission mode of instruction to a focus on improving the learning and mastery of content by students (Wiggins & McTighe, 1998). For example, learning to facilitate therapeutic play sessions is a foundational competence with a distinct knowledge base. Compare the following scenarios with the goal of teaching students facilitation skills for group play.
life department. She distributes therapeutic play session descriptions and pairs students to co-develop a play session outline as homework (with a rubric specifying the required elements). At the next lesson, she has pre-arranged for students to facilitate their sessions in class with school-age participants from a campus childcare center (see Figures 3 and 4).

After a debriefing discussion of what went well and what didn’t go well, she may require students to rework their play session outlines to be more explicit, and to peer review them before resubmission. These learners may have a broader comprehension of facilitating therapeutic play sessions because they did the hard work of learning experientially. They may be more engaged and motivated by live facilitation and their instructor’s modeling, and hands-on interaction with children where they could perceive their own effectiveness. They may be excited to consider what they would change if they could repeat their play session. Their revised session outlines can become a celebration of insight as a take-along featuring a class-produced booklet and CD-ROM for each learner, ready to replicate and modify as actual play sessions during a practicum or internship.

**What Does It Mean To ‘Think Like a Child Life Specialist?’**

The above comparison cues educators and clinical supervisors to be more intentional about designing instruction as trainers who profess promoting the power of play to cope with medical events. Schulman (1999), a physician educator and former President of the Carnegie Council for Advancement of Teaching, suggests beginning with the learning question of how one might think when practicing a profession. For our purposes, the learning question might be, “What does it mean to think like a child life specialist?” Because we hold the APIE (Assess, Plan, Implement, Evaluate) process in common with other allied health professions, we might answer:

- **THINK like an assessor** who uncovers the pediatric patient’s coping style and developmental needs;
- **Think like a planner** who gathers the right play/coping resource at the right time to reduce the child/family’s anxiety;
- **Think like an implementer/facilitator** of medical play and family-centered interventions so the child/family understands what is happening during hospital stays; and,
- **Think like an evaluator** who measures and reports effectiveness of interventions, justifies existing services as evidence-based practice, and promotes new services.

According to Wiggins & McTighe (1998), the next step in planning learning is to identify and design engaging courses or lessons around four central topics. For a child life context, these may be:

- **Big ideas that have enduring value beyond the classroom**—how to help your own children cope with pain or master medical events when you become a parent;
- **Performance skills that reside at the heart of the discipline**—learning to facilitate medical play with teaching dolls or to provide distraction, preparation, and support for procedures;
- **Concepts that need clarification of abstract or often misunderstood ideas**—using minimally threatening language to talk to children about healthcare experiences; and,
- **Central values that offer potential for engaging students**—the excitement of shadowing a child life specialist in outpatient surgery, gowning in scrubs, and escorting a patient and her parents to the surgery suite for anesthesia induction; afterwards, writing a reflective report about your experience (See Figure 2).

**How Can Educators and Supervisors Emphasize Learning Goals?**

Wiggins and McTighe (1998) provide a model called ‘backwards design’ where an instructor considers six facets of understanding to plan content that will generate specific learner behavior:

- **Explanation**—using theories as justifiable accounts of events, actions, ideas;
- **Interpretation**—generating translations that provide meaning;
- **Application**—applying knowledge in new situations and diverse contexts;
- **Perspective**—expressing critical and insightful points of view;
- **Empathy**—getting inside another’s feelings and worldview; and
- **Self-knowledge**—displaying wisdom about one’s own ignorance, patterns of insight, and bias that prejudices understanding. Figure 5 reveals how these six facets might be matched to learning activities and expressed as learning goals in a syllabus or field placement manual across various lessons or sessions. This practice may help learners understand why the instructor/supervisor selected a learning activity, and how learners will benefit related to a particular facet of understanding. I display these in my syllabus and review them at the beginning of the lesson.

Constructing teaching goals focused on how the student will learn contrasted with mastering knowledge of job topics offers a colossal learning curve for educators and supervisors. For example, what is the learning goal for having students view the classic *My Little Clock?* The instructor’s goal may be for students “to understand reactions to hospitalization.” But that encompasses a whole

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**Table 5. Learning Activities Matched To Learning Goals Based On Six Facets Of Understanding (Wiggins & McTighe, 1998)**

<table>
<thead>
<tr>
<th>Learning Activity</th>
<th>Learning Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course introduction and syllabus</td>
<td>✓ Gain perspective on the course and course goals</td>
</tr>
<tr>
<td>My Little Clock [Video]</td>
<td>✓ Develop empathy from a child’s viewpoint</td>
</tr>
<tr>
<td>PowerPoint Lecture/Reading: Separation Issues</td>
<td>✓ Be able to explain separation anxiety and generalize what you know to scenarios in a quiz</td>
</tr>
<tr>
<td>PLAYSHOP: Play-Doh &amp; Poetry</td>
<td>✓ Gain self-knowledge of whether you are playful by creating a sculpture and interpretive poem</td>
</tr>
<tr>
<td>Review a medical play session template</td>
<td>✓ Apply a model to create a medical play session outline</td>
</tr>
<tr>
<td>PowerPoint Lecture: Bibliotherapy in Child Life</td>
<td>✓ Be able to interpret bibliotherapy as psychosocial intervention in child life and generalize a context for using a selected book</td>
</tr>
</tbody>
</table>
subset of smaller goals as performance skills. One goal could be to develop empathy for the child’s perspective as a patient (see Figure 5). Another goal might be improving skill at paying attention, really noticing the child’s expression of emotion (ask students to make a written list of observed emotions as active learning, not to simply view the film). Another skill might be developing fundamental respect for the child’s rights and identifying what those rights might be in a hospital environment.

In a textbook titled Classroom Assessment Techniques (Angelo & Cross, 1993), readers can access a reproducible template titled The Teaching Goals Inventory that helps college instructors become more aware of what kind of learning they want to accomplish in a course. This planning tool is also available online where a report generator will complete the calculations and show how well your planned activities fit teaching and learning in a specific course (see Online Resources section). The Carnegie Academy for the Scholarship of Teaching and Learning (CASTL) Institute helps faculty learn how to assess learning and teaching visible as ‘community property’ (Bernstein, Nelson Burnett, Goodburn, & Savory, 2006). For example, a ‘Gallery of Teaching’ profiles online teaching portfolios (see Online Resources section).

**What Teaching Practices Foster Engagement with Learning?**

Teaching emerges most of all from one’s identity while professing a profession (Palmer, 1997), hopefully, a passionate advocate of child life. Three techniques that foster engagement in my child life courses may trigger other educators and supervisors to identify their own strategies to promote learning:

- **Feature your philosophy of teaching and learning in your syllabus** (see Figure 6). I profess Parker Palmer’s ethic to “Live the lesson you create” by honoring the Child Life Council’s recommendation that course instructors should be child life specialists. An example of how I ‘live the lesson’ involves modeling the ‘anticipatory guidance’ a child life specialist employs to support children and families about what will occur during a medical event. On the first day of Child Life Psychosocial Interventions, students meet me at a local hospital for a tour by three child life specialists working on distinctive units. I provide written instructions with a hyperlink to the hospital Web site featuring directions to the pediatric unit and outpatient surgery locations, and a hyperlink to a virtual tour of the Ronald McDonald playroom in the oncology center. Students still experience the anxiety many parents describe of going to an unfamiliar destination (and the stress of ‘wayfinding’ once they are inside the hospital). But I ease and support them with clear directions in a format that NetGen learners prefer (an email with instructions).

- **Infuse learning with enjoyment.** Humorist Josh Billings noted, “There ain’t a lot of fun in medicine but there’s a heck of a lot of fun in medicine.” A child life specialist should be a playful person. An example of how I ‘live the lesson’ involves ‘anticipatory guidance’ to calm a distressed child. I often employ ‘distraction’ to calm a distressed child. I pay attention, really noticing the child’s expression of emotion (ask students to make a written list of observed emotions as active learning, not to simply view the film). A child life specialist employs to support children and families about what will occur during a medical event. On the first day of Child Life Psychosocial Interventions, students meet me at a local hospital for a tour by three child life specialists working on distinctive units. I provide written instructions with a hyperlink to the hospital Web site featuring directions to the pediatric unit and outpatient surgery locations, and a hyperlink to a virtual tour of the Ronald McDonald playroom in the oncology center. Students still experience the anxiety many parents describe of going to an unfamiliar destination (and the stress of ‘wayfinding’ once they are inside the hospital). But I ease and support them with clear directions in a format that NetGen learners prefer (an email with instructions).

- **Cultivate alliances with child life specialists and departments to provide directed experiences, volunteer participation, and service learning that animates coursework and excites students for the career.** Child life specialists at Gundersen Lutheran in La Crosse and St. Joseph’s Children’s Hospital in Marshfield are tremendous collaborators. Their involvement, modeling, and mentoring is a fundamental strength for growing learners into specialists. We work together to synthesize learning goals for independent studies that help students acquire hours in pediatric playrooms to understand the child life role. I share students’ written reports that convey how these specialists support learning. Working with students excites them and myself about practicing child life and helps us remember how it was to be a novice in the profession. Educators typically feature child life specialists as guest speakers in classes and some have the potential to host teleconferences and distance learning in technologically equipped classrooms. Educators might schedule volunteer orientations during class time to ease and accelerate students’ access to direct hospital or agency experiences. This approach afforded me with 18 bonafide volunteer opportunities during fall 2009, many of whom I supervised in an annual flu shot clinic where I provide pro bono services. A flu shot clinic is an ideal medical event for a learner to verify whether he/she has ‘the right stuff’ to calm a distressed child. Can the student learn to tolerate distress while keeping a light tone?
with a class contest to design a child life t-shirt. The winning design might be distributed as iron-on transfers that students can adhere to a favorite shirt. An instructor can model playfulness with a syllabus animated by compelling graphics (see Figure 5), and convey good humor in a cover letter to students in a syllabus conveying what’s important in a course (O’Brien, Millis, & Cohen, 2008) (see References section). Providing a new graphic syllabus (Nilson, 2007) may help NetGen learners accustomed to the excitement of YouTube and interactive media comprehend the big picture of a course better than a text syllabus.

An example of promoting enjoyment as a child life value is a final course session in Child Life Psychosocial Interventions which meets once weekly for two hours. In Fall 2009, this lesson featured camping and art-making. Co-presenters and the instructor set up a virtual camp in the classroom and class members brought Snuggies™, pillows, blankets, and a pre-planned food item for the camp buffet. After presenting a PowerPoint displaying therapeutic outcomes of camping as psychosocial intervention, the presenters facilitated making an edible campfire with pre-packaged supplies for each class member (http://www.kckpl.lib.ks.us/ys/cooking/FIRE.HTM). To close their segment of the lesson, they formed the class into a circle and replicated the Hole In The Wall Gang Camp’s ritual finale projected onscreen. In tandem with the campers in the video, the class grasped hands and ‘waved’ a group hug shifting hands up and over heads to hold each other’s backs (http://www.holeinthewallgang.org/Page.aspx?pid=658). Next, a second set of co-presenters explained therapeutic outcomes of art-making in a PowerPoint. They facilitated construction of Smile-Makers Make-Your-Own snow globe stickers to familiarize peers with common child life supply sources. They toured online sites such as virtual cookie decorating as a potential bedtime activity (http://www.theoworlds.com/christmas/). They concluded by facilitating completion of a sand art holiday project to simulate playroom group activity. Such active learning fosters engagement.

**Recommendations For Learning Child Life Practice**

It was thrilling to attend the Child Life Academic Summit hosted by Wheelock College in May 2009 following the Annual Child Life Conference in Boston. The magnificent work of the Child Life Education and Training Committee assuredly helps child life educators and clinical mentors begin to standardize expectations for academic course content and practice competencies. But the maculate human skills of teaching and learning remain a private and mysterious endeavor between instructors or supervisors and their students. Helping students learn to think like a child life specialist is exquisitely difficult given the explosion of knowledge about how people learn, and the demand for complex thinking and relating in healthcare delivery. Many child life educators are ad hoc instructors who work as clinicians and therefore may not have routine access to professional development regarding teaching and learning. Full-time educators can collaborate with these clinical instructors to embrace learner-centered approaches by loaning best practice resources (Nilson, 2003) and providing access to online campus centers for teaching and learning. When teaching and learning become more intentional and more active, the profession benefits and advances from such re-creation. Ultimately, today’s NetGeneration learners will perpetuate excitement for knowledge and skill-building as they become clinical supervisors and educators themselves.

**ONLINE RESOURCES**

- **Evaluating the NetGeneration**
  This comprehensive electronic resource promotes understanding of colleagues related to technology.

- **Journal of the Scholarship of Teaching and Learning**
  [https://www.isupui.edu/~josott/](https://www.isupui.edu/~josott/)
  This progressive online journal makes visible how to prioritize learning and elevate teaching and learning to a scholarly endeavor where teaching and learning are community property for all to see.

- **How People Learn: Bridging Research and Practice**
  [http://www.nap.edu/audioplayer.php?record_id=6160&n=0](http://www.nap.edu/audioplayer.php?record_id=6160&n=0)
  This free podcast hosted by the Institutes of Medicine explores the importance of how people learn to prepare for practicing a profession (requires audioplayer).

- **Teaching Goals Inventory**
  This online self-assessment and report generator allows a course instructor to sort 52 possible practical learning goals that fit what is being taught in a course (e.g., learn terms and facts, develop an openness to new ideas, improve ability to follow directions and use time effectively).

- **Carnegie Academy for the Scholarship of Teaching and Learning**
  This online resource highlights advances in learning related to medical education and provides a gallery of learning with digital features such as teaching portfolios.

- **The Course Syllabus: A Learning-Centered Approach, 2nd Edition**
  See excerpts of the table of contents and index of this ‘gold standard’ reference for new and experienced instructors.

**References**


G is for Gender Roles

continued from page 1

are based on assumptions and perceptions formed from gender stereotypes. When developing gender schema, children often incorporate these societal stereotypes into their own beliefs. Shaw (1998) states that “these are assumptions made about the characteristics of each gender, such as physical appearance, physical abilities, attitudes, interests, or occupations” (p. 24).

Research conducted regarding gender bias and stereotypes in children’s literature highlights how characters’ roles have been presented in ways that are limited in diversity. Most of this research has focused on the lack of female main characters in books, and the stereotypical roles female characters portray. Kortenhaus & Demarest (1993) analyzed 60 popular books written between 1970 and 1986. Of these books, only one showed a mother working outside of the home. More recently, Gooden & Gooden (2001) analyzed 1464 illustrations in 83 picture books written between 1995 and 1999. They determined that 23% of the illustrations focused on male characters and only 19% focused on females. When the actual roles of the characters were analyzed, males were seen in 25 different roles, and rarely seen in stereotypical female roles, such as caring for children, grocery shopping, or completing household chores. Females were seen in 14 roles, such as caring for children as mothers and grandmothers, and cleaning and doing laundry. It must be noted that these studies were conducted with North American books and gender roles, and may not accurately represent books and gender roles in other cultures.

Because child life specialists play a critical role in the education and support of children in the healthcare setting, they have the opportunity to influence the diversity of gender roles presented to children in picture books by carefully evaluating books before sharing them with children. While taking into consideration cultural sensitivities or differences, some aspects of children’s books that child life specialists can look for are:

• Do both males and females have important, valued characteristics and personality traits regardless of gender?
• Are both male and female characters logical, emotional, strong, or vocal, depending on the situation?

Child life specialists can get involved in discussions with children about the characters and their roles in the stories they read with children. For example, one could ask children if the characters in the stories could be reversed (could the princess have rescued the prince?), if they think a male or female wrote the story, or what the story tells us about males and females. In addition to carefully selecting books and leading discussions, child life specialists could address gender bias and stereotypes through activities such as role playing, dramatic or medical play, or art activities. For example, have children illustrate stories with gender neutral names and discuss their choice of males or females for lead roles, or role play and discuss how male and female characters might change the outcome of a particular book or story. Such interventions in an early childhood classroom have been associated with a significant change in occupations children felt were appropriate for males and females (Trepanier-Street, & Romatowski, 1999). Similarly, child life specialists can play a role in influencing these schemas through the books and activities they use with children.

Because the contents of books can influence children’s development of gender schemas during early childhood, child life specialists may want to make careful selection of books and complementary activities in their programs. The presentation of books that include a balance of male and female characters in a diversity of roles may enhance the use of books for educational and entertainment purposes in the healthcare setting.

REFERENCES


Creating Games
Continued from page 5

tion. For example: “Have you ever had a party with seven princesses?” or the silly situation like, “Have you ever danced with a hippopotamus?”

GAME EVALUATION AND RESULTS
McCue (1988) cites four conceptual categories of medical play: 1) role rehearsal/reversal, 2) medical fantasy play, 3) medical art, and 4) indirect medical play. The Frog game would be characterized as “indirect medical play” as it is a game with a medical theme and purpose. The game would most commonly be played after surgery (to facilitate fluid intake), but can also be played before surgery. Pre-surgery play may initiate conversation which would be an excellent opportunity to clear up any misconceptions the child may have.

Playing the Frog game serves the purpose of indirect medical play: familiarization, exploration, and education regarding a medical event (McCue, 1988). It also provides an opportunity for children to gather information while building relationships. This process helps desensitize children to the medical experience through engaging in conversation about tonsils, adenoids, and the importance of drinking fluids after surgery. The characters of the game (frogs named Tommy/Tina Tonsil and Amy/Alfie Adenoid) also add an educational component to the playful experience.

Preliminary results indicate that the Frog game has been received positively by staff and patients. Ms. Hartke reports that the children appear to enjoy the game very much. The game helps patients forget about what is going on and just enjoy playing, especially when they get to ring the bell. Children also respond well to the attention and support they are getting while playing the game. Families note that their children seem to enjoy playing the game and that they like having a happy and cooperative child. What is critical for Ms. Hartke and nurse practitioners from that department is the opportunity to provide a positive alternative for accomplishing the discharge goal.

Playful, enjoyable interventions, such as this and other games, can reduce some frustration and fatigue which can sometimes make the discharge experience a very unpleasant situation for patients and families.

SUMMARY AND FUTURE APPLICATIONS
A game can be a fun, clever, and successful child life intervention. Child life specialists, with their insight and expertise in child development, are in a unique position to generate and develop ideas for new games. When creating new games or modifying existing games for therapeutic use, Swank (2008) considers it essential to reflect on the purpose, to add an element of fun, to consider a variety of learning styles, to keep in mind age appropriateness, and to make sure the game can serve diverse populations. The use of games provides a way for child life specialists to meet specific needs of children. Creating, developing, and using games can be one of many ways to reach and to serve children through their natural language of play.

REFERENCES
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- Ed and Diane Grant
Distinguished Service Award

Continued from page 1

Missi’s enterprising spirit and outstanding contributions to the profession will be celebrated at a special presentation of the CLC Distinguished Service Award at the 28th Annual Conference on Professional Issues in Phoenix. First bestowed upon Emma Plank in 1988, the Distinguished Service Award is presented once a year by the CLC Executive Board to an individual in the field of child life who has contributed significantly to the development of the profession.

Missi began her career as an intern at Johns Hopkins, and after two rotations, was convinced that she wanted to work there in pediatric oncology. “At first I worked there part time on weekends, and during the week I worked at a small orthopedic hospital in Baltimore, until eventually a full time position became available at Hopkins,” says Missi. She spent five years at Johns Hopkins, where she says leaders Jerriann Wilson and Belinda Ledbetter taught her much about how a quality program can work. After a brief period working as a developmental therapist in North Carolina, in 1995, Missi moved to a growing child life program at AFLAC Cancer Center at Children’s Healthcare of Atlanta (CHOA), where she coordinated child life programming for pediatric cancer patients. While in Atlanta, Missi earned her master’s degree in professional counseling at Georgia State University.

In 2000, Missi moved to Texas with her husband Henry, who had a job opportunity in Austin. During her first year there, she worked for the Childhood Cancer Survivorship Network, and she also began to explore the world of private practice and consulting as a child life specialist and counselor. “As professionals, I think many of us have a hard time charging for our services, even though there is a huge need for what we do. It may be because of working in the hospital where we do not charge a fee for service,” Missi reflects. “At times it wasn’t easy.” So, when Missi met fellow child life specialist Meredith Cooper, LPC, MA, CCLS, she felt ready for a change.

In their collective years working in hospital settings, the two child life specialists had witnessed the need for community based services for children impacted by illness, including those with a parent or other family member who has been diagnosed with a serious condition. Together, Missi and Meredith developed the concept for Wonders & Worries, a nonprofit organization that could offer more formalized psychosocial services for children and families outside of the hospital setting. With the support of the Lance Armstrong Foundation, they conducted a pilot support group in 2001. The benefits of the program proved to be overwhelming, and Wonders & Worries was officially incorporated later the same year. Although Missi left Austin in 2003 to return to Atlanta, as co-founder she remains a member of the Wonders & Worries Board of Directors, and her involvement in the formation of the organization is one of her proudest accomplishments. Today, Wonders & Worries offers services free of charge to hundreds of families in Austin and surrounding areas, and has established a strategic plan for a national expansion. Missi currently is focusing on the expansion initiatives.

After returning from Austin, Missi took a position as Program Director at the recently established Camp Sunshine House in Atlanta. Ironically, it had been Missi who, during her days as a child life specialist at CHOA, had pitched the idea of providing year round support services for families at a community based facility to Camp Sunshine. “Fortunately for me, by the time I returned the Atlanta, they [Camp Sunshine administrators and Board of Directors] had done all the work of getting the funding and making that vision a reality . . . and they needed someone to run the psychosocial support services at the Camp Sunshine House. I got butterflies the first few days I was in the house!” she says.

During her time at Camp Sunshine, Missi was able to apply her unique experiences in settings both within and outside of the hospital, and take on an entirely new role as editor of Child Life Beyond the Hospital, a Child Life Council publication (2008). “I think the [limited] availability of hospital-based jobs will continue to be an issue,” Missi argues, “and it will be important to learn how to apply child life skills in outside [alternate] settings, and how to find the opportunities that are out there.” To create the book, Missi solicited contributions from 22 individuals who collaborated on a total of 19 chapters, each introducing a unique environment in which child life specialists are applying their skills. Several chapters are written from Missi’s own experiences working in private practice, camp settings, and nonprofit child life services. “Non-hospital based practice is still in its infancy,” says Missi. “We’ll have bumps and bruises along the way, but figuring it all out is going to be exciting.”

“As professionals, I think many of us have a hard time charging for our services, even though there is a huge need for what we do. It may be because of working in the hospital where we do not charge a fee for service . . . At times it wasn’t easy.”
In addition to her recent work on *Child Life Beyond the Hospital*, Missi has contributed articles and chapters in a number of other publications, including the *Handbook of Child Life* and the *Journal of Pediatric Oncology Nursing*. A lengthy list of Missi’s past conference presentations cover a wide range of topics reflecting her broad experience and skill set.

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Missi’s involvement with CLC began back in 1989 with one of her first jobs as a child life specialist, where she was urged to participate on the Child Life Application Review Committee (certification). “At first, I was concerned about it, but when I became involved, I got a chance to interact with so many people I admired.” After a number of years on the review committee, she became chairperson for the Child Life Certifying Committee from 1997-2000. She served as President-Elect from 2000-2002, President from 2002-2004, Chair of the Past Presidents Council from 2004-2006, and has since been a member of both the Conference Planning Committee and the Web and Online Networking Task Force (WONAT). Missi is especially proud of her work as President of CLC. “It was a time of such great momentum and growth,” she remembers. Under Missi’s leadership, the Child Life Council selected a new executive director after the departure of former director Deborah Brouse. She also led the organization in one of its first formal strategic planning initiatives, which helped to lay the foundation for the current CLC strategic plan. “During that time we took the next step as an organization,” says Missi.

To newer professionals, Missi offers this piece of advice: “Hone your clinical skills, and get involved at some level. While you don’t have to be in charge, it will give you confidence, and it will enhance your professional network and practice. For me, my work with CLC has been one of my most enriching experiences.”

“Non-hospital based practice is still in its infancy. We’ll have bumps and bruises along the way, but figuring it all out is going to be exciting.”

Currently living in Raleigh, North Carolina, Missi has continued her consultation and clinical supervision work, and is staying active as a volunteer leader with CLC and other organizations. Add to this the job of being Mom to 5-year-old Emma — “the best thing I’ll ever do” — and Missi is keeping very busy!

Please join us in celebrating Missi’s achievements at the Distinguished Service Award Presentation, which will take place on Sunday, June 13, during the Closing General Session of the 28th Annual Conference on Professional Issues in Phoenix.

### Executive Director

Continued from page 3

and share files of all types (including documents, presentations, pictures, video and more) with colleagues.

This platform will also play host to a new, online Directory of Child Life Programs. We are thrilled that a directory component is already part of the system, and will allow us to begin that effort sooner rather than later. The success of the first online edition of the Directory, along with the rest of this new professional networking platform, will rely on members embracing it and sharing information with their colleagues. This exciting new set of tools should be valuable to the profession – and, we hope, fun! We will be getting the background work done and will be launching this new platform soon – so hang on, and stay tuned, and we hope to see you there!

### 2011 Call for Abstracts

**CHILD LIFE COUNCIL**

**29TH ANNUAL CONFERENCE ON PROFESSIONAL ISSUES**

**MAY 26-29, 2011**

**SHERATON CHICAGO HOTEL & TOWERS**

**CHICAGO, ILLINOIS**

The Sheraton Chicago Hotel & Towers is Chicago’s premier downtown riverfront hotel, just off Michigan Avenue, and within a short walk of Navy Pier, Millennium Park, museums, shopping and entertainment.

The hotel offers spectacular views of either Lake Michigan or the city skyline.

Abstract submissions for the CLC 29th Annual Conference will be accepted through the CLC Web site beginning June 15, through July 30, 2010.

For more information visit www.childlife.org.
CLC Calendar

**May**
1. Deadline for written requests to withdraw from June administration of the Child Life Professional Certification Exam
12. CLC Webinar: The Power of Group

**June**
1. CLC 28th Annual Conference registration deadline
10-13. CLC 28th Annual Conference on Professional Issues, Phoenix, AZ
10. Child Life Professional Certification Examination, Phoenix, AZ
15. Call for Abstracts opens for 2011 Conference
30. Deadline for recertifying by Professional Development Hours (PDHs)
30. Deadline for applications for the November administration of the Child Life Professional Certification Exam for those educated outside the U.S. and Canada

**July**
15. Deadline for Bulletin and Focus articles for Fall 2010 issue
30. Call for Abstracts deadline for 2011 Conference

**August**
31. Deadline for applications for the November administration of the Child Life Professional Certification Exam for those educated within the U.S. and Canada

Visit the Child Life Marketplace
If you haven’t had the opportunity to visit the Child Life Marketplace, you could be missing out! The directory provides convenient access to contact information from a growing number of organizations that work with the child life community, and some vendors are also offering discounts and special offers exclusive to CLC members. If you have worked with one of the businesses or nonprofit organizations listed in the Marketplace, consider sharing your experiences with your colleagues by rating and commenting on a listing. Be sure to visit regularly to check out what’s new on the site!