CLC Hosts International Summit on Pediatric Psychosocial Services

Dennis Reynolds, MA, CAE; CLC Executive Director

Immediately following the 32nd Annual Conference on Professional Issues in May 2014, CLC hosted a two-day International Summit at the Hilton Riverside in New Orleans. Forty-six delegates bringing ideas from six continents, 45 countries, and multiple professional backgrounds discussed the global state of pediatric psychosocial care and development of these services around the world. The Summit was made possible through a generous grant to CLC from Disney Corporate Citizenship as part of the second year of the Advancing the Field of Play Initiative.

Delegates first attended the CLC Annual Conference and then met together to constitute The International Summit on Pediatric Psychosocial Services. While there were two keynote presentations at the Summit, the vast majority of the time was spent in a panel presentation format, with delegates describing the state of pediatric psychosocial care in their respective countries and addressing their circumstances in the context of various topics.

The Summit began with a brief “open mic” session where delegates were invited to share impressions of the CLC Annual Conference. The consistent feedback indicated a high regard for the child life profession. They were awed that there is an

Child Life Alphabet

Y is for Young Adults

Jessica Irven, MS, CCLS, LRT/CTRS; UNC Health Care, Chapel Hill, NC; Phoenix Society for Burn Survivors

Young adulthood is the age at which the transition to independence in decision-making and medical care typically occurs. The age defined as young adulthood varies according to culture, family, and even personal opinion. An alternate term “emerging adults” (Arnett & Tanner, 2006) provides an especially accurate perspective in facilitating independence within the health care setting. Child life specialists working with young adults can provide an invaluable service by recognizing each individual’s developmental level, personality, needs, and wishes during this process.

Specific recognition of this population’s unique needs is an evolving health care trend. A joint statement by the American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians-American Society of Internal Medicine (2002) identified the provision of focused service to young adults as a key health care priority. In particular, the statement illustrates that there should be a strong focus on “maximizing individuals’ lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood” (p. 1304). Additionally, The National Alliance to Advance Adolescent Health (n.d.) states that, “serving young adults must not only include choices and control, but also empowerment to facilitate developmental progression toward independence.”
**PRESIDENT’S PERSPECTIVE**

**Looking Back, Looking Forward**

Carla Oliver, MSW, CCLS

What an exciting time it is to begin my journey as president!

At a time of major change and uncertainty in health care, nearing the end of CLC’s 2012-2014 Strategic Plan, and at the beginning of new CLC initiatives—who wouldn’t be excited (and, ok, maybe a little nervous)!

I enter this chapter feeling well prepared. After working so closely with an incredibly talented and dedicated CLC Board of Directors under the amazing leadership of Amy Bullock Morse this past year, and now partnering with our new board and Sheri Mosely as our president-elect, I feel extraordinarily confident about the direction CLC is taking!

Looking back, I have to laugh when I think about how I began my journey with CLC. I had just completed my internship at Rainbow Babies and Children’s Hospital, under the guidance and leadership of Mary Barkey, MA, CCLS, Ellen Hollon, MS, CCLS, and Rose Resler, MA, CFCS, CCLS. It was the early nineties, and I was ready for my first job ANYWHERE! Several of my mentors encouraged me to attend the Annual Conference on Professional Issues, which was in Chicago. I was completely overwhelmed, reaching out to every hiring manager in attendance, interviewing in hotel rooms, trying to get to every session, and being in a big city, on my own, for the first time.

I also recall being in complete awe of the leadership of the organization. I was inspired by then-president Susan Salisbury-Richards, who was succeeded by Kathleen McCue, MA, LSW, CCLS. I remember thinking to myself, “I want to be like them when I grow up.”

I have been a member of CLC since I declared child life as my major. Even then, I considered membership to be a professional responsibility, despite my financial situation. As child life was still a fairly young profession, I felt compelled to support the organization whose purpose was to advance the field of child life, my passion.

Throughout my journey with CLC, I have been amazed by the passion and commitment of its members. From my colleagues on the board, to the hundreds of members who volunteer their time to advance our profession, to the students and new professionals who are just becoming involved and sharing their thoughts and ideas—I know that I am beyond fortunate to work with so many talented and dedicated people.

I have been fortunate to work with the incredible CLC staff, a small but mighty group who work tirelessly to carry out the many initiatives and programs that benefit each of us. We are lucky to have such a committed and hard-working group handling the day-to-day operations of our organization.

The CLC Conference in New Orleans this year was a huge success and a wonderful experience. There were excellent presentations that focused on so many aspects of the child life profession. I am grateful to our Conference Planning and Local Host Committees for offering content for people at all stages in their careers as child life specialists. For me, it was truly a challenge to choose which sessions to attend! There is one word to describe the way I felt throughout the conference: humbled.

As the board gets down to business for the 2014-2015 term, I would like to share with you a bit of the exciting work ahead of us. A Health Care Task Force has been struck to closely examine changes in health care that may affect the child life profession. This committee consists of leaders who are closely tuned in to current trends, and their recommendations will contribute to the direction of our new Strategic Plan, which will be the focus of our energies in early 2015.

Once the plan is finalized, it will provide the framework for the direction that our organization will take in the coming years. If you have ideas, suggestions, or feedback that may inform our work, please know that the board genuinely appreciates and welcomes your input. Please contact strategyplanning@childlife.org with your thoughts by December 1, 2014.

It is important to the board and to me that we take a moment to thank each of you for supporting CLC through your membership. Beyond this, I would like to extend my gratitude to those members who go the extra mile by volunteering on a CLC committee or task force. I am so grateful for all of the hard work currently underway by the staff, committees, and task forces working on different activities related to the Strategic Plan, and look forward to sharing the exciting products of their efforts in the year ahead!
FROM THE EXECUTIVE EDITOR

The Power of Writing
Jessika Boles, MEd, CCLS

At the ripe, creative age of eight, I entered my very first writing competition. As a fourth grader in a suburb of San Francisco, competition was fierce. None other than my best friend, Jamie, had crafted an amazing short story featuring our favorite Power Rangers characters, and Mario (the cute boy in class) had penned a poem about basketball that could teach everyone a thing or two about imaginative rhyming. Then there was myself—the quiet, shy girl with glasses who sat in the back of the class, secretly reading novels stashed between the covers of my grammar textbook. I remember telling my mother that I wanted to write a poem and enter the contest, and her response was encouraging as always: “I’m sure whatever you write will be wonderful.” I still had my doubts.

You see, it wasn’t the writing I was afraid of—it was how others would respond to my own thoughts, feelings, and experiences publicly on the page for all to interpret and judge. Nonetheless, this was my chance and I had to go for it; besides, all of the cool kids in class were already writing! I thought long and hard, and sought inspiration from every corner of life. With a notebook in my pocket, I drafted countless stanzas about my favorite books, games, and television shows. Then, one day, it just came to me! As I furiously scribbled away on the wood-floored entry way of our house, I knew I had struck literary genius! I read my poem to my mother and she agreed—it was “the one.” She helped me tweak a few lines and phrases, and I proudly turned it in to my teacher the next morning.

Two weeks later, when the contest ended, “Why Does Dad Snore?” received an honorable mention. Even more meaningful than the award was the acceptance I gained from my peers, and the personal satisfaction of knowing that I had put myself out there and found success simply in the act of trying. From then on, a writer was born.

Fast forward a couple of decades, and I now find myself in an interesting juxtaposition—as the new executive editor of Bulletin and Focus. Although I can still hear that once-timid and less-than-confident version of my writer self, her whispers are mostly replaced by a very real conviction in writing as a vehicle for knowledge, opportunity, collaboration, change, and as a process of self-exploration. After all, writing is a communal enterprise; the thoughts we form and translate to the page are always a reflection of the people who have brought us to our current moment in our current form. The stories I tell are born of relationships with others, and the truths I share are co-constructed pieces of anecdotal experience blended with systematic evidence from a variety of sources. Writing, then, is a way of being in the world that we are all naturally endowed with, and that we are all equally owed.

Although we have a right, a responsibility, and a need to write, that doesn’t always mean that writing is easy. It can feel slow and mechanical at times, especially if we are out of practice. Writing can feel uncomfortable, like tearing off a band-aid and exposing a vulnerable part of ourselves to the outside elements—like our peers. Or, writing can feel mentally, emotionally, and physically exhausting as we live two lives at once, both in the present and on the page.

However, writing can also feel exciting, inspiring, and liberating as the words on the page prove the boundlessness of the human heart and mind. Just a single written page can provide a sense of satisfaction, accomplishment, and personal pride. And writing can create and maintain friendships, can renew and re-invigorate relationships, and document the lives and legacy of these emerging beginnings and continued bonds.

In my new position as executive editor, I think I would summarize my vision for the next two years as: writing is everything, and everyone can write. The power of Bulletin and Focus comes from the direct lines between clinical practice, developmental theory, and the academic and professional communities. We strive to invite a wide range of submissions and we appreciate the ideas and creativity of all who wish to write. We offer a collaborative review process through which authors can receive and respond to feedback, including an available writing mentor program for those who would like help finalizing their article for Focus. In addition, as editors we are always available to provide input on ideas for articles, offer feedback on works in progress, or to help answer questions about the writing and submission process.

Regardless of your ability, experience, and comfort level, we are here to support you in this valuable, revelatory journey. Bulletin is one of the only precious spaces we have to share our innovative programs, record our practice-changing experiences, and document our history and evolution as child life specialists, researchers, academics, students, administrators, and members of the field that we all so very much believe in. All that’s left to do, then, is to trust your instincts, silence your timid self, and grab a pen (or laptop). We can’t wait to help you speak your truths and, as a result, change us all for the better. Happy writing!
International Spotlight

A Different Kind of Student Experience
Joanne Hochu, MEd, CCLS, BC Children's Hospital, Vancouver, BC

Imagine you are about to travel to a foreign country to work in your daily profession, using a second language (a language with which you are familiar but not totally at ease in using) to elevate your qualifications under a supervisor's scrutiny and evaluation. This is happening right now in various parts of North America within the child life profession. From September of 2013 to June 2014, the staff in the Child Life Department at BC Children's Hospital (BCCH) in Vancouver, British Columbia welcomed and supervised several students who came from abroad.

Karen Leung, BSW, and Phoebe Ko, BSW, hospital play specialists from Hong Kong, Karen van Zijl, BA, M DIAC, a play therapist from South Africa, all completed their child life internships at BCCH as a step toward becoming Certified Child Life Specialists.

These international students were welcomed and supported by BCCH's director of Patient and Family Centered Care, Diane Hart, MA, CCLS, EDAC. The circumstances for the students initiating conversations about internships at BCCH with Diane were serendipitous. In one situation, a conversation with Diane at the 2012 CLC Conference led to the possibility of an internship at BCCH. In the second instance, two physicians (one from Hong Kong and one from BCCH) were having a dialogue about integrating child life services into a new children's hospital under construction in Hong Kong and drew Diane into their conversation. From there, the possibilities of internship opportunities grew.

The students registered through one of our local universities, the University of the Fraser Valley (UFV), where they completed prerequisites making them eligible for application to the clinical internship experience. The students applied to our hospital and were interviewed for internship positions as is standard protocol. From there, UFV assisted each of them with obtaining their student visas so that they could register for internships and monitored their experiences throughout the internship. They were provided with support from the university for any student issues that arose while they were in Canada.

Each professional took risks in undertaking clinical internship experiences. Phoebe and Karen from Hong Kong were initially unsure about working in their third language of English (both speak Mandarin and Cantonese) and were concerned whether their English was proficient enough to work effectively with patients and families. Karen Van Zijl felt comfortable in her second language of English (her first being Afrikaans), but occasionally asked what the English word was for a concept she was thinking of in Afrikaans.

Karen and Phoebe's husbands remained in Hong Kong while they were in Canada, while Karen Van Zijl's husband and children came to live with her in Canada while she completed her internship.

Our department has learned valuable lessons from the amazing sacrifices each of our international interns made to undertake an internship so far from their respective homes. Each of them left jobs, colleagues, and everything with which they were familiar in their home environments. In North America, they faced the daunting task of working in a different language to communicate and connect with patients, families, and staff who are immersed in cultural ways very different from their own. They came to the clinical internship with many questions about professional and clinical experiences they have had in their home settings. Ensuing discussions went beyond what we experience with typical students, to include questions such as, “In Hong Kong, how would the environment or resources differ?” “Have similar experiences with health care team members happened in South Africa?”

We were also reminded throughout these encounters how much international colleagues must work to gain acceptance for the child life profession in environments unfamiliar with the field or with concepts such as family-centered care. Our international interns continue to advocate, network, and make connections with those wanting to elevate the psychosocial care of children and their families in their settings. Each of these professionals has an amazing amount of dedication and resilience. They have taken risks to further the child life profession as well as their personal skills to take back and implement in their home countries.

The challenges have been few and the benefits great for our child life department. On a personal level, we have been energized and enriched by the commitment and knowledge our international colleagues have brought to our setting. We realized that many of our workplace challenges and issues are similar. We gained a deeper appreciation for the value and acceptance of our profession within our own hospital setting in light of the uphill struggle our international colleagues face with far fewer resources available to them.

The news we have been following about the development of our profession across the world has new meaning for us. In a small way, we feel like we are contributing to building an international knowledge base and supporting the Child Life Council's strategic initiative in reaching out to those who support the continuing development of the psychosocial needs of children and their families facing health care challenges around the world.
The American Academy of Pediatrics Policy Statement on Child Life: Crafting a Supportive Document

Chris Brown, MS, CCLS
UF Health Shands Children’s Hospital, Gainesville, FL

At its first meeting in 1930, the American Academy of Pediatrics (AAP) Executive Board appointed several committees, one of which was the Committee on Hospitals and Dispensaries, designed primarily to recommend ways in which U.S. hospitals could improve the care of children. The mission of the committee, renamed the Committee on Hospital Care (COHC) in 1955, is “to collaborate with AAP members, pediatric specialists, families, national organizations and hospital providers to develop and disseminate standards, policies, guidelines, and expert advice supporting the delivery of safe and effective patient and family-centered hospital care of children in conjunction with the patient’s medical home.” (American Academy of Pediatrics, n.d.). Since 1973, child life has had an invited seat at the AAP table. The first liaison to the committee was Emma Plank, MA, appointed by the Board of the Association for the Care of Children’s Health (ACCH), followed by B. J. Seabury, MA, and Jerriann Wilson, MEd, CCLS. When ACCH was disbanded in 1999, the Child Life Council was invited to continue this valuable liaison role. CLC has thus been represented by Jerriann Wilson, Chris Brown, MS, CCLS, and, presently, Barbara Romito, MA, CCLS.

In 1985, the first statement, “Child Life Programs for Hospitalized Children,” was published in the journal of the American Academy of Pediatrics (American Academy of Pediatrics Committee on Hospital Care, 1985). Interestingly, the stated intent of the article was to describe and defend what was seen as a vulnerable program in a fiscally challenging climate:

There is increasing emphasis on the finances involved in the care of children in hospitals. In times of financial difficulty, biosocial programs may be curtailed. One of the most progressive, useful, and humane programs to be initiated in recent years is the child life concept. These programs are essential to quality care, and the Committee on Hospital Care of the American Academy of Pediatrics is concerned that existing child life programs may be endangered and plans for new programs abandoned, because of fiscal restraints. The purpose of this statement is to describe the concept of child life, its nature, function, and inherent worth. Information is provided for physicians, hospital administrators, government officials, and others who make decisions affecting the sponsorship of child life programs in children’s hospital units. (p. 467)

The statement has evolved to reflect the growth and development of the profession itself and has been greatly expanded via several revisions, with both the 2006 and most recent version being officially co-authored by the Child Life Council. On a 5-year cycle that determines revision, reaffirmation, or retirement of each AAP policy statement, a detailed “intent” process is required, including proposed revisions and a literature search. Throughout the process, several AAP committees and sections review and provide feedback to the statement. Final approval is required by a unanimous vote of the AAP Board.

continued on Focus page 2

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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Policy Statement: Child Life Services

Committee on Hospital Care and Child Life Council
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Abstract

Child life programs are an important component of pediatric hospital-based care to address the psychosocial concerns that accompany hospitalization and other health care experiences. Child life specialists focus on the optimal development and well-being of infants, children, adolescents, and young adults while promoting coping skills and minimizing the adverse effects of hospitalization, health care, and/or other potentially stressful experiences. Using therapeutic play, expressive modalities, and psychological preparation as primary tools, in collaboration with the entire health care team and family, child life interventions facilitate coping and adjustment at times and under circumstances that might otherwise prove overwhelming for the child. Play and developmentally appropriate communication are used to: (1) promote optimal development; (2) educate children and families about health conditions; (3) prepare children and families for medical events or procedures; (4) plan and rehearse useful coping and pain management strategies; (5) help children work through feelings about past or impending experiences; and (6) establish therapeutic relationships with patients, siblings, and parents to support family involvement in each child’s care.

Child Life Programs

During the 1920s and 1930s, early hospital play programs were initiated at several children’s hospitals, including Mott Children’s Hospital, Babies and Children’s Hospital of Columbia Presbyterian, and Montreal Children’s Hospital. In 1955, Emma Plank, under the direction of Dr. Frederick C. Robbins (Nobel Laureate), developed the first Child Life and Education division at Cleveland City Hospital. Plank is considered a founding “mother” of the profession, and her landmark publication, Working With Children in Hospitals, serves to educate many about the unique needs of children in the health care setting.

Today, hospitals specializing in pediatric care routinely include child life programs, with more than 400 programs in operation in North America. Child life services are recommended and offered to varying degrees in community hospitals with pediatric units, ambulatory clinics, emergency departments (EDs), hospice and palliative care programs, camps for children with chronic illness, rehabilitation settings, and some dental and physician offices. In cases of hospitalized or ill adults, certified child life specialists (CCLSs) may be consulted to work with children of adult patients, particularly in end-of-life cases, trauma, and critical care.

Child life programs are not unique to North America; similar programs can be found in other countries such as the United Kingdom, Japan, Kuwait, the Philippines, South Africa, Serbia, New Zealand, and Australia. The provision of child life services is a quality benchmark of an integrated patient- and family-centered health care system, a recommended component of medical education, and an indicator of excellence in pediatric care. An experimental evaluation of 1 child life program model showed that child life interventions resulted in less emotional distress, better overall coping during the hospital stay, a clearer understanding of procedures, and a more positive physical recovery as well as posthospital adjustment for children enrolled. Patients spent less time on narcotics, the length of stay was slightly reduced, and parents were more satisfied. Other studies have found that child life interventions play a major role in calming children’s fears and result in higher parent satisfaction ratings of the entire care experience.

There are a number of variables to consider in identifying adequate child life staff-to-patient ratios. Although a ratio of 1 full-time CCLS to 15 inpatients is useful as a guideline, a number of factors should influence specific staffing allocations. Generally speaking, child life services should be available to meet identified patient or family needs 7 days a week. In hospitals with very small pediatric units and low outpatient volume, 1 CCLS may provide services in both the inpatient and outpatient areas, including consultation services to the ED.

References


With primary recommendations that child life services should be delivered as part of an integrated patient- and family-centered model of health care, that those services should be provided by a Certified Child Life Specialist, and that the research base and financing of child life services be promoted, the AAP policy statement (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014) continues to serve as a valuable resource for child life professionals in their advocacy efforts and validation of our work.

Serving as CLC’s liaison to the AAP Committee on Hospital Care for the past eight years, and following in the footsteps of our field’s most illustrious leaders who’ve served in this capacity before me, has been a humbling and growth-producing experience. I still find it remarkable that CLC has been granted this special relationship, particularly given that the only other organizations with liaison positions on the committee are the American Hospital Association and Children’s Hospital Association. The physicians who’ve made up the committee over this period, most of whom do not work in large children’s hospitals, have openly welcomed a “psychosocial” voice at the table. Beyond the resulting Child Life Services Policy Statement, this inclusion has enabled rich conversations about the needs of children and their families in healthcare settings. As we all know, these collaborations are critical, both in our individual hospitals and in the public policy arena, to the quality of care delivered to patients and their families and to the child life profession.
In hospitals with high-volume pediatric emergency services, more than 1 CCLS is generally required to enable 7-day coverage of the ED. In larger hospitals, 1 or more CCLSs are typically assigned to each inpatient unit or outpatient area, including standing and/or rotating schedules to provide weekday, evening, and weekend coverage. In any case, staffing plans should be sufficient to meet fluctuations in anticipated and unanticipated staff absences, season swings in patient census, and nonclinical community activities (eg, increased visits and in-kind donations during the holiday season, variations in individual patient and family needs).

Child variables (temperament, coping style, and cognitive abilities), family variables (parental anxiety, presence, and involvement), and diagnosis/treatment variables (the number of invasive procedures) are known to affect psychosocial vulnerability and thus influence the child’s particular child life intervention needs. A combination of psychosocial risk assessment, medical/treatment variables (eg, the proportion of patients with isolation precautions, the volume of patient/family teaching needs), and the time requirements associated with particular interventions directly affect operational staff-to-patient ratios in both inpatient and outpatient settings. Table 1 lists variables that typically require child life interventions of greater frequency, duration, or complexity, thus influencing effective CCLS-to-patient ratios.

The credentials of a CCLS currently include the minimum of a bachelor’s degree in child life, child development, or a closely related field; the successful completion of a 480- to 600-hour child life internship under the supervision of a CCLS; and passing a standardized certification examination. Advanced degrees in child life are also available, and CCLSs often develop particular areas of expertise related to the patient populations they serve.

In some settings, child life services are augmented by child life assistants (or activity coordinators or child life technicians). Child life assistants are typically required to have core college coursework, such as an associate’s degree in child development, and experience with children in group settings. They generally focus on the “normalization” of the health care experience, providing play activities, coordinating special events (eg, community visitors, holiday celebrations), and maintaining the playroom environment. Both CCLSs and child life assistants actively participate in the orientation, training, and supervision of volunteers, thereby contributing to volunteer effectiveness, satisfaction, and retention. This collaboration enables the CCLS to conduct an assessment and delegate as appropriate, allowing patients with varying degrees of psychosocial vulnerability and activity levels to be supported by the team member whose skills and knowledge are most closely aligned with patient/family needs. Although volunteers are a valuable supplement, they can never be considered an adequate replacement for trained/certified professionals.

CCLSs are part of an interdisciplinary, patient- and family-centered model of care, collaborating with the family, physicians, advance practice providers, nurses, social workers, and other members of the health care team to develop a comprehensive plan of care. Child life contributions to this plan are based on the patient’s and family’s psychosocial needs, cultural heritage, and responses to the health care experience. For example, child life specialists can participate in the care plan by teaching a child coping strategies for adjusting to a life-changing injury, promoting coping with examinations for alleged abuse, assisting families in talking to their children about death, facilitating non-pharmacologic pain management techniques, and communicating the child’s developmental and individual needs and perspective to others. These interventions are most effective when delivered in collaboration with the entire health care team.

**TABLE 1. FACTORS NECESSITATING OR SUPPORTING A LOWER RATIO OF PATIENTS TO CCLSs**

- High volume of patient-family teaching needs (eg, surgeries and other medical procedures), especially when combined with high patient turnover rate
- High proportion of patients requiring 1-on-1 interventions (eg, isolation rooms, ventilator-dependent patients, examination/treatment room interventions, critical care units)
- Multiple simultaneous needs (eg, ED during peak hours)
- Frequent time-consuming demands (eg, support during lengthy medical procedures, end-of-life support)
- Significant nonclinical demands, such as supervision of child life students, representing child life on hospital committees, public relations and marketing activities, and other administrative duties

**THE THERAPEUTIC VALUE OF PLAY**

Play is an essential component of a child life program and of the child life professional’s role. In addition to play’s developmentally supportive benefits and as a normalizing activity for children and youth of all ages, it is particularly valuable for children who are anxious or struggling to cope with stressful circumstances. Erikson writes, “To play out is the most natural autotherapeutic measure childhood affords. Whatever other roles play may have in the child’s development . . . the child uses it to make up for defeats, sufferings, and frustrations.”

Play in the health care setting is adapted to address unique needs based on developmental level, self-directed interests, medical condition and physical abilities, psychosocial vulnerabilities, and setting (eg, bed-side, playroom, clinic). Play as a therapeutic modality, including health care play or “medical play,” has been found to reduce children’s emotional distress and help them cope with medical experiences. Research has shown that physiologic responses, such as palm sweating, excessive body movement, tachycardia, and hypertension, can be reduced with therapeutic play interventions.

Play can be adapted to address the developmental and psychosocial needs of patients in every pediatric age group. For example, infants and toddlers benefit from exploratory and sensorimotor play, and preschool-aged children enjoy fantasy play and creative art activities. Opportunities for parents to engage in play activities with their young children are beneficial to both patient and family, alleviating some feelings of helplessness in parents and assisting in the child’s hospital adjustment. School-aged children and adolescents seek play that contributes to feelings of mastery and achievement, which is one reason video games are so popular with this age group. Patients in this age group also benefit from activities that allow them to maintain relationships with peers and establish
new connections through, for example, online networking and the availability of teen activity rooms in the hospital setting.27

Auxiliary programs, such as animal-assisted therapy, infant massage instruction, use of therapeutic clowns, performing arts, and artist-in-residence programs, often used in conjunction with child life services, provide additional outlets for patients of all ages and their families.28,29 Live, interactive programming, such as hospital bingo or patient-produced videos (broadcast over a closed-circuit television system), can be a particularly effective way to engage patients restricted to their rooms for infection control or medical reasons. Expressive therapies, such as those provided by distinctly certified play therapists, music therapists, and art therapists, can be offered to complement child life programs and to provide support for particularly vulnerable patients.30,31

**Psychological Preparation**

Preparing children for hospitalization, clinic visits, surgeries, and diagnostic/therapeutic procedures is another important element of a child life program. It is estimated that 50% to 75% of children develop significant fear and anxiety before surgery, with recognized risk factors such as age, temperament, baseline anxiety, past medical encounters, and parents’ level of anxiety.32 Children’s anxiety in the perioperative environment is associated with impaired postoperative behavioral and clinical recovery, including increased analgesic requirements and delayed discharge from the recovery room.33 More than 50 years of research and experience support 3 key elements of the preparation process: (1) the provision of developmentally appropriate information; (2) the encouragement of questions and emotional expression; and (3) the formation of a trusting relationship with a health care professional.34 A recent systematic review of preparation effectiveness evidence concluded that children who were psychologically prepared for surgery experienced fewer negative symptoms than did children who did not receive formal preparation. In addition to reducing anxiety and providing a more positive experience for the patient and family, research demonstrates that preparation and coping facilitation interventions decrease the need for sedation in procedures such as MRIs, resulting in lower risks for the child and cost savings in personnel, anesthesia, and throughput-related expenses.35–37

Preparation techniques, materials, and language must be adapted to the developmental level, personality, and unique experiences of the child and his or her family. Learning is enhanced with “hands-on” methods versus exclusively verbal explanations. Photographs, diagrams, tours of surgical or treatment areas, actual and pretend medical equipment, and various models (eg, dolls, puppets) are used to reinforce learning and actively engage the child.32,33 Interpreter services are used as appropriate to ensure understanding in patients or families who do not speak English or for whom English is a second language. Most parents have a strong desire for comprehensive information about their child’s care and should be included in the preparation process. In cases in which children demonstrate avoidant preferences or when preparation before the event is not possible, the CCLS’s focus may change from that of imparting information to other supportive strategies, such as teaching behavioral coping skills and preparing parents to support their child during a medical procedure.

**Pain Management and Coping Strategies**

When combined with preparation and appropriate pharmacologic interventions, nonpharmacologic strategies for pain and distress management have proven successful in terms of patient/family experience, staff experience, and cost-effectiveness.13,39–40 Strategies such as swaddling, oral sucrose, vibratory stimulation, breathing techniques, distraction, and visual imagery have been shown to decrease behavioral distress and pain experience in children during invasive medical procedures.41–43 In addition to advocating for the appropriate use of analgesics, CCLSs are often directly involved in the utilization of nonpharmacologic pain management techniques and coaching or supporting patients and families before and/or during distressing medical procedures.44,45 They can also provide valuable education and training to nursing, medical, and other personnel and students, thus supporting health care team member competencies in the provision of developmentally appropriate, psychosocially sound care.46,47 Multifaceted institution-wide protocols such as the “Ouchless Place” and other similar programs incorporate the standard utilization of both pharmacologic and nonpharmacologic techniques, preparation of patient and family, environmental considerations, and training of all health care team members.48,49

Research has demonstrated that children are less fearful and distressed when positioned for medical procedures in a sitting position, rather than supine.50 CCLSs are often involved in facilitating the use of “comfort holds”: techniques for positioning children in a parent/caregiver’s lap or other comforting position. In addition to reducing the child’s distress and gaining his or her cooperation, these techniques generally require fewer staff to be present in the room, facilitate safe and effective accomplishment of the medical procedure, decrease parent anxiety, and increase parent satisfaction.51–53 With a goal to limit the use of papoose boards and alleviate the practice of multiple staff members holding a child down, these techniques provide a viable and more humane alternative in most cases.

CCLSs may also develop “comfort kits” for use in treatment areas to include age-appropriate distraction items such as bubbles, pop-up and sound books, light-up toys, and other visual or auditory tools.54 There is emerging evidence that mobile devices can be effective in minimizing patient perceptions of pain and anxiety during distressing medical procedures.55 CCLSs can also advocate for a more welcoming environment in treatment and examination rooms on pediatric units as well as outpatient settings. Their background and training are helpful in designing settings that are appropriately stimulating, nonterrorizing, and interactive.

**Family Support**

The presence and participation of family members is a fundamental component of patient- and family-centered care and has a significant positive effect on a child’s adjustment to the health care experience.56 When parents or other family members are highly anxious about the child’s illness or diagnostic and treatment regimens, such anxiety is easily transmitted to the patient.57 CCLSs help facilitate the family’s adjustment to the child’s illness and health care experience. They can help family members understand their child’s response to treatment and support caregiving roles by promoting parent/child play sessions and sharing strategies for comforting or coaching the child during medical procedures.

Siblings of pediatric patients present with their own unique anxieties and psychosocial needs, needs that are often not assessed or addressed. Siblings, much like children of
adult patients, can be helped to comprehend a family member’s illness via therapeutic play and educational interventions or by offering support during hospital visits, including critical care and end-of-life situations. CCLSs are often involved in providing grief support or legacy activities, such as hand molds or memory boxes for siblings and other family members in the event of the death of pediatric or adult patients.

**Recent Developments in Child Life Services**

The scope of child life programs has developed beyond pediatric inpatient medical–surgical settings to include outpatient and other areas in which child life expertise can be effectively applied to support children and families in stressful situations. The provision or expansion of dedicated child life programming in areas such as emergency services, surgery, imaging, specialty care clinics, dialysis centers, palliative care, and neonatal intensive care has become more prevalent. The increase in patients diagnosed with autism spectrum disorders has presented opportunities for child life specialization in supporting this population in the medical setting.

Over the past several years, child life programs have adapted to the great variety of patients and illnesses seen in pediatrics. Younger, less mobile patients who have more complex medical conditions may need greater individualization of care from the CCLS, for example, when group interaction is not possible. Activities that enable social interaction, such as Internet connectivity and closed-circuit television programming, are particularly helpful for patients who are isolated for infection control or confined for monitoring reasons. Given the increasing survival rate of patients with cystic fibrosis, cardiac conditions, and other chronic illnesses, more teenagers and young adults face the challenging transition to adult health care.

Acknowledging team goals to normalize the transition process and address patient and family anxieties or questions, CCLSs can assist in this transition by providing education and helping patients to communicate their needs, fears, hopes, and expectations.

Although evidence supports the value of child life programs, financial pressures in many health care settings have threatened the growth and sustainability of this essential service. Recent literature has demonstrated the benefits of child life interventions in reducing sedation-related costs, and additional research is underway to further evaluate the cost-effectiveness of child life services.

Child life programs are recognized as contributing to a culture of patient- and family-centered care as well as to customer satisfaction measures, increasingly important from an incentive-based reimbursement and accreditation standpoint as well as marketing and public reporting of outcomes. Child life and ancillary services, such as creative arts therapy, often attract a segment of the population that may otherwise not be inclined to provide philanthropic support to a hospital. Child life leaders are regularly involved in community outreach, public relations, and funding of development activities.

**Additional Considerations**

Child life services contribute to an organization’s efforts to meet the standards set forth by The Joint Commission with regard to effective communication, patient- and family-centered care, age-specific competencies, and cultural competence. The CCLSs’ psychosocial and developmental expertise and their keen awareness of the benefits of patient- and family-centered care provide a useful perspective at the systems level. Child life representation is often incorporated into hospital committees, such as ethics, patient/family satisfaction, safety, environmental design, and bereavement. In many cases, child life professionals provide leadership for activities such as patient and/or family advisory councils and hospital-wide staff education.

Child life expertise has applications beyond conventional hospital care. Interventions can help children transition back to their home, school, community, and medical home. CCLSs often collaborate with local school districts to arrange hospital or homebound education, and hospital-based teachers may be incorporated into child life program administration.

For hospitals or other health care settings considering the initiation or expansion of child life services, the Child Life Council offers a consultation service to support existing program review and development, new program start-up, interdisciplinary education, and written standards of care. In some community hospital settings with few pediatric beds and minimal pediatric outpatient or ED visits, the provision of full-time child life services may not be financially feasible. In such cases, it is recommended that part-time or consultative services of a CCLS be obtained to assist in the ongoing education of staff, students, and volunteers as well as to advise on a psychosocially sound, developmentally appropriate, patient- and family-centered approach to care.

**Conclusions**

Child life services improve quality and outcomes in pediatric care as well as the patient and family experience. Although more research is needed, there is evidence that child life services help to contain costs by reducing the length of stay and decreasing the need for sedation and analgesics. Patient/family satisfaction data and interdisciplinary team member feedback further confirm the positive effects of child life programs on children, families, and staff. It remains essential for child life services to adapt and grow with the changing health care delivery system in support of the highest possible quality of care for children and their families.

**Recommendations**

1. Child life services should be delivered as part of an integrated patient- and family-centered model of care and included as a quality indicator in the delivery of services for children and families in health care settings.

2. Child life services should be provided directly by certified child life specialists in pediatric inpatient units, emergency departments, chronic care centers, and other diagnostic/treatment areas to the extent appropriate for the population served. In hospitals with a small number of inpatient or outpatient pediatric visits, ongoing consultation with a certified child life specialist is recommended to educate health care team members and support developmentally appropriate, patient- and family-centered practice.

3. Child life services staffing should be individualized to address the needs of specific inpatient and outpatient areas. Child life

* The American Academy of Pediatrics (AAP) believes that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with him or her. These characteristics define the “medical home.”

continued on Focus page 6
continued from Focus page 5

specialist-to-patient ratios should be adjusted as needed for the medical complexity of patients served, including psychosocial and developmental vulnerability as well as family needs and preferences.
4. Child life services should be included in the hospital operating budget as an essential part of hospital-based pediatric care. Advocacy for financing of child life services should occur at the facility, community, state, and federal levels.
5. Additional research should be conducted to evaluate the effects of child life services on patient care outcomes, including patient and family experience/satisfaction, staffing ratios, throughput, and cost-effectiveness.

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REFERENCES
Research, Publications, and Presentations: A Conversation with Judy Rollins, PhD, RN

Most child life specialists will recognize Judy Rollins, PhD, RN as one of the authors of *Meeting Children’s Psychosocial Needs Across the Health-Care Continuum* (2005), a well-known and heavily-referenced book for many professionals working with children and families in a health care setting. Dr. Rollins is well versed in a variety of research areas, with over one hundred publications across multiple disciplines. She has been an active contributor as a researcher in both national and international health care issues, has developed arts programming for children, families, and health care professionals in a variety of settings, and is also an adjunct professor for Georgetown University School of Medicine in Washington, DC. Her special areas of interest and expertise involve children with cancer and using creative arts and art-based research to work with children. She serves as an editor for three major publications; she has been awarded numerous scholarships, and awards for her work. She has also been awarded numerous scholarships and awards for her work.

Given the opportunity to interview Dr. Rollins for this “Research Corner” column, I was especially interested in her experiences co-authoring *Meeting Children’s Psychosocial Needs* (2005) and in learning how the book really came to fruition. I focused my interview questions on the challenges and obstacles to creating the publication and any advice that Dr. Rollins had to offer those wanting to get started in conducting research and submitting manuscripts for publication.

Curious how the initial idea for the book came about, I inquired about what inspired Dr. Rollins to undertake this project. She shared that from experience, she knew that she had a passion for reading and writing about psychosocial issues and family-centered care. In the late 1980’s, Rollins and one of her colleagues, Rosemary Bolig, PhD, discussed writing different monographs on various issues of psychosocial care. As they further discussed this option, Rollins suggested that they write a book instead of separate pieces. She noted that the book *Emotional Care of Hospitalized Children* by Madeline Petrello (1980) had previously been published, and that *Child Life in Hospitals: Theory and Practice* by Richard H. Thompson and Gene Stanford (1981) and Richard H. Thompson’s *Psychosocial Research on Pediatric Hospitalization and Health Care: A Review of the Literature* (1985) were also currently available in print. After making a few calls to confirm that no one else in the field was working on a book similar to what they had envisioned, Rollins and Bolig began contacting publishers and writing a proposal; they were fortunate that the first publisher they approached accepted their proposal and issued them a contract.

*Meeting Children’s Psychosocial Needs* (2005) has multiple contributing authors. Dr. Rollins mentioned that in the beginning, she and Bolig had planned on being the sole authors. However, after beginning the writing process and realizing the amount of work involved, Carmel Mahan, MEd, CCLS was invited to join the project, which led them to realize that utilizing contributing authors who were experts in their respective fields would result in a stronger text. Several of the contributors came from previous project connections, while others were approached or selected because of their research or expertise in a specific content area.

As many researchers and writers know or quickly find out, projects can quickly take a very different path from original ideas. I was curious to ask Dr. Rollins what kind of modifications they ended up making to their plans for the book and also inquired as to whether she felt that the final product turned out as they had envisioned. Dr. Rollins noted that apart from adding a chapter on spirituality, some changes with the publisher, and the cover not looking exactly as they had imagined, the book ended up as they had planned.

As it is widely known that research and publication are critical to any given field, I asked Dr. Rollins about her thoughts regarding the particular importance of research to the field of child life. She commented that research is critically important to the profession, explaining that not only does research justify the need for child life services, but the publication of research disseminates significant information about child life and promotes best practices.

Many child life professionals want to conduct research, but do not necessarily know how to get started. Dr. Rollins shared that “one of the best things to do is read what others have written” and to take note of the perspectives of others, their presentation style, topics, and how they put their ideas into writing. Rollins also suggests attending conferences and other presentations to gather similar information about emerging areas of interest in the field. When writing, making presentations, or conducting research, Rollins mentions that it can often be easier in the beginning to engage in the process with other people. While it can be helpful to pair up with someone who has specific expertise, the individual or individuals involved do not necessarily need to have previous or in-depth experiences; “You can learn together,” she states.

Finally, I asked for advice for those who might be hesitant to conduct a research study, publish a book, or make a presentation at a professional conference. Again, Dr. Rollins offered sound advice and wise words: “Find a topic that you know about, a topic that you are curious about, but most of all, a topic that you care about. Find that topic that arouses your passion. You’ll be eager to find out more about it and share what you know with others.”

Starting a research project, writing for a publication, or submitting a proposal for a conference presentation can be hard. However, as Dr. Rollins noted, research, publications and presentations are crucial for moving a field forward, and for sharing what we know with others. If you are passionate about a topic, grab a colleague and brainstorm about how you can get the information and knowledge that you have out to others who need it. Once you dive in, you will surprise yourself with what you have to share with others—and getting started is usually the hardest part!

**References**

Empathy Explored


Child life professionals know that empathy is vital to connecting people with each other, but what happens to those who have difficulty feeling or showing empathy? Bruce Perry, MD, PhD, and Maia Szalavitz’s book, Born For Love, highlights different aspects of empathy, or a lack thereof, in today’s world. Through case studies, the book demonstrates how environment can shape empathy in positive and negative ways. This book can provide those working in helping professions with an understanding of empathetic responses and ways to teach empathy. Readers will feel a sense of passion and an urgency to focus on solutions that will prevent empathy from becoming endangered.

Author Maia Szalavitz is a researcher who has written numerous articles on neuroscience and public policy. Dr. Bruce Perry is a clinician, researcher on children’s mental health, and professor of psychiatry who has written several books dedicated to improving the lives of children who are at higher risk for negative outcomes. Born For Love chronicles 12 diverse individuals and groups whom the authors have studied. The book is divided into chapters co-written as “we” to avoid the confusion of alternating voice. The authors’ writing style is easy to read and intertwines research, humor, real-world examples, and case studies to hold the reader’s attention. Various important topics and significant facts are repeated throughout the book to encourage deeper learning and comprehension.

Born For Love details the human evolution of empathy. Humans are relational and need connection with others, especially in the early years, to establish empathy. The authors describe empathy as an emotional tool that allows humans to create bonds with others. It is these relationships that can foster, or diminish, the ability to relate to others. Empathy is vitally important because it helps individuals share experiences with one another, and Born For Love continually uses poignant relational stories to illustrate these points. One example is the story of Brandon, who, as a young child, was placed in front of the television for hours at a time. Brandon’s mother suffered from depression and was unable to provide positive human interactions. Because of his circumstances, Brandon never learned appropriate emotional responses or how to show empathy.

Each chapter introduces a different topic exemplifying how empathy is developed, displayed, and how it is endangered. Although the chapters appear to logically build upon each other, one of the book’s weaknesses is that there are sections that do not seem to support the book’s theme. The authors provide some very in-depth case studies, but these occasionally detract from the point of the chapter and make it difficult for the reader to form real-world applications. At the end of each chapter, a brief summary is provided. The book concludes with an epilogue summarizing and interconnecting the themes presented throughout the book, along with examples and obtainable goals for creating an “action plan” to promote empathy in a changing world.

While the confidentiality of individuals is maintained throughout the book, the authors do not always use “person-first” language when describing impairments or disabilities. For example, the authors often use “autistic child” instead of “child with autism.” Much of the information in this book can be utilized in child life practice; however, the book appears to be geared more toward teaching young parents or “yet-to-be” parents about the power of empathy throughout their child’s development. Born For Love also speaks to the power of resilience and gives encouragement to those who have struggled with a difficult past.

Multiple examples are offered throughout the book to explain the strong connection between empathy and emotional health. Many of the impacts of empathy on the stress-response system are common problems encountered in the medical setting: anxiety, depression, obesity, chronic illness, and addiction. The authors focus a great deal on the physiological development of empathy, providing helpful resources for child life specialists for teaching coping skills and self-regulation during stressful situations. Readers will ultimately gain insight into ways to promote effective coping through the use of empathy.

This book showcases many different examples of empathy development, both environmental and biological, that child life specialists can use to influence their own practice. Understanding empathy at a deeper level can help child life specialists help others. Overall, this book would be a good resource for any child life specialist because it is easy to read, provides real-world examples, enhances insight into empathy, and offers solutions to potential challenges when empathy is absent. Born For Love has many applications in the field of child life and for others who work in a helping or relational profession.
International Summit

Continued from page 1

annual conference attended each year by nearly 1,000 people with mutual interest in pediatric psychosocial care. The opening keynote address was delivered by Bruce Perry, MD, PhD, the neuroscientist who delivered the keynote address at the 2013 CLC Annual Conference in Denver. (See also a review of Dr. Perry’s book, Born for Love, in this issue.) It was a perfect way to start the Summit: confirming a scientific basis for the importance of the psychosocial component in the overall provision of medical care and treatment. The other keynote featured CLC member Deb Vilas, MS, CCLS, LMSW, who provided an overview of play in North American hospitals and highlighted some of the important issues and considerations in the use of play in child life.

There were eight panels during the Summit, each presented by three to four delegates. The topics of the panels included:

- Approaches to pediatric psychosocial care – child life, hospital and health play, social pediatrics, and others
- The role and importance of established professions in providing pediatric psychosocial care
- The role of government, child protection, and rights of the child
- The role of non-profit organizations and non-governmental organizations in fostering pediatric psychosocial care
- The cultural dimension and perceptions of the role of play in health care
- Relationships between psychosocial care providers, medical teams, and other support providers
- Academic preparation, clinical training, and certification
- Expanding pediatric psychosocial care to a national or system scope

While there was some structured small group time, rich discussion also took place over breaks and meals. There was such an amazing diversity of countries represented; delegates came from large and small countries, from highly developed and developing countries, and from populations ranging in the presence of medical care from 2.7 physicians per 1,000 people to 1 per 100,000. Despite these differences, delegates were bonded by a passion for the cause of children’s health and by a growing understanding and appreciation of the importance of psychosocial services in pediatric health care.

Despite their varied backgrounds and circumstances, delegates found themselves discussing common challenges. Among these were a lack of understanding of the results that child life and hospital play can achieve in diagnosis, treatment, and recovery; prioritization of funds available for the health care system; a reluctance of governments and hospital administrators to recognize and pay for services without a stronger body of empirical research; and a lack of inclusion of pediatric psychosocial education in the preparation and training of health care professionals.

While the challenges are large, there was a strong bond formed among the delegates, and they returned to their respective homes dedicated to spreading awareness and appreciation of pediatric psychosocial care principles, practices, and perspectives. Already, we have heard from many delegates who, in just the first month after the Summit, have held meetings with administrators and health officials, and given presentations to key hospital staff and professional societies about what the pediatric psychosocial perspective can bring to the table in terms of quality of care, normalization of children’s lives, patient safety, and cost savings. With the amount of activity reported, one of the most rewarding aspects of the Summit is that the impact can be measured in a matter of days, weeks, and months, rather than years.

For CLC, being able to organize and hold this Summit has been a huge step in meeting one of our major strategic objectives outlined in the CLC 2012-2014 Strategic Plan: that of global engagement. The CLC Board of Directors which developed the strategic plan recognized that in an increasingly shrinking world, involvement in global development should not be considered a luxury or an afterthought; that this involvement has positive ramifications for the development of child life in North America as well. It is not CLC’s intent to become “the” pediatric psychosocial association worldwide, but rather to work with other countries and regions of the world to address common challenges and bring about culturally appropriate solutions that contribute to the welfare of children who encounter the health care system.

Among so many of CLC’s laudable priorities, we are privileged to include active participation of the child life profession in the global advancement of the care of children. And we have been particularly fortunate to have such a strong supporter of that effort in Disney.

2014 International Scholarship Recipients

The Child Life Council has been awarding international scholarships since 2010 to aid in supporting health care professionals who practice outside of North America in attending the Annual Conference on Professional Issues. Five international recipients were able to attend the May 2014 conference in New Orleans with funding from these scholarships. Each of the scholarship winners has written a summary of their conference experiences; their thoughts have been posted to the Global Perspectives Blog on CLC Community. We encourage you to read each blog posting at http://community.childlife.org/globalperspectives and be inspired by the stories of what each scholarship recipient learned and how they intend to spread information about the psychosocial care of children in their home countries.

2014 International Scholarship Recipients:

Dina Nasser, RN, MPH
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Ezgi Perktas
Child Development and Educational Specialist
Ankara, Turkey

Mariami Modebadze
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Qi Cheng, MS
Child Life Specialist
Beijing, China

On a personal note, I want to thank all of the delegates who attended the International Summit for participating in six days of intensive learning, teaching, and discussion during the Annual Conference and the International Summit, and for their passion and commitment as they returned home afterwards. Many kudos to the CLC staff and several CLC members who worked on the project; in particular, I’d like to thank Ellen Hollowell, MS, CCLS, who helped to identify and contact many of the delegates last fall, and Catherine Boland, CCLS, LMP, who coordinated many of the Summit activities and communications.
Y is for Young Adults

Continued from page 1

The experience of a serious medical condition or chronic illness can shape the pace at which adolescents and young adults transition to independence. The emotional and social impacts of a serious or chronic illness can alter an individual's self-perception, causing the adolescent to resume or prolong dependence on parents and caregivers. Many young adults in these situations achieve significantly fewer milestones, or do so at an older age than their peers (Stam et al, 2006).

Developmental considerations for working with this group include acknowledgment of healthcare's impact on three main areas: 1) functional independence, 2) access to normalizing peer relationships (e.g., social and emotional supports), and 3) identity development. Erikson (1993) described two developmental stages experienced by teens and young adults: identity versus role confusion (about ages 12 to 18), and intimacy versus isolation (about ages 18 to 40). Developing close and bonded relationships is equated with feeling secure and successful during this life stage. The alternative, loneliness, can be caused and worsened by the isolation created by a medical condition and treatment. For these reasons, opportunities for positive and age-appropriate social interaction, such as support groups and workshops, are important in serving young adults, both for emotional support as well as identity development.

Identity is formed through attaching meanings to the roles one plays in social experiences (Stryker & Burke, 2000). Positive social interaction with peers is key in serving this population: Health care providers serving young adults who face chronic or life-threatening illness can minimize the potential harm of these medical experiences by encouraging positive social contacts, which can in turn increase feelings of autonomy (Stam, et al., 2006). In facilitating increased perceptions of autonomy and positive aspects of identity, child life specialists can help to empower young adults to assume an active role in their healthcare. By supporting their patients’ experiences of feeling capable, accountable, and assertive, child life professionals can positively impact and even protect a young adult’s emerging identity.

The healthcare setting may feel overwhelming and may not be structured to accommodate, and assertive, child life professionals can help to empower young adults to assume an active role in their healthcare. By supporting their patients’ experiences of feeling capable, accountable, and assertive, child life professionals can positively impact and even protect a young adult’s emerging identity.

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The health care setting may feel overwhelming and may not be structured to invite young adults to actively participate in their own care. By providing emotional support, access to positive social experiences, and medical education, and by empowering choices that lead to functional independence for the young adult, child life specialists can provide customized care for this unique population.

REFERENCES


Scenes from the Life

Courtnee Hoogland, MA, CCLS, CIMI; UC Davis Children's Hospital, Sacramento, CA

During the month of November, our department created “Thankful Trees” in the waiting spaces of our PICU and NICU. A letter of thankfulness was posted to the families acknowledging how their bravery and love were demonstrated by their presence at the hospital supporting their children. Families and staff were then encouraged to write their own thankful messages on “leaves” and place them on the tree.

The tree began to fill up immediately with leaves of thankfulness and, as the child life specialist for these units, I would get calls with requests for more blank leaves.

“I am thankful to be a mother to a child with special needs.”

“Thankful my baby girl is getting better every day. God is good.”

“I am thankful for my co-workers.”

And one child wrote: “I like the nurses.”

These creations provided opportunities for us to inspire each other. The best part was that all could participate, from staff to parents to siblings. It encouraged us to celebrate thankfulness!

STRATEGIES AND SOLUTIONS FOR SERVING YOUNG ADULTS

1. Values clarification and goal setting for self-advocacy: Focus on future plans, life path, values, life skills, social skills, and long-term goals in addition to more immediate healthcare-related goals.

2. Transition resources and teams: Provide concrete tools for knowledge and self-advocacy to facilitate young adults’ involvement in their care. Collaborate across medical services, teams, and resource areas and ensure basic medical access. Consistency is key: Using the same tools (e.g., treatment checklists), and routinely inviting self-advocacy, can alleviate the stress of transitioning between different methods of service delivery.

3. Keep a strengths-based focus: Celebrate advances and successes in functional independence and identity. Because a young adult’s identity is largely defined through relating to others, keep interactions positive and affirming. Doing so can reinforce feelings of capability and empowerment.

4. Independence is an evolving process: Young adults are on a path to independence and identity development, which unfolds over time. Supporting this evolution provides a unique opportunity to empower success by honoring young adults’ wishes while facilitating responsibility and autonomy as the patient completely transitions to adult-centered care and the child life specialist’s therapeutic relationship is formally completed.
CLC Calendar

October
1  Deadline to submit articles for consideration for Winter 2015 issue of Bulletin and Focus
15  CLC Webinar – Promoting Quality Play in Medical Settings in a Media-Saturated World
15  Deadline to withdraw from November Administration of the Child Life Professional Certification Exam
31  Late Deadline to recertify with Professional Development Hours (late fee and additional paperwork required)

November
1-15  Child Life Professional Certification Exam Administration Testing Window
7-10  CLC Board of Directors Meeting
19  CLC Webinar – The Academic and Clinical Preparation of Child Life Specialists: Pedagogical Approaches to Integrative Learning in Higher Education

December
31  Last day to reinstate lapsed CCLS credential

January 2015
1-31  Start planning your Child Life Month events and activities for March!
1  Deadline for Bulletin and Focus articles for consideration in the Spring 2015 issue
31  Deadline for applications for the March 2015 computer-based Certification Exam Administration (January 15 for those educated outside of the US or Canada)
31  Deadline to submit certification maintenance fees

Upcoming Events

November 3, 2014
21st Annual Child Life of Greater New York Professional Development Conference
New York Academy of Medicine, New York, NY
Contact Nicole Almeida at nalmeida@winthrop.org or (516) 663-2761
For information, visit www.CLGNY.com

November 3 - 6, 2014
Moving Forward with Family- and Patient-Centered Care: An Intensive Training Seminar
Hyatt Regency Cambridge, MA
Website and Registration: www.ipfcc.org

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

A New Look for the Bulletin is Coming in Spring 2015!
The Child Life Council Bulletin will soon be transitioning to a completely digital publication! The electronic version will include:
- more robust features
- full-color graphics
- the ability to download single articles and full issues
- and more!