CLC to Celebrate A Monumental Year, A Monumental Profession at 30th Annual Conference

This year, more than 1,000 CLC members and friends will assemble in Washington, DC for our 30th Annual Conference on Professional Issues. In addition to taking advantage of the unparalleled networking and educational sessions that members have come to expect from this annual event, conference attendees will enjoy a variety of special observances in commemoration of the Child Life Council’s 30th anniversary. CLC invites you to celebrate “A Monumental Year, A Monumental Profession” by joining us for the 30th Annual Conference, May 24 – 27, 2012, at the Washington Marriott Wardman Park Hotel.

The opening session keynote will be delivered by Steve Gross, the Chief Playmaker and founder of the Life is good®: Playmakers (formerly Project Joy), a non-profit that uses joyful play to strengthen and heal children whose lives have been deeply impacted by poverty, violence, and illness. Award-winning speaker, writer and peace advocate Jeni Stepanek, PhD, will give the keynote presentation at the closing general session. Dr. Stepanek is the author of the New York Times bestseller, Messenger: The Legacy of Mattie J.T. Stepanek and Heartsongs, and her inspirational messages about disability, grief, parenting, education, health care, collaboration, and hope are frequently shared in the media.

The Power of Play: A Peace Corps Perspective

Krista L. Burgbacher, MS, CCLS
Gilda’s Club Western Pennsylvania, Pittsburg, PA

In the eleven years since I became a Certified Child Life Specialist, I have had the opportunity to work in several different hospitals and with countless families. While working in the medical setting I prepared patients for procedures and tests, supported them in both the activity room and at bedside, and provided countless hours of distraction during periods of anxiety. For both personal and professional reasons I found myself needing to seek out a new career opportunity, but I did not want to abandon my knowledge of child life and accompanying skillset for an entirely different field. When one’s training is so specific and jobs in the hospital setting are limited, where does a child life specialist go next?

“Non-traditional” or “alternative” child life settings encompass many different areas outside of the traditional hospital and medical setting including early intervention services, non-profit organizations, mental health centers, hospice programs, and even private practice (Child Life Council, 2008).
PRESIDENT’S PERSPECTIVE

Pushing Forward as a Profession

Toni Millar, MS, CCLS

My roles as president of CLC, director of a child life program, and coordinator of our hospital’s student program require me to visit and navigate the CLC website frequently. Although I log in to CLC Community daily, I also occasionally like to browse through the myriad of information available throughout the main site. In doing so I recently reviewed the Child Life Timeline, and although I have looked at it many times before, this time I saw it in a different light. In addition to the familiar, committed-to-memory milestones, I recognized the moments of risk-taking that needed to occur to push us forward as a profession. Beginning with Emma Plank, we had pioneers in our field who weighed the fear of risk with the positive outcomes that could possibly result, and forged ahead. As the Child Life Council embarks on our 30th anniversary year, I would like to explore this a bit more by looking at some of the risks already taken, and those that inevitably lie ahead.

Joan Chan, BJ Seabury, Gene Stanford, Ruth Kettner, Evelyn Oremland, Joan Kingson, Sallie Sanborn, Mary Barkey, Richard Thompson, and Laura Gaynard are only a few of the familiar names of pioneers who helped to shape our profession and clinical work as child life specialists. However, for those of you who have had the opportunity to watch interviews conducted with some of these legends on the “History of Child Life” 25th anniversary DVD (highly recommended for all CLC members), you will recall that their accomplishments did not come easily. They all had visions and goals that would provide improved patient- and family-centered care. They often faced adversity, ridicule, and defeat in their quest to promote and implement psychosocial interventions that seem a “given” today in our daily child life clinical work. Furthermore, they all pushed the boundaries. This seems to be an inherent and essential component for our profession’s advancement.

After reviewing the child life profession’s timeline, I then reviewed the CLC Annual Conference programs back to 2005, when they were first archived on the CLC website. I wanted to see if the topics offered for intensives and seminars reflected clinical practice innovations and growth. I found that each conference was strategically comprised of core competency fundamentals, as well as new evidence-based ideas. Each year offered a multitude of seminars on play, pain management, student programming, ethics, patient- and family-centered care, research how-to’s, and more. Conference evaluation suggestions and ever-changing health care practices widened the scope of psychosocial-focused seminars to include art therapy, music therapy, non-traditional child life settings, disaster management, and the use of technology, to name a few. This tells me that our pioneering spirit and ability to take chances is not confined to a few adventurous souls from the child life profession’s early years. Even with the challenges that have come with health care and economic changes, and the “do-more-with-less” mantra we are all facing, child life specialists are forging ahead with that same passion and determination that we so admire in the pioneers who came before us.

In addition to the growth that has been achieved in child life clinical practice, we can be proud of our growth as a profession, which has reflected the risks that have been taken over the years. To start, CLC was formed in 1982 and had 235 members by the end of 1983. In 1986, a credentialing process for professional child life certification was established. The first official strategic planning session, called “Vision to Action,” commenced in 1996. In 1998, CLC provided the first professional certification exam. In 2008, CLC published Child Life Beyond the Hospital, a book which discussed the many ways that child life specialists could expand their psychosocial services into non-traditional settings. Today, with an association that is more than 4,800 members strong, the CLC Board of Directors has finalized the organization’s Strategic Plan for 2012-2014. All of these are examples of provocative, sometimes controversial changes that have propelled the child life profession forward.

I encourage and challenge each of you to reflect on chances you have taken in your own child life career to improve patient/family care. Was it advocating for comfort positioning, the use of the treatment room instead of a toddler’s bed for an IV start, or even starting a new child life position in an area that is unfamiliar with child life? These are your own pioneering moments. Like many of the child life “legends” from the past, if you are committed to your vision and persevere, you can make your own history. I look forward to looking at our timeline in 10 years and seeing some new names, your names, beside new initiatives and accomplishments.
FROM THE EXECUTIVE EDITOR

Progress Over 30 Years
Anne Luebering Mohl, PhD, CCLS

One of the exciting things about being a child life specialist is that every day is different. There are so many tasks that fall under our job descriptions (and many things we do outside of our job descriptions) that it's often difficult for some of us to describe a typical day. To me, this is a great advantage—I can't imagine a job where I sit at a desk, doing the same thing day after day.

Besides the variety within my own job, I'm struck by the variation of other child life specialists' roles and responsibilities. When I meet new child life professionals and learn about their jobs and career paths, I'm inspired by how different many of them are from what the first “play ladies” must have imagined as they forged their way into hospitals. The diversity of child life work and the growth of the field over time inspire me to think of even more areas where the principles of child life would benefit children and families in the future.

This year, as we celebrate 30 years as an organization, it is natural to reflect upon accomplishments we have achieved together and the many people who have contributed to making child life what it is today. I've recently spent some time reading through some of the Bulletin archives on the CLC website. It's interesting to see the diversity and growth that has been documented through Bulletin and Focus. Although only the issues from the past eight years are online, browsing through them is a fun way to learn what has changed and what has stayed the same.

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We strive to have each issue of Bulletin and Focus reflect the advancement and growth of our profession as we expand into a variety of new areas, and this issue, the first in our year-long anniversary celebration, seems to me to be especially diverse and forward-focused. This issue includes a look back at two members' first conference experiences—one 26 years ago, and the other just last year. We have articles by two members who are applying child life outside of the hospital setting. There are resources for professionals working in more traditional settings; one featuring a hospital's annual event showcasing its child life program to the community, it serves, another a review of a book about pain. We have reports from the recipients of the international scholarships to Annual Conference, people who are spreading child life to areas not previously served. Finally, the Focus article highlights an area of importance for the future of child life—evidence-based practice—which will increase our visibility as a legitimate discipline within the medical setting.

As we look forward to the next decade of growth and diversity in child life, the Bulletin and Focus team members are excited to be contributing toward our growth as well as documenting our journey along the way!

BULLETIN/FOCUS CORRECTION

There was an error in printing a graph in the Fall 2011 issue of the Focus, in the article Pre-Adolescent and Adolescent Youth with Asthma: A Current Health Issue, by Ali Chrsler. The corrected graph has been included on page 4 of the Focus. The Bulletin/Focus Editorial team apologizes for this omission.

Child Life Council
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To contact a Board member, please visit the CLC Member Directory at http://www.childlife.org/Membership/MemberDirectory.cfm.

2012 Elections

The 2012 elections for the CLC Board of Directors will take place this Spring. The CLC Nominating Committee will present the slate of recommended candidates for approval. In constituting a slate, the Nominating Committee considers all names put forward and each qualified candidate participates in an assessment and interview process to identify his or her interests and strengths in serving the Child Life Council. As in recent years past, CLC will hold the election online and an electronic ballot will be emailed to each member with voting privileges.

To learn more about the nominations process, the primary duties of a Board member, and the attributes and qualifications sought in CLC leaders, please visit the Nominations & Voting section of the CLC Website at http://www.childlife.org/Membership/NominationsandVoting.cfm.
Looking Back, Looking Forward

To honor CLC’s 30th anniversary this year, the Bulletin is featuring a special column entitled Looking Back, Looking Forward, presenting the experiences of seasoned and new child life specialists along the course of their professional journeys. We would like to introduce this column with the series’ initial installment, which focuses on the experience of two child life specialist’s first attendance at Annual Conference. We welcome you to join us in celebrating our history and our future through Sharon McLeod’s and Jessica Fralic’s recounts of their first conferences in 1986 and 2011, respectively. We hope you enjoy this special anniversary column and will look forward to reading your fellow child life colleagues’ stories throughout 2012!

Brushes With Greatness: My First CLC Conference

Sharon M. McLeod, MS, CCLS, CTRS, Cincinnati Children’s Hospital, Cincinnati, OH

It was 1986, and the Child Life Meeting on Professional Issues was being held prior to the annual Association for the Care of Children’s Health (ACCH) Conference in San Francisco. Our hotel was right downtown. CLC must have negotiated a good room rate because the hotel was under renovation.

Several things made this a remarkable year for the profession and for me. First, it was the inaugural year for child life certification. Many of us walked around with blue buttons printed with “I’m CCLS R U?” and that was long before anyone knew about texting vocabulary. We were encouraging colleagues to become certified.

This was the beginning of my term as Secretary of the CLC Board of Directors. I was scared to death. I took office immediately following the conference. New Board members flew in early at our own expense to observe the Board meeting held prior to the conference. Ruth Snider was presiding over her last Board meeting and Fran Ritter was becoming the new CLC President. Like me, Richard Thompson was new, having been just elected President-Elect.

I met Doris Klein who was in the middle of her two-year term as Member-at-Large. We became fast friends. One morning when we were walking to a neighborhood café for breakfast, we were very excited to come upon Emma Plank, who was also on her way to find breakfast. We asked her to join us, which she did, and we had a marvelous time interacting with “Nushi” as she invited us to call her. How amazing to spend time with the woman most responsible for the work of child life specialists today.

Doris Klein taught me the art of networking. She knew how to make use of every moment at conference. The best example she demonstrated for me was when she made a reservation at a nice restaurant by Fisherman’s Wharf for ten people. She suggested that I invite four conference attendees and she’d invite four conference attendees to join us. We ended up with a wonderful table of ten child life professionals who got to know each other and share accomplishments and challenges. To this day, I cherish the new individuals I meet at child life conferences.

On Saturday, the attendees at the Child Life Meeting on Professional Issues were loaded onto buses and taken across the bay to Oakland. We arrived at Mills College where Evelyn Oremland, professor at Mills College and chairperson for the child life major, was our hostess. This could not have been a more special time in my professional career. Erik Erikson, who was well into his eighties, gave us a short lecture on his life and career path, and afterward we enjoyed lunch with Erik and Joan Erikson and Emma Plank. I had to pinch myself to be sure I really was in the presence of individuals whose work I had studied intensely and held in such high esteem.

I am delighted to share this collection of 1986 conference memories in celebration of 30 wonderful years of CLC’s existence. I hope the strategies developed today will propel CLC to many more anniversary celebrations.
Soaring in Chicago: My First CLC Conference

Jessica Fralic, BAA (CYS), CCLS, IWK Health Centre, Halifax, Canada

This past May was my first time attending the CLC Annual Conference and the theme promised that child life specialists would “soar to new heights.” I didn’t think I knew how to fly, let alone soar, but I was determined to go to conference and test my wings.

Attending the CLC Annual Conference has been one of the goals at the top of my professional “to do” list since becoming a Certified Child Life Specialist in 2008. I wanted to experience the energy and excitement of conference that I had heard about from so many of my colleagues. I wanted to take that next step in my professional journey. In July 2010, a colleague, Jennifer Lynch, and I decided to submit an abstract for a poster. Our submission was titled Playing Outside the Toybox and provided ideas for play when toys have been removed from ambulatory waiting areas in instances such as H1N1. A few nerve-wracking months passed, and our abstract was accepted. I was going to conference! I was going to soar!

The poster presentation was the first step of my conference journey. I was also invited to sit on the research panel for the Second Annual Student Research Symposium and attend the Research and Scholarship Task Force meeting, and I was registered for the Clinical Supervision Pre-Conference Full-Day Intensive. All of these experiences would be new for me. I was excited and running full speed ahead.

While flying to Chicago Wednesday morning, I was overwhelmed with emotions. I felt anxious for the presentations and new professional experiences over the next few days, but mostly I was excited to meet other child life specialists from around the world, learn what other professionals are doing in their practice, and learn new ideas to put into practice myself. I had been waiting two years for this moment, and it was finally here. I wanted my first child life conference to begin.

My conference experience began Thursday morning when I picked up my badge and tote bag. The other child life specialists that I work with have conference totes and use them daily for distraction items, so I was excited to finally have my own. I had the fortunate opportunity to attend the full day Live Clinical Supervision intensive with facilitators Diane Rode and Gloria Mattera. Diane and Gloria’s passion for clinical supervision was contagious, and I left the session that afternoon feeling excited and encouraged to engage in this practice with my colleagues at home. I was soaring!

Friday morning as I stepped off the elevator I could hear the buzz of excitement in the lobby. As I turned the corner I was enveloped in a sea of child life professionals, some reuniting from previous conferences, others meeting for the first time. I anticipated future conferences where I would be one of those people catching up with old friends and colleagues from previous years. I was eager for conference to officially begin.

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I attended several motivating sessions, leaving each one more excited and energized than the last. Breathe, Relax, Imagine was my favorite. Nancy Klein presented and practiced research-based relaxation techniques as a non-pharmacological approach to pediatric pain management. I have utilized various relaxation techniques with children before but my confidence and skill increased as a result of this session. I could not wait to get back to work, share what I learned with others, and put my newly-learned techniques into practice.

Being surrounded by so many other child life specialists was an incredible feeling, and I instantly felt an increased sense of pride in my profession. It was the first time I had met so many new people and not once did I have to explain what a child life specialist was. Both the sessions I attended and presented were exciting and motivating. All of the preparation and hard work leading up to conference was worth it. Child life specialists are not only skilled in helping calm you down before a presentation; they also make a great audience. I was soaring to new heights!

At my first Research & Scholarship Task-force meeting Saturday morning, I found myself surrounded by professionals such as Donna Koller and Jessika Boles, researchers whose names I had heard or read many times. I listened attentively, absorbing all of the ideas and insight I could find from these remarkable women, while feeling a huge sense of involvement within the child life research community.

Conference wasn’t all work; playing is what child life specialists do best! There was time to explore the Windy City and to celebrate the profession and the wonderful people who have made contributions to it. Alongside many child life team members from home and afar, we celebrated the retirement of Linda Skinner, Chief of IWK Health Centre, where I work. I felt honored and privileged to share this experience with her, to see the amazing friendships she has made through her years in child life, and to celebrate the contributions she has made to the profession. It was truly inspirational.

The conference theme was fulfilled for me: I did soar to new heights and beyond at my first CLC Annual Conference. It was an extraordinary experience both professionally and personally, and my experience soaring continues today. The first thing I did when I got back to work after conference was to collaborate with Meghan Kelly, a colleague I met during conference, to submit an abstract for 2012. I encourage anyone who has not yet attended conference to do so; you will soar too!
Spotlight on Child Life Month

Child Life Month is just around the corner! In an effort to encourage programs to find unique ways for their organization to celebrate Child Life Month, we are presenting this story about what Hasbro Children’s Hospital is doing within their community to get the word out about child life. We hope their story provides inspiration for you to find new ways to celebrate child life month in March!

Doctors at Play: Showcasing Child Life in the Community

Kerri Baker, MS, CCLS, Hasbro Children's Hospital, Providence, RI

A t one point or another, most child life specialists have searched for a way to inform the community about our role in the health care field. Whether it’s bumping into an old friend from high school or meeting a family for the first time, there can be a moment when we say what we do and people are surprised to hear that this career exists. While it can be challenging to constantly explain all of the aspects of the job, I feel that we have a responsibility to find a way to make others aware of the educational background, training, and expertise we possess, as well as the services we provide.

Reaching out into our communities is one way that we, as child life specialists, can educate children and families about our role in health care. Over the past few years a co-worker and I have been inspired by another local hospital to increase community awareness of the child life profession. Karen Swartz, MS, CCLS, and I have partnered with the Providence Children’s Museum to host an annual “Doctors at Play” event, which, in the two years since its inception, has served more than 600 families. We offer this event on a Saturday in March, as one of our hospital’s activities for Child Life Month.

Our goals for the event are to expose children to medical play and hospital experiences in a neutral setting while also explaining the role of child life specialists. To do this, we create a makeshift “playroom” complete with medical supplies and activities. We include stations where children can make their own doctor’s bags, put a cast on their finger, or learn about and use real medical equipment at the teddy bear clinic. At the “clinic” children have access to blood pressure cuffs, stethoscopes, syringes, Band-Aids, anesthesia masks, and a variety of other clinical equipment and supplies. Their bears endure surgery, IV pokes, multiple immunizations, various boo-boos, and anything else a child’s imagination can produce. There is also a table where kids can make a pinwheel as we explain the benefits of distraction in coping with procedures. In addition, we coordinate with our transport team and have an ambulance at the entrance to the museum for children to climb into and explore.

For this occasion we have assistance from our hospital’s child life specialists, volunteers, and hospital school teachers, all of whom are gracious enough to attend the entire event and help with preparation. Although preparing for this day takes several weeks, reaching out to that many children and families in such a short amount of time is priceless. Community events like this are a great opportunity to increase recognition of the field of child life and showcase some of the wonderful benefits of this role. The program has turned out to not only be a wonderful opportunity for our hospital and child life department, but for the museum as well. Museum staff have been pleased with the turnout and were eager to make this event into an annual offering.

There are many moments that come to mind when I think about this experience and how it has made a difference in children’s feelings about medical care. I watched children who entered the play area with some apprehension, but left wearing a surgical cap and mask (and too many Band-Aids to count). Staff members at each table listened to stories about broken legs, car accidents, and other health care events children had experienced. Discussions about the correct uses for medical items took place many times throughout the day. I heard parents speak about their own history with hospitalization and how they would have loved to have a child life specialist present during their admission. I spoke with parents who were so pleased to know that should their child ever need to be hospitalized, someone would be present for both the parent and their child. All of the discussions and activities provided a positive space for children to work through misconceptions and begin to learn about the health care environment.

Doctors will forever be viewed as experts in their field. They work hard to perfect their skills and master their areas of expertise, and spend years on research hoping to find new techniques or better ways to improve the lives of their patients. Children have the role of being experts in their field – the field of play. Children spend years perfecting their skills, mastering the arts of play, imagination, and creativity. Through play they learn about themselves, their strengths and weaknesses, and how to interact with others. Children truly are “doctors at play.” Although we may sometimes feel that play is forgotten or devalued, child life specialists know how important it is to create an environment where play is respected. While it can sometimes feel like a daunting task, the more we continue to strive to meet the needs of patients and families both within and beyond our hospital walls, the more opportunities we have to impact development and bring greater recognition to this field.
Perspectives from the Worldwide Outreach Scholarship Winners

As the practice of child life continues to grow internationally, CLC remains committed to supporting its members abroad with scholarship awards to conference. The stories below share the “first-timer” conference attendee experiences of four of our colleagues working to support children and families around the globe.

LOUISE MARBINA
ROYAL CHILDREN’S HOSPITAL, MELBOURNE, AUSTRALIA

After an eventful trip from Australia via Dallas, Houston, and St. Louis, I finally arrived at the CLC 29TH Annual Conference on Professional Issues as one of the Worldwide Outreach Scholarship recipients. Instantly, I felt inspired by the warm welcome and professional focus at the international new attendees evening. It became apparent very quickly that some of the professional issues that my team and I had been grappling with over the past year were common to all those in attendance. High on the agenda for everyone were the issues of funding, hospital-wide recognition, staffing, professional titles, and ongoing professional development.

Having held the position of manager of educational play therapy and music therapy at The Royal Children’s Hospital (RCH) for just over a year, I was particularly keen to move to a new state-of-the-art facility at RCH in November of 2011, and attending the CLC Conference enabled me and my team to review and implement service improvements across many of the areas we service. We have developed comprehensive competency frameworks to support RCH educational play therapy clinicians in both play and procedural support. We have refocused our assessment and prioritisation process so we can be sure we are targeting services where they are most needed, and we are becoming increasingly involved in a number of hospital-wide multidisciplinary collaborations.

As we operate within tighter and tighter financial constraints and are asked more and more to demonstrate the tangible difference we make to hospitalised children and their families, our focus needs to be on internationally robust and evidence-based best practice. Attending this year’s conference has inspired me to embrace the many changes that all of our departments will face over the coming years.

I would like to take the opportunity to thank the CLC Board of Directors for providing me with the opportunity to attend the conference. Participating in this wonderful professional development opportunity enabled me to see firsthand how well-established, valued, and professional child life is within pediatric health care and how other programs can aspire to this, too.

MEGUMI AIYOSHI, MA, CCLS
NATIONAL CENTER FOR CHILD HEALTH AND DEVELOPMENT, TOKYO, JAPAN

Child life specialists have been working in Japan since 1997. The number of child life specialists working in Japan has grown to 26 child life specialists in 25 hospitals today, so most of the child life specialists are one-person programs. The good part of the one-person program is that we can work with and support very closely other health care professionals at the hospital. However, the difficult part is that we can’t get the support from other child life specialists. The only thing we can do is call each other on the phone or send e-mails to communicate and ask for support and advice from other child life specialists at the other hospitals. I was lucky to have three classmates who graduated at the same time as I did. At the beginning, we called each other every night. Sometimes we ran into the situation where we really needed to give psychological support to each other, for example, when there was a lot of death in a ward.

This April we established the Japanese Association for Certified Child Life Specialists. The purpose of this association is to maintain our professional level as child life specialists, to advance our professional knowledge and techniques, to provide peer support, and to do research in order to provide better support for children and their families in hospitals in Japan. We have started a case study discussion on Skype. Every month we discuss a case, and we have a good discussion on how to support the child and the family. During the discussion we also face dilemmas, and sometimes this dilemma discussion takes more time than talking about the case.

At the conference in Chicago, I attended the Live Clinical Supervision Intensive. I have learned how to run supervision groups and have come to understand how supportive they are. After I attended the clinical supervision, I realized that what we needed in our case study discussions on Skype was not only to focus on cases, but also to discuss our professional and personal dilemmas and feelings about cases. The members of our association need to learn how to support each other as professionals in order to become more skilled child life specialists. Even though child life specialists in Japan do not work at the same hospital, using the skill of clinical supervision we can share and support our dilemmas and discuss the difficult situations in a supportive way. Our hope is that our association will function as a Department of Child Life in Japan where child life specialists are able to have opportunities to have lectures from professionals or professors in related fields, hold lectures and workshops to advance ourselves, and participate in clinical supervision to support ourselves.

Lastly I would like to thank all the CLC members and conference staff for choosing me for the scholarship and providing me this wonderful experience in Chicago.

continued on page 12
The Power of Play: A Peace Corps Perspective

Anna K. Montgomery, CCLS, Washington State University, Pullman, WA

Play. Though this word is more difficult to say in the Rwandan language of Kinyarwanda — gukina — it is no more difficult to do. As a Certified Child Life Specialist serving in the Peace Corps in this East African country for the last two years, I was mesmerized by how easy play could be. Here in America, when children come into the hospital, how often do we pop in a movie or give them a video game to play? How different the picture looked as I spent time in a rural Rwandan hospital. Instead of bringing along a favorite toy, a child would be admitted to the hospital with their own bed sheets, as they weren’t always provided to go along with the thin mattress on the wobbly bed. To paint the picture of the setting just a little bit more, let me tell you about the ward itself. Children with malnutrition, HIV, influenza, and malaria, were all rooming together, with no closed doors to separate them. Another ward housed the fracture and burn units. In both of these areas the children had no privacy and very limited space. Families shared their meals brought from home, and patients watched each other get dressings changed, have IVs inserted, and sometimes even vomit.

As I came through, they watched me too. At first some were skeptical. “Who is this woman, and what is in her bag?” they asked. But it didn’t take long for me to establish rapport, despite the language barrier. I pulled out a small container of soap and water, and we soon had bubbles, smiles, and laughter in the unit. Play didn’t stop there. Though I had limited access to store-bought toys, handmade bean bags and dolls seemed to do the trick.

These little bits of cloth that I’m sure would easily be overlooked in most American toy boxes suddenly seemed marvelous. I had no idea that I could do so much with so little. Of course, I used the dolls to teach the children and families about IV starts and dressing changes, but it was the children who did most of the teaching. They taught me about creativity. It turns out there are about a zillion different things to do with bean bags, from stacking to passing, throwing as high as the ceiling, or getting them at just the right angle so as to balance on the edge of a mosquito net. They discovered that a bean bag could be hidden for a treasure hunt, used for a musical instrument, utilized as a distraction tool (both for themselves and the nurses) and balanced on their heads. Their ideas seemed endless, as did their joy. They had so little, and I didn’t have much to give. However, not a lot was required.

The truth here is that play is powerful. It’s not necessarily what you have; it’s not all the toys in the toy box, or that cool musical thing that lights up and spins. What is important is giving a child the opportunity to play wherever they are. What’s important is reaching out to children through play and recognizing that play can and does make a difference. I watched as play made tears turn into smiles and cries turn into song. As I worked within the hospital, the children soon discovered that I knew their language. Yes, their parents seemed touched that I’d learned Kinyarwanda, but for the kids, what mattered was that I knew play. And so do you!
Unveiling a Standard for Knowledge Translation: An Evidence-Based Practice Model for the Child Life Profession

Jennifer Staab, CCLS, MS, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH, Co-Chair, EBP Committee

Within health care, there has been a growing movement to be more consistently grounded in and guided by evidence-based practice (EBP). The goal of promoting EBP has led to an increase in the development of evidence-based practice statements at all levels of health care provision (Audet, Greenfield, & Field, 1990; Lomas, 1991). EBP statements integrate the best available evidence into a cohesive and conscientious summary, which includes a comprehensive review of the most pertinent evidence and recommendations for practice. The purpose of an EBP statement is to help guide health care decisions.

Evidence is ranked based on the method by which it was collected; this includes randomized controlled trials, descriptive studies, qualitative research, case reports, quality improvement studies, and expert opinion. The Institute of Medicine defines EBP statements as, “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances” (Institute of Medicine, 1990, p. 38). Child life specialists with training in research methods and statistical analysis have the opportunity to play an instrumental role in the development and implementation of EBP statements. Numerous opportunities exist for child life specialists to question current practices and use evidence to provide more effective care and support for their patients and families.

The Child Life Council (CLC) recognizes the value of utilizing evidence-based practice to guide clinical care and decision-making. One of the goals delineated in the CLC’s 2008-2011 Strategic Plan states: “Child life practice will be advanced by evidence-based practice developed and published by child life professionals” (Child Life Council, 2008). As areas such as nursing, mental health, and others in health care become increasingly more focused on the identification and delivery of practices that are rooted in scientific research, it has become even more imperative that the field of child life begin to apply the best available evidence to clinical decision-making. This process may both add credibility to the role of child life specialists within the health care team and promote child life specialists to be recognized as a respected resource regarding the psychosocial needs of patients and their families.

Recommendations for the development and implementation of EBP include the need for the process to be guided by a conceptual model (Grahm, Tetroe, & the KT Theories Research Group, 2007, Melnyk & Fineout-Overholt, 2011). As both the child life profession and the use of evidence-based practice (EBP) grow, identifying one common EBP model to be used in the field of child life is an important next step in advancing the profession. Using one model will provide consistency among child life professionals in conducting and implementing EBP and will aid clinicians in applying evidence to practice.

The Child Life Council’s EBP Committee was charged with encouraging the development and implementation of evidence-based practice in the field of child life. The committee researched other EBP models used by health care professions and institutions; however, the search determined the child life profession needed a new EBP model that would take into consideration the typical evidence available regarding child life and the values of the child life profession. In May of 2011 the EBP committee created a model for EBP which was approved by the Child Life Council Board. This model will guide the creation of future EBP summaries and guidelines for child life professionals. This EBP model provides a framework for developing and implementing evidence-based practice. Each step of the process is outlined in the model (see Figure 1).

Step 1. Assess Practice Need. The first step delineated in the EBP model is to identify a need for change or clarification of best practice (e.g., child life specialist assesses that children newly diagnosed with diabetes...
vary in their ability to cope with the lifestyle changes that their treatment requires. Questioning the efficacy of current child life practice is important to the growth of the field. The priority of addressing a particular practice problem within the field of child life and the clinician’s specific practice setting (e.g., unit, clinic, division, institution) should be considered. Change is more likely to occur when the issue being addressed is aligned with the goals and strategic plan of the organization.

Step 2. Develop Clinical Question. Once the problem is identified and its priority determined, the next step is to develop a clinical question. This question must be formulated in a way that is both searchable and answerable. To help ensure that the question meets both of these criteria, questions should be posed using the PICO format (i.e. Patient population, Intervention or Issue, Comparison treatment, and Outcome). For example, a PICO question might ask, “In children newly diagnosed with diabetes (P), how do psychosocial interventions (I) versus no psychosocial interventions (C) affect children’s coping outcomes (O)?” This step is vital to the EBP process, as a well-built, focused clinical question helps drive the later steps outlined in the model. The book Evidence-Based Practice in Nursing and Healthcare provides a thorough overview of using the PICO format (Melnyk & Fineout-Overholt, 2011). The book also discusses alternative PICO formats that may be beneficial.

Step 3. Search for Evidence. The next step is to search for evidence. The key words in the PICO question are used as the search terms. Finding the right information to answer a given question often depends on the sources searched. Thus, it is important to consider all appropriate databases when searching for evidence. Some useful databases for conducting EBP in health care include CINAHL, Cochrane Databases, MEDLINE, and PsycINFO, but many more sources are available.

The first step in searching the evidence is to see if there are any meta-analytic reviews addressing the clinical question. Meta-analytic reviews are quantitative reviews of the results from each study. Unfortunately, many of the questions we pose as a profession have not been reviewed by others or are out of date. If no systematic reviews are available, the next step is to conduct a review of all of the available evidence independently. Only studies that are relevant to the specific PICO question should be included in the review.

Step 4. Critically Appraise Evidence. Once the relevant evidence has been gathered, the next step is to critically appraise the evidence. In order to critically appraise the evidence clinicians must have a basic understanding of research methodology and statistical analysis. When reviewing quantitative studies, it is important to consider whether the study results are valid, reliable, and applicable (Melnyk & Fineout-Overholt, 2011). It is important to pay close attention to the effect size when evaluating the results of a study. The effect size is signified by a single statistic, usually represented as d. The larger the effect size, the greater the predicted impact of the intervention. An effect size of .80 or higher is thought to support the implementation of the particular intervention into practice (Cohen, 1988). When an effect size is lower than .80 it is recommended that caution be used in applying the results to practice.

Clinical trials are often touted to be the main focus of EBP, but clinicians can also use qualitative evidence to answer their questions about quality patient care. The LEGEND (Let Evidence Guide Every New Decision), developed at Cincinnati Children’s Hospital Medical Center to critically appraise the evidence, was identified by the EBP committee as the resource that will be used universally in the child life profession for critically appraising research articles. LEGEND provides user-friendly tools and resources to help guide clinicians through the critical appraisal process for a variety of study designs. Resources for using LEGEND can be found at
can realistically be incorporated into current team of experts helps to ensure that EBP. Using the guidance of an interdisciplinary expertise is another critical step in the model. Clinical expertise and judgment can also help guide EBP when the evidence available is weak or inconclusive. Applying clinical judgment to EBP is an important step to ensure that care is individualized to meet the unique needs of each patient and that any potential health or safety risks are considered. When developing an EBP statement it is recommended that an interdisciplinary panel of experts with research backgrounds and knowledge of the topic be created to help evaluate evidence and make recommendations for implementation into practice.

Step 6. Incorporate Patient and Family Values and Preferences. EBP demands complex and careful decision-making based not only on the available evidence, but also on patient and family characteristics, situations, and preferences. The condition and circumstances surrounding a patient can change quickly and the way a patient responds to a particular intervention can vary drastically. Therefore, the goal of creating EBP statements is not to develop a one-size-fits-all, cookbook-style guide to care delivery, but rather to provide clinicians with the guidance and information they need to promote best practice. Patients and families should be included as part of the interdisciplinary EBP panel developing and reviewing the EBP statement to ensure that their values and preferences are considered.

Step 7. Develop EBP Statement. The next step is to summarize the evidence, incorporating clinical expertise and patient/family values and preferences into a comprehensive EBP statement. The statement should include possible implications and recommendations for practice and future research needs. When expert opinion is used, this should be identified in the statement. Health benefits, side effects, and potential risks or contraindications for care delivery should also be addressed.

Step 8. Implement EBP into Practice. Knowledge translation is an important concept in implementing EBP into practice. The Knowledge Translation Program, Faculty of Medicine, University of Toronto (2004), defined knowledge translation as “the effective and timely incorporation of evidence-based information into the practices of health professionals in such a way as to effect optimal health care outcomes and maximize the potential of the health system.” Studies that have explored the impact of evidence-based practice statements on actual health care practices suggest that development and circulation of evidence-based practice statements alone is not enough to change the practice of clinicians (Cabana et al., 1999; Kosecoff et al., 1987; Lomas et al., 1989; Lomas, 1991). While there are many research studies and evidence-based practice summaries to help guide practice, actually implementing the EBP into everyday clinical practice can be a major struggle. This has led to greater awareness of the importance of using active dissemination and implementation strategies, often referred to as a “knowledge translation plan.”

Child life specialists can spend months working hard to develop an evidence-based practice statement or guidelines, but without a plan for disseminating that information to the target audience (i.e. parents, nurses, physicians) it may never impact practice. Key questions for child life specialists to consider when using the EBP model are “How do you plan to get staff to buy into it and change their current practice?” and “How will you ensure that it is adopted?” To enact change, not only will education on the practice change be needed, but new processes and tools needed to transform practice must be developed. For example, child life specialists at Cincinnati Children’s Hospital Medical Center incorporated the recommendations of the Child Life Council’s EBP statement on child life assessments (Koller, 2008) when developing the Psychosocial Risk Assessment in Pediatrics (PRAP) tool to aid staff in incorporating evidence-based practice into their assessments and prioritization of patients.

Step 9. Evaluate EBP. The final step is to evaluate the efficacy of the practice change, which should be a continuous process. Outcome measures should be developed prior to implementation to aid data collection. Outcome measures can be quantitative, such as the frequency of the use of a papoose board in the ED, or qualitative, such as parent satisfaction with care. The results and outcomes should be evaluated to determine whether the recommendations outlined in the EBP statement need to be refined. The EBP statement should be modified accordingly.

This model has been developed to systematically guide the implementation of EBP to aid child life specialists interested in EBP. While there are often many individual and organizational obstacles to conducting EBP, the Child Life Council and EBP Committee are dedicated to helping support the development of EBP. The child life EBP model, summary of steps, and link to LEGEND resources are available on the Child Life Council website on the Resource Library page.

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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References

continued on Focus page 4
Correction

The table which was included as part of the Fall 2011 Focus article, Pre-Adolescent and Adolescent Youth with Asthma: A Current Health Issue, by Ali Chrisler, was incomplete. The last several articles that were included in the review were inadvertently omitted when the issue was being printed. The Bulletin/Focus editorial team offer sincere apologies for any inconvenience this omission has caused. The entire table is reproduced below.

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<th>TABLE 1. REVIEWED ASTHMA LITERATURE</th>
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Non-Traditional Settings

continued from page 1

Whether one is a seasoned child life specialist or new to the profession, non-traditional settings offer unique opportunities that differ from the clinical medical setting and allow the specialist to utilize a variety of child life skills.

The value of child life practices in non-traditional settings is supported by an ecological systems theory view of children and families. This systems theory includes not only the individual, but also expands to encompass the individual’s family and those people and groups in the surrounding environment (Bronfenbrenner, 1979). When an individual’s life is interrupted by hospitalization, illness, trauma, or even death, repercussions extend far beyond that individual. Due to stressors associated with events, family members and close friends often reach out for additional support from community programs. Child life specialists employed in non-traditional child life settings can use their skills to support the clients who turn to these programs for support outside the hospital setting.

Organizations that are not familiar with the typical duties of a child life specialist may not have a comprehensive understanding of our skills and training, and often, positions that could be appropriate for someone with child life experience may not list child life specialists as possible candidates for the position. By simply reviewing the Child Life Mission below, one can see how the abilities of a child life specialist can be incorporated into many settings outside the traditional hospital setting:

“We, as child life professionals, strive to reduce the negative impact of stressful or traumatic life events and situations that affect the development, health and well-being of infants, children, youth and families.” (Child Life Council, 2011)

For those seeking opportunities as child life specialists in a non-traditional setting, this mission statement helps to validate the need for child life within a program.

There are many challenges when embark-
**Annual Conference**

continued from page 1

Here are some other things to look for in the 2012 conference schedule:

- Attendees may choose from two Full-Day Intensives or three Half-Day Intensives on Thursday, May 24, a choice of three additional Half-Day Intensives will be offered on Saturday, May 26.
- Debut of a new networking event, Connect 4 Success (which replaces the Networking Roundtable events from past conferences)
- Tours of three local hospitals: Children’s National Medical Center, Inova Fairfax Children’s Hospital, and Johns Hopkins Children’s Center
- Extended Exhibit Hall hours on Saturday, May 26 from 8:30 a.m. – 12:30 p.m.
- Premiere of CLC’s 30th Anniversary DVD, currently in production by the Archives Management Group
- Two time slots to speak with Poster Presenters
- Poster Quiz for PDH offered electronically after conference, rather than on paper during conference

Keep an eye on your mailbox for the full conference program which will contain information about these and other conference activities. To download an electronic version of the program, register online, or to make hotel reservations at the special CLC conference rate of $159 per night (single/double), plus tax, please visit the Annual Conference section of the CLC website at www.childlife.org. To ensure room availability at Washington Marriott Wardman Park Hotel, be sure to make your hotel reservations early!

**EARLY REGISTRATION FEES**

(Deadline of March 16, 2012)

Professionals:
- CLC Members $335
- Non-Members $435

Full-time Students and Retired Professionals:
- CLC Members $260
- Non-Members $360

**REGULAR REGISTRATION FEES**

(Deadline of April 16, 2012)

Professionals:
- CLC Members $435
- Non-Members $535

Full-time Students and Retired Professionals:
- CLC Members $310
- Non-Members $410

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**Myra Fox**

Myra Fox, one of the founders of child life, passed away in September 2011. Myra began her career as a child life specialist at Children’s Hospital Boston in 1964, and she became the director of the child life department in 1976. When Myra retired in 2008, her achievements were chronicled in a special feature on NBC Nightly News. In that interview, Myra said she was most proud of the fact that she “...was very much involved in changing the environment at Children’s. I didn’t set bones or fix hearts, but I could at least influence the environment.” This will be part of her enduring legacy — changing the health care environment for children and families everywhere. We will miss Myra, but will always remember the impact she had on the child life profession.

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CLC Annual Report: The Year 2011 in Review

Dennis Reynolds, MA, CAE
CLC Executive Director

The Child Life Council had a good year in 2011. Even amid continuing economic uncertainty and a changeable health care landscape, CLC grew in membership, had our greatest attendance ever at the Annual Conference in Chicago, and benefitted from the hard work and dedication of our committee and task force volunteers, whose many impressive accomplishments promise to move the profession of child life forward.

CLC Membership Tops 4,800

As of December 31, 2011 CLC membership had reached 4,800 members, compared to approximately 4,400 members at the end of 2010. This is almost a 10% increase in membership over the course of the year. In recent years, much of CLC’s steady growth has been attributed to increases in the number of student members. However, in 2011 the number of professional members grew by almost 10% (compared with a 3% growth rate from 2008 to 2010). Currently, CLC has almost 2,900 professional members, more than 1,500 student members, and over 400 associate members.

Annual Conference and Online Webinars

In May 2011, 1,100 individuals assembled in Chicago—the largest number of attendees to ever participate in a CLC Annual Conference. After a day of pre-conference intensives and hospital tours, the conference opened on Friday morning, May 27, with a keynote address by Dr. Larry Gray from the University of Chicago. Over the next two days, attendees selected from more than 50 professional development workshops and networking activities, shared best practices, discussed issues, challenges, and solutions in all matters pertaining to child life and perused the products and services of a record-breaking 68 exhibitors. The Annual Conference concluded on Sunday with an inspiring musical performance from The Penguin Project®. In addition to conference, CLC also offered learning activities through six online webinars, for a total of 9 additional PDH (Professional Development Hours) opportunities for CCLSs.

Certification Update

More than 400 individuals passed the Child Life Professional Certification Exam in 2011, and more than 98% of current Certified Child Life Specialists maintained their certification status. The Child Life Certifying Committee (CLCC) developed a number of policy and procedural documents, and clarified the content areas to be covered in the child life practice course taught by a CCLS that will be required of anyone taking the certification exam during the fall of 2013 or later. A Recertification Task Force consisting of representatives both from CLCC and the general membership attended to a full range of issues surrounding PDHs and made a number of important changes. More information about certification changes and updates can be found at: www.childlife.org/certification.

CLC Community Continues to Serve as Networking Hub, Online Resource for Members

During 2011, CLC Community marked its first anniversary as the online professional networking platform promoting the exchange of information, resources, and ideas among CLC members. The online tools offered through CLC Community include the Membership Directory, which helps members to make direct connections, and the Directory of Child Life Programs, which provides key information about child life programs, helpful for students seeking internship opportunities, as well as professionals interested in doing a base level of benchmarking with other programs.

Some of the most frequently used features of CLC Community are the CLC Forums. There was very active discussion on many of the five forums available—including the general forum and dedicated forums for the child life academic, internship coordinator, program leader, and student and intern communities. There were more than 4,000 posts on the forums during 2011. In addition to the extensive general use of CLC Community, dedicated private discussion forums and file sharing tools have streamlined and enhanced collaboration between members of each of CLC’s many committees and task forces.

Committees and Task Forces Moving the Profession Forward

During 2011, a total of 20 CLC committees and task forces worked to address a variety of complex issues and needs within the child life profession. Although their combined accomplishments are too numerous to provide a comprehensive list here, each committee and task force writes a semi-annual blog in CLC Community to outline the group’s current activities. Reviewing these blogs is an excellent way for members to keep up to date on the important work of each group.

Here are just a few of the products, policies, and procedures developed by CLC’s committees and task forces in 2011 and approved by the CLC Board:

· The Recertification Task Force came up with a series of major changes to requirements and opportunities for earning professional development credits for the recertification cycle.

· The Academic Task Force complemented its earlier core curriculum recommendations for undergraduate child life programs with curriculum recommendations for graduate programs.

· The Internship Task Force completed its development of curriculum modules to accompany the essential components of internship training and also developed an evaluation tool to promote consistent assessment of child life interns across internship programs.

· The Education and Training Committee grappled with the issue of internship interview and offer dates and came up with a recommended procedure designed to introduce greater uniformity for students and internship programs alike.

· The Child Life Certifying Committee developed a new Code of Professional Practice.

· A special task force developed a new CLC position statement, The Value of the Certification Credential in Child Life Services.

· The Leadership Development Committee wrote a paper, Building a Leadership Development Program for the Child Life Council, continued on page 13
Scholarship Winners

continued from page 7

MARIA FATIMA GARCIA-LORENZO, MA, CCLS
KYTHE, INC., MANILA, PHILIPPINES

I belong to a group called Kythe, Inc. We are a group of trained professionals and volunteers in the Philippines who enable and empower people to care and share through our child life programs. The professionals in our group either have a psychology, social work, nursing, or midwife background. After Kythe enters into a memorandum of agreement with a hospital, these professionals are either hired by Kythe or by the hospital to implement the child life program. I, being a Certified Child Life Specialist, train these professionals to become child life coordinators. When a child life coordinator earns a Master’s Degree in a child development course, then he or she is called a child life specialist. Kythe supports the child life program in 10 hospitals and at present has seven child life coordinators, three child life specialists, and one Certified Child Life Specialist.

It is quite difficult to become a Certified Child Life Specialist if you are living in the Philippines. The travel expenses to the United States, plus board and lodging, are quite prohibitive. I was so happy when the Child Life Council chose me to be one of the scholars this year. I found it invaluable that I was given the chance to update my skills and acquire new ones. The conference was both a reprieve and a sanctuary. It was a reprieve because it allowed me to momentarily pause and reflect on what I have done and where I want to go. It was a sanctuary because it allowed me to meet with kindred spirits who revitalized the mission I set myself to 20 years ago. Finally, the conference gave me the opportunity to be updated on the current practices and policies which I can cascade to the child life coordinators and specialists in the Philippines.

The first important thing I learned at the conference and which our group will implement in the Philippines is research and educational practice. I am absolutely grateful to the staff there.

At the conference:

- I have been working hand in hand with Morgan Livingstone, Child Life Officer for the Daisy Eye Cancer Fund (DECF) of Toronto, Canada. We have completed data collection to study “Staff and Parents’ Perceptions of Child Life,” replicating a study done by Laura Gaynard. Data analysis is currently ongoing. The DECF has helped Morgan Livingstone provide week-long child life seminars for the Sally Test Centre for the last four years.
- At the DECF conference, I shared my US trip and was asked to document about my experience on its website.

Let me now share with you about the program for which I work, The Sally Test Paediatric Centre. Our primary goal is to help children undergo the process of hospitalization with minimal stress and anxiety. We are hoping to become Certified Child Life Specialists in the near future. Our four child life health workers prepare children for procedures and organize and coordinate medical play. Ward workers help the child life health workers by taking activities to the bedside. We have one playroom which welcomes children from all the pediatric wards. Young patients participate in organized activities during the day such as reading books, playing games and puzzles, school work and crafts, and dancing. For an hour on clear days both ambulatory and wheelchair-bound children play outside. An outreach group goes to five clinics.

Winning the scholarship was such an honor for me and our young child life program. My hopes were to learn more about the child life profession and meet the people who run the Child Life Council, as well as have a look at an American hospital. Being my first time out of Africa, the flights seemed very long. I had a rough time getting to Chicago because of tornados and flight delays. I am very thankful to Ramona Spencer and her friend from the CLC who waited until 1 AM for my delayed flight!

Going through the sessions I selected was exciting for me. Everything was interesting and educative to me and to my fellow staff members in Kenya with whom I have shared the information. I was delighted to receive The Happiest Baby on the Block DVD as a gift from the presenters of that session. The DVD has become a continuing educative tool for medical staff and caregivers at our hospital. All the sessions were so inspiring, helping me love my role as a child life health worker and manager even more.

Meeting so many colleagues throughout the world who care about children was an inspiration I will long remember. I am exceedingly grateful for the opportunity the CLC gave me. My winning the scholarship also gave me a chance to visit Riley Children’s Hospital, a partner hospital to people working at AMPATH in western Kenya. What a different and interesting experience that was! I am deeply grateful to the staff there.

After the conference:

- I conducted sessions for the staff of the Sally Test Paediatric Centre at Moi Teaching and Referral Hospital in Eldoret as well as for other hospital staff.

- I have been working hand in hand with Morgan Livingstone, Child Life Officer for the Daisy Eye Cancer Fund (DECF) of Toronto, Canada. We have completed data collection to study “Staff and Parents’ Perceptions of Child Life,” replicating a study done by Laura Gaynard. Data analysis is currently ongoing. The DECF has helped Morgan Livingstone provide week-long child life seminars for the Sally Test Centre for the last four years.

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Caring for abandoned children brought to the hospital by Good Samaritans has also become part of our job. During the day we care for them, returning them to the wards each evening. These children stay with us until they are placed in orphanages within Eldoret. The length of their stays may vary from 1-2 weeks to 1-2 years.
Review of A Child in Pain: What Health Professionals Can Do to Help


By Joanne Weltzer and Christa Peterson, Seattle Children’s Hospital, WA

In A Child in Pain: What Professionals Can Do to Help (2010), Dr. Leora Kuttner, a distinguished pediatric clinical psychologist specializing in helping children and adolescents cope with illness and painful medical procedures, provides an extensive overview of the definition of pain and the history of pain management, as well as how to assess and alleviate pain in children, adolescents, and young adults. Kuttner divides the book into three parts: (1) how to measure and communicate with children in pain, (2) how to choose between pharmacological, non-pharmacological, and physical interventions for pain, and (3) how to manage pain-related anxiety. Throughout each section of the book, Kuttner shares the most up-to-date research on pain in children.

A Child in Pain: What Health Professionals Can Do to Help builds on Kuttner’s previous work (A Child in Pain: How to Help, What to Do, 2008) and incorporates research findings from multiple scientific journals in the areas of pediatric medicine, child development, and child psychology. Kuttner’s work is relevant and contributes significantly to the growing body of evidence suggesting that pain management in children is of paramount importance. Having pain addressed and treated is a matter of ethics and a patient’s right. Through detailed discussion of pharmacological and psychological methods for evaluating and treating pain in children and adolescents, Kuttner lends credence to her belief that everyone can play a role in managing and relieving children’s pain regardless of profession. In a sense, the goal of this work is to spread the word that pain is and should be everyone’s concern. This book also highlights the importance of health care providers’ validation of children’s pain through tangible examples of critical patient interactions.

Although A Child in Pain: What Health Professionals Can Do to Help is primarily geared toward health care providers, caregivers and families of hospitalized children can also benefit from the information that Kuttner presents. Depending on readers’ backgrounds, they may have difficulty understanding some of the neurophysiological explanations of how pain and certain medications work, but the case vignettes in each chapter help to summarize the topic presented. In all, Kuttner’s book is a valuable resource that would aid any person seeking to help children coping with pain.

References


2011 In Review

continued from page 11

to serve as the descriptive foundation for CLC’s evolution of a leadership development program.

Last year was a tremendously successful and productive year, thanks in large part to the contributions of a dedicated group of volunteers and the support of the entire CLC membership. We thank each of you for the part you have played in our ongoing progress and growth, and are committed to making even greater strides in 2012, CLC’s 30th anniversary year. We hope you will join us in celebrating this important milestone by engaging with the organization now and throughout the year. Participate in one of CLC’s educational offerings by attending the 30th Annual Conference in Washington, DC, or sign up for a webinar. Join the discussion on CLC Community Forums and blogs, or more informally through CLC’s Facebook, LinkedIn, and Twitter pages. Finally, consider making 2012 the year you commit to volunteering on a committee or task force! As this issue of the Bulletin goes to press, the CLC Board of Directors just finalized an ambitious new Strategic Plan for 2012-2014, which is now available on the website. The support and participation of CLC volunteers will be absolutely essential to meeting the goals and objectives outlined in the new plan.

To learn more about CLC’s plans for 2012 and beyond, visit CLC Community and read the latest installment of the Executive Director’s Blog: “2012: What to Expect – Laying Groundwork for Major Things to Come”

Upcoming Events

Hospitals and Communities
Moving Forward with Patient- and Family-Centered Care: An Intensive Training Seminar—Partnerships for Quality and Safety
Hosted by the Institute for Patient- and Family-Centered Care
March 19-22, 2012
Emory Conference Center Hotel
Atlanta, GA
www.ipfcc.org | 301-652-0281
Not Just Child’s Play: Lessons Learned from Urban Young Adults

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A year ago, I took my first steps into my new clinic, an outpatient facility for children, adolescents, and young adults with HIV. When I imagined my new job, I pictured emotional disclosure conversations, art projects to promote adjustment, and games to reinforce the concept of the immune system. I imagined my new patients and thought of little hands, school-aged smiles, and babbling babies. I got that. But I soon realized that this picture of innocent childhood was difficult to find in our urban setting. Instead, most of my patients were not children or even adolescents but young adults who had acquired HIV behaviorally and who described lives ridden with violence, grief, and family chaos.

I struggled initially with learning how to approach young adults, how to change my interventions to meet their needs, and how to talk, walk, and present myself in a manner that would be comforting for them. Those worries, though, were quickly assuaged by the rapport I built with my first young adult patients. I learned from them that change was not necessary. I stumbled upon this conclusion while facilitating a young adult support group with a colleague. We had been rushed formulating a plan for education and had not developed a group project to promote socialization. I thought about what format would be appropriate, what activity would be well received, and how sophisticated the materials would need to be in order to appeal to young adults. Coming up blank and pressed for time, I grabbed fabric and fabric markers and headed over, all the while thinking, “They’re going to laugh at this.” Instead, they dove in, working together to create a quilt that represented the group. They became so enthralled by the exercise that they didn’t realize the session had ended. When we informed them that time was out, they requested to stay and keep working.

Since that group session, I’ve found myself teaching young adults about their illness with the same materials I use with school-aged children. I’ve found myself leading painting sessions with finger paints, using dolls and stuffed animals to encourage compliance, passing out coloring books and board games, distracting during injections, and facilitating medical play. I have often wondered why these young adults were so receptive to interventions that seemed to precede them developmentally.

According to the family stress model, when families experience economic hardship, children are at risk for developmental difficulties; additionally, children within urban, lower-SES communities experience greater emotional distress (Conger & Dogan, 2007). The stress of maintaining the financial ability to protect one’s family is felt by all members of the household, especially adolescents who inherit the responsibility of caring for younger members of their family. Urban children often have substantial caretaking and homemaking responsibilities, as they prepare meals and care for their community. Within an environment wrought with financial strain and shared responsibilities, could play be something that young adults from urban settings, despite their chronological age, crave? Could it be something missing that we, as child life specialists, could provide?

I met Veronica*, a 22-year-old young woman with behaviorally-acquired HIV about two months into my position. I was asked to work with her on barriers to medication adherence, a topic she had struggled with since she was diagnosed at age 20. During my initial assessment with Veronica I noticed she was significantly interested in my work with younger children. She asked numerous times about my interventions, my dolls, my art supplies. And when describing to her how I thought I could help her through conversation and goal setting exercises, she seemed disappointed. Attempting to put a smile back on her face, I said jokingly, “or we could just make a doll that would remind you to take your meds.” Her face lit up. Since that conversation, Veronica has made a “medicine buddy,” as well as a painting to explore emotions related to taking her medicine and a movie chronicling her adjustment to HIV. Also since that conversation, Veronica’s adherence has improved.

Not all young adults meet me with the same enthusiasm. Sure, I have patients who roll their eyes at me when I ask if they want to play the Wii or make a video diary. But every once in a while I’ll have a 23-year-old ask if he can make a bracelet for his girlfriend, a 20-year-old request a glitter wand during injections, or a 24-year-old ask for a Barbie Styling Head to practice braiding.

We say so often how important it is to provide children, despite their illness or disability, with a sense of pure childhood; how therapeutic play and socialization can truly be. The young adults in my clinic have taught me that the benefits of play do not cease with maturation, but instead remain. I believe that for some young adults the desire for play is dormant; but for others, it’s there, waiting for the right person to come along and ask, “Monopoly or Sorry?” I have many more years to learn lessons from my patients. I’m grateful, though, that this first year has come with a lesson that has enabled me to give moments of childhood back to those who may still thirst for it.

References


Milestones

Retired

Linda Skinner, BEd, CCLS, retired from her position as Professional Practice Chief of Child Life and the Coordinator of Child Life Centre Wide for the IWK Health Centre in Halifax, Canada. Linda was first hired in 1972 as a child life specialist, in 1977 became the Assistant Director at the IWK Children’s Hospital, and was promoted in 1981 to the position of director of the program. Her title changed in 1998 with the hospital-wide changes. Linda has been a pioneer in the field of child life in North America and is known for her leadership, enthusiasm, innovation, and relentless commitment to the true meaning of family-centered care. Her passion for the profession of child life has never wavered. She has been a mentor, educator, clinician, leader, consultant, researcher, and author within the profession, in Canada, the US, and around the world. As a CCLC and ACCLC Board member and through her involvement on numerous committees and task forces, she has influenced our profession in countless ways. Congratulations to Linda on her 37 years of service in child life!

* Patient name has been changed for confidentiality
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- Registration now open for Annual Conference—register online today!
- 31st Child Life Professional Certification Exam applications due for those educated outside of the U.S. or Canada
- 31st Certification maintenance payments due for Child Life Professional Certification

**March**
- 1-31 Celebrate Child Life Month!
- 16 Early bird deadline for lowest CLC Annual Conference registration fee
- 31 Child Life Professional Certification Exam applications due for those educated in the U.S. or Canada
- 31st End of certification maintenance fee grace period (deadline to pay with a late fee)

**April**
- 15 Deadline for submissions for the summer issue of Bulletin/Focus
- 16 CLC Annual Conference regular registration rate deadline

**May**
- 1 Deadline for written requests to withdraw from the May Child Life Professional Certification Exam
- 24 Child Life Professional Certification Exam Administration, Washington DC
- 24-27 CLC 30th Annual Conference on Professional Issues, Washington DC

**June**
- 30 Deadline to apply to recertify through Professional Development Hours (PDHs)