On Sunday, June 10, during the Closing General Session of the 25th Annual Conference on Professional Issues, the Child Life Council Distinguished Service Award will be presented to Christina Brown, MS, CCLS, currently the Director of Child Life and Education at The Children’s Hospital of Philadelphia. The CLC Distinguished Service Award, first bestowed upon Emma Plank in 1988, is presented once a year by the CLC Executive Board to an individual in the field of child life who has contributed significantly to the development of the profession.

Thanks to her many contributions and unswerving dedication to the field of child life, Chris Brown is already a well-known figure to many in the profession. She has been the Director of Child Life and Education at The Children’s Hospital of Philadelphia for nearly 12 years, and one of her proudest accomplishments during her time there has been the growth of her department from a staff of 12 to more than 60 individuals. “Back then [in 1995] the child life department didn’t have as many resources,” she says. “But now we have a great interaction with the rest of the hospital staff, which enables CHOP to be one of the premier children’s hospitals in the country. I take a lot of pride in that.”

Chris knew early on that she wanted a career working with children, but what about her first inspiration to become a child life specialist? “It started with [the soap opera] All My Children,” she jokes. While she was a student at Purdue University, working toward a degree in Child Development and Family Studies, Chris took a social work class that had a volunteer requirement. Chris remembers thinking, “Hey, why not volunteer at a hospital? It looks so interesting on TV!” Her hospital volunteer experience, though not nearly as glamorous as the hospital life portrayed on All My Children, was her first exposure to working with children in a healthcare setting.

During her first few years out of college, Chris worked as a teacher, but it was not long before she began working toward a career in child life. “I loved kids, and I knew I wanted to work in a hospital setting,” she says. “I am one of the few lucky people that have found a career that is meant for me.” In 1987, Chris

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Entering the Zone of Ethical Proximal Development: The Child Life Specialist as a Teacher of Ethics

Paul Thayer, M.Div, Wheelock College, Boston, MA

Child life specialists often observe and discuss ethical issues. Most often, however, child life specialists wait for a patient and family to make a decision, and then support them after the decision has already been made. Seldom are child life specialists active participants in the decision-making process. This article explores possibilities about how child life specialists might become more proactively involved in ethical decision-making by actively using their teaching, listening, and play skills to advance children’s ethical development.

Rather than being just observers of ethical reasoning, what if child life specialists were to use more fully their facilitation and instructional skills to become teachers of ethical skills? Children dealing with immediate ethical concerns could certainly benefit from the interventions of a child life specialist who could encourage ethical exploration through conver-

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On the Horizon in 2007: Honoring the Past – Imagining the Future

Erin Munn, MS, CCLS, Johns Hopkins Children’s Center, Baltimore, MD

As our upcoming Annual Conference theme states so nicely, our 25th Anniversary in 2007 is a time for celebrating accomplishments past and present and for working toward the future. The Annual Conference in Orlando will serve as the cornerstone of this celebration; be sure to check out your conference program and the CLC Web site for more information on the exciting events planned!

In the midst of commemorating a significant milestone, CLC remains dedicated to the future of child life – to our continued growth and improvement as professionals and as an organization. Three major initiatives for our 25th anniversary year highlight that commitment:

• Implementation of our Association Management System (AMS)
• Redesign and upgrade of our Web site
• Update of the CLC strategic plan

The launch of the AMS system, combined with the redesign of our Web site, will change how we connect with CLC in an online community. Planned enhancements include more efficient online transactions with CLC, improved member services, including a new online Career Center, and – with the implementation of a Web site search feature — increased accessibility to the wealth of information available at www.childlife.org. The investment that CLC has made in these initiatives is directly tied to the strategic plan. Their implementation is an example of how strategic planning serves to identify and prioritize goals and to align resources and infrastructure to achieve key outcomes for our members and our organization.

In 2003, the CLC Board, led by then-President Melissa Hicks, recognized that a strategic approach to planning would best serve the organization and its members by defining the issues of greatest importance and charting the course, or direction, to address those issues in the form of strategic goals and objectives.

The first strategic plan was developed and presented in 2004. The plan focused on five focus areas: member care, professionalism, public relations, research and partnerships, each with its own goals and objectives. The

infrastructure of CLC, including staff and board composition, as well as committee charges and tasks, was realigned to support the strategic plan. In addition, a multi-year business plan was developed that supported the strategies outlined in the strategic plan.

Over the past three years, the CLC Board, staff, and committee chairs and members have continued to implement the strategies identified in the plan. Progress toward the goals of the plan has been substantial in some areas, such as member care and professionalism, but less satisfactory in others like research and public relations.

A key component of strategic planning is regularly reviewing and updating the plan, and realigning the resources and infrastructure essential for effective implementation of our goals. Making these regular adjustments is what allows CLC to remain nimble and responsive to an ever-changing professional environment that affects both the organization and our membership.

A formal process of review and adjustment of the strategic plan began in the last quarter of 2006 and continues into 2007. Members of the board, CLC staff, and committee leaders have participated in the process, and feedback from members (through the 2006 membership survey, conference evaluations, conversations with program leaders, and other avenues) has been a critical factor.

The Strategic Planning Task Force met in February to create formal recommendations for the CLC Board.

What will be achieved by reviewing and revising the plan?

• Adjusting goals and prioritizing objectives based on current conditions and resources
• Anticipating future needs of our members through identification of external and internal trends
• Reallocating resources and adapting infrastructure to better meet priority goals and objectives

What does updating the strategic plan mean for members?

• Revising the plan will ensure our members gain greater return on their investment in CLC membership and heighten the value they bring to their organizations.
• Improved services and new programs
Much of the strategic plan was based on member data – what members have told us they want from CLC. In addition, members of the Strategic Planning Task Force – including board members, volunteer leaders, and CLC staff — have been carefully selected to represent the diverse membership of CLC. Utilizing these resources, we have a clearer picture of what current programs and services are valued, and what new programs would be of greatest impact.

Based on recommendations from the Strategic Planning Task Force, the CLC Board will move forward with adjusting goals and objectives, reallocating resources, and restructuring work groups over the next year. Keep your eyes open for updates in the work groups over the next year. Keep your eyes open for updates in the Bulletin and on the Web site as the year progresses.

Strategic planning is an ongoing process that has no completion date. CLC leadership and staff will continue to annually monitor and adjust strategy based on changes in the environment. This approach requires us to recognize that change is an essential part of progress. Our "road map" for growth and development as an organization must likewise be adapted to changing circumstances. Only in doing so will CLC continue to be successful in its mission to serve child life professionals as they empower children and families to master challenging life events.

AMS Rollout Begins: Fast and Easy Service Offered Through Web

Child Life Council is pleased to announce that the Association Management System, also referred to as AMS, is now available online. AMS is a database and e-commerce system designed to streamline and improve the quality of your everyday interactions with CLC by providing safe and secure direct access to your membership profile online.

All members and certified child life specialists have received an email from Child Life Council with a pre-assigned username and password. Users may now access their profiles from the Web site at www.childlife.org. Upon logging in to the system, you may, if desired, select a new username and password – preferably one that will be easy to remember as you will want to log in whenever you visit the new site.

First and foremost, we ask that you check your user profile. Under the new system, your user profile is the primary record that CLC will maintain to track your membership, certification, and other pertinent transactions. In order to best serve you, it is crucial that we have the most up-to-date contact information on file. Moving forward, your primary email address will be the principal means by which CLC communicates important member announcements, account information, and receipts. It will also serve as the main identifier for your record in the system. Please take a moment to review your record to ensure correct spelling of your name, preferred and secondary address information, and to answer new questions to track membership demographic information.

Conference registration is also now available online. Please be sure to log in prior to using the online registration system in order to receive your membership discount. This will also make the online registration process more efficient, by pre-populating your contact information into the form! Please note, however, that any updates you make to your contact information in the conference registration process will not update your main user profile; it’s important to make those changes directly to your profile.

Keep an eye out for announcements as other functions are rolled out over the next few months. The complete AMS system will offer expanded functionality including membership renewal, certification annual maintenance fees payment, publications orders with automatic member discounts, a career center - and much, much more!

By automating basic transactions and membership information, CLC staff will be better able to serve your needs by focusing on high-quality connections with the membership. We understand that your time is valuable, and hope that these improvements to the CLC Web site will make your life just a little bit easier!

MILESTONES
Hired: Amy Bullock, MSED, CCLS recently accepted a position as Director, Child Life/Child Development Services at Mattel Children’s Hospital at UCLA Medical Center in Los Angeles, California.

Marriage: Jessica Sisson, CCLS and Matt Bryson, CCLS were married on October 14, 2006, marking the first CLC-documented marriage between two child life specialists. The Brysons met while working together at Phoenix Children’s Hospital. Jessica is now a child life specialist at Children’s Rehabilitative Services at St. Joseph’s Hospital, and Matt is a child life specialist in the emergency room at Phoenix Children’s Hospital.

Birth: On February 7, Professional Resources Committee Chair Vanessa Gramm-Mackey and her husband Bill celebrated the arrival of their first child, Gabrielle Elizabeth Mackey.

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To reach a Board Member by phone, please contact CLC at 800-CLC-4515 or email c1staff@childlife.org.
Service Award

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obtained a master’s degree in Child Care Administration from Nova University.

Prior to her time at CHOP, Chris served in child life director positions for several other facilities, including Cook Children’s Medical Center, MetroHealth Medical Center, and James L. Kernan Hospital; she has also worked as an instructor for the University of Akron in Ohio, and Howard Community College in Columbia, Maryland.

Her history of volunteer leadership, both with Child Life Council and other organizations, is impressive. For CLC, Chris served as the first Chair and President of the Child Life Certifying Commission, providing leadership in the original development of the Certified Child Life Specialist (CCLS) designation. She also held the positions of CLC President-Elect from 1988 to 1990, President from 1990 to 1992, and served as President-Elect and President of the Association for the Care of Children’s Health (ACCH) from 1995 to 1999. Currently, she works in a volunteer or advisory capacity for Hugworks, Children’s Seashore House of The Children’s Hospital of Philadelphia, and is a lead counselor for Camp Sanguinity, a pediatric oncology camp.

Chris is a published author and has contributed to several texts in the child life literary canon, including the fourth edition of the Guidelines for the Development of Child Life Programs. She represents CLC as a member of the American Academy of Pediatrics Committee on Hospital Care, working on the recently-released updated Policy Statement on Child Life Services. The revised statement appeared in the October 2006 issue of Pediatrics, the peer-reviewed, scientific journal of the AAP, and included significantly expanded content and stronger recommendations for expansion and integration of child life services.

In addition to her work on these important child life resources, Chris continues to be a sought-after speaker on a wide variety of topics, with an exhaustive list of presentations to her credit.

Chris also works as a child life program reviewer, providing valuable feedback to child life programs on how to improve the quality of their services. She conducts program reviews worldwide both as an independent program development consultant and in an official capacity for Child Life Council, “I have been able to step outside of my own program - as a consultant, lecturer, educator, program reviewer - and contribute to the development of psychosocial care,” Chris reflects. “As an administrator, this is often where you get your sense of accomplishment. By teaching, and helping to ensure that resources are available for child life specialists, you are influencing those experiences indirectly for children.”

When asked what advice she has for aspiring child life leaders, Chris points out that, “not everyone has the need or desire to be a director or administrator, but all of us can be leaders. Determine your strengths. Are you a great presenter? An effective mentor? Look for outlets to do that. Being a leader in child life is primarily about looking for opportunities to step up to the plate. Get involved at any level, by sitting on local committees or work groups, and looking for opportunities with CLC. And don’t just volunteer once. Stick with it over time.”

Chris remembers one of her first experiences in leadership. “It was back sometime in the early 1980’s – I was at an ACCH meeting, and they were looking for someone to explore the possibility of developing a certification program for child life specialists. I looked around, and no one was offering to take the lead. I didn’t have any particular expertise, but I thought to myself, ‘I’ll try it,’ and raised my hand to volunteer.”

It is precisely this proactive, can-do approach that has helped Chris to become such a standout in the child life profession. And her adventurous spirit has carried over into her personal life, as well. In her spare time, she is a member of the Philadelphia Flying Phoenix dragon boat team. Last year, her team went to the National Women’s Club Dragon Boat Championships and won a gold medal. But it’s her work on the CLC team, and in the child life profession, that has earned her this latest honor, the CLC Distinguished Service Award. Congratulations Chris!

Editor’s Note: As we go to press, Chris is preparing to broaden her horizons once again as the Director of Child Life and Family Centered Care at the new Dell Children’s Hospital in Austin Texas. We wish her luck in her new adventures.

CERTIFICATION CORNER

CHILD LIFE PROFESSIONAL CERTIFICATION EXAM RESULTS FOR 2006

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Certification Due to Expire in 2007? TIME TO RECERTIFY!

If you plan to recertify by PDHs, the deadline for submission is June 30. If you intend to recertify by exam, regular exam application deadline dates apply. If you haven’t started filing out your PDH paperwork yet, check out the CLC Web site to access the new online PDH submission process.

2007 FALL EXAM SITES

There are currently six sites scheduled for the November 7, 2007 exam administration:

- Boston, MA
- Dallas, TX
- Indianapolis, IN
- Los Angeles, CA
- New York, NY
- Salt Lake City, UT

Child Life Professional Certification exam applications are due by June 30 for all candidates educated outside the US and Canada, and by August 31 for all candidates educated within the US and Canada. Please refer to the CLC Web site to see if additional sites have been added and to access the new online exam application.

Please contact Danea Williamson with any questions at 301-881-7090, ext 14 or by email dwilliamson@childlife.org.
Introduction

The dying and death of a family member who plays a significant role in a child's internal and external world can produce a profound negative impact on his or her psychosocial well being. “However, with adequate family resources, competent substitute care, and emotional support, bereaved children are better able to return to previous levels of functioning. When death can be anticipated, as with a terminal illness, physicians and other health care professionals have an opportunity to ameliorate the impact of the loss” (Christ & Christ, 2006, p. 197). This article focuses on ways child life specialists can ease the impact of the upcoming death for the children of dying adult patients. The article also outlines developmental stages of grief and offers recommendations for age appropriate support.

The anticipation of death has been described and idealized as a time when people can say goodbye and finalize unfinished business. This description loses sight of the painful and possibly traumatic experience of witnessing a loved one struggle with grave illness. The process can be overwhelming, as is the loss of familiar family structure and identification with a healthy family. Historically, the medical field has frequently failed to address and treat children confronted with dying and death issues. It was not until 1992 that the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health finally defined the pediatrician's role in caring for bereaved children. However, in the next issue of Pediatrics, Dr. Wanda Panosh (1992) noted that her medical training had “no effective formal guidance in the area of grief and bereavement” (p. 779). Aside from the lack of formal training, most physicians treating adults are not accustomed to working with children, nor do they have an abundance of time to do so. These factors can explain why many children's psychosocial needs are not addressed before and after an adult's death. “Other reasons for the lack of services are the myths about grieving children. There has been a long-standing debate about children's capacity to grieve. As a result, children's grief has not received much attention from clinicians and researchers” (Kirwin & Hamrin, 2005, p. 65).

There has been sensitivity and growth in this area. Medical professionals now have greater access to psychosocial guidelines, recommendations, and interventions for use when communicating bad news with dying adults (Girgis & Sanson-Fisher, 1998; Walsh & Girgis, 1998). Breaking bad news is defined by Waldridge & Waldridge (1996) as delivering news that drastically alters the patient's view of her or his future. Specific steps for breaking bad news to patients include the offer of assistance to discuss issues with children and other family members. It is recommended, “If children are involved, then bring in a health professional used to dealing with children” (Girgis & Sanson-Fisher, 1998, p. 57). The child life specialist is the health professional who routinely mediates and facilitates communication with pediatric patients. They receive from us direct information and their responses are heard. We educate and advocate for treating children while family members are dying in our medical centers. This helps everyone involved at a time when feelings of hopelessness are paramount. The dying are reassured to know this support is the basis for resiliency and their children will survive the painful separation while continuing to thrive. We spearhead this process by advocating, educating and supporting a family-centered care approach.

The child life specialist skillfully incorporates age appropriate educational methods through play and creative art therapies to enhance exploration and comprehension. In turn, the child's development continues during a family crisis to prevent fragmentation or miscommunication, which disrupts normal developmental processes.

Erika Leeuwenburgh, LPC, ATR-BC, CCLS, Chief, Section of Child Life/Creative Arts Therapy Services, Joseph M. Sanzari Children's Hospital at Hackensack University Medical Center

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Dying and Death of a Loved One

continued from FOCUS page 1

**ADVOCATOR: WHERE WE BEGIN**

A fundamental role of the child life specialist is to be an advocate. We routinely recommend age-appropriate treatment for children and increased communication with their families. In her book *Working with Children in Hospitals*, child life pioneer Emma Plank wrote, “It is [as] the child’s advocate against the system that the child-care (now called child life specialist) worker fulfills her most important role” (Plank, 1962, p. vii). Child life specialists speak to the emotional, developmental and familial needs of children in health care centers. Children experiencing dying and death in their families, particularly those who lose their parents, are at risk for “serious emotional and behavioral problems that can lead to the development of some major psychiatric disorders.” (Kirwin & Hamrin, 2005, p. 62).

Many medical centers embrace family-centered care. Patients who are dying may want contact with children in the family, and children may need to maintain a physical and emotional bond with that family member. When children’s visits with dying patients are supported by child life staff or adult family members, the encounters can be mediated to decrease stresses, address parenting challenges and enrich communication. (Christ & Christ, 2006; Swick & Rauch, 2006; Saldinger & Porterfield, 2003). Preparation is imperative and necessary to provide choices regarding visitation and closure. Child life specialist Kathleen McCue noted in her book, *How to Help Children through a Parent’s Serious Illness*, that children of seriously ill parents “always have the right to know what’s going on. Not only is that knowledge their right, it is one of their greatest needs” (McCue, 1994, p. 6).

The child life specialist helps to establish a child’s understanding about the hospital milieu. By exploring the physical and psychosocial changes related to the loved one’s anticipated death, children are helped as they gain knowledge. The overwhelming transformations that occur as death approaches may be explained in a manner children can grasp. This support serves as a foundation for a greater understanding of death. For example, the author uses clay with children to create images of how cancer would appear if it were a creature. This self-made three-dimensional symbol engages the child in play and is an educational tool about the illness. The disease is an abstract concept for the young. It becomes understandable when the imagination is stimulated in the form of creating a creature within the play. Participation in this process helps to define the illness and produces a vehicle for future exploration about the medical condition.

A 5-year-old boy’s brother was hours from death. His family asked the author to help share the painful news with the boy. The sibling was reminded of the cancer creature previously created. It was described as having grown too big and strong inside his brother’s body and the medicine was unable to stop the cancer. The cancer was stopping his brother’s body from working and was going to kill his brother. At this point the child collapsed to the floor and his mother held him while he cried.

“Anticipatory grief is grief expressed in advance when the loss is perceived as inevitable” (Aldrich, 1974, p. 4). Nancy Webb’s *Helping Bereaved Children: A Handbook for Practitioners* reminds us that “information should be given based on the child’s ability to comprehend the future and anticipate future events” (Webb, 1993, p. 82). The child life specialist may educate staff and family about children’s developmental stages, ability to cope, and recommend when and how information is delivered. The specialist models behavior and open communication through verbal dialogue, as well as using play and the arts to engage, to educate, and to make an abstract experience concrete, tangible, and understandable. We, as child life specialists, have the responsibility, and the response ability to address all adults involved, and to give voice to the plight of children. We can provide interventions which strengthen the child’s ability to survive a traumatic experience.

**EDUCATOR: PREVENTING RISKS AND BREAKING “BAD NEWS”**

Children and adults learn from an interactive process when they integrate information through observation, exploration, and discussion. The child life specialist skillfully incorporates age appropriate educational methods through play and creative art therapies to enhance exploration and comprehension. In turn, the child’s development continues during a family crisis to prevent fragmentation or miscommunication, which disrupts normal developmental processes.

Most children have limited life experience with dying and death, and benefit from professional help to cope, understand and minimize psychological damage. The debilitating illness and ultimate loss of a parent has great significance. Parents have a fundamental role in their children’s development and emotional well-being. The parent fosters a sense of stability, organization, and support. The parent who is dying is often incapable of providing these supports. The hospital’s foreign environment is intimidating, as are the patient’s physiological changes, which can be frightening. The child witnesses these changes while consciously or unconsciously anticipating death. Therese Rando (2000) has written that “traumatic anxieties more typically associated with grieving after the

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**FOCUS**

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death are readily apparent during the illness phase; the undermining of the sense of the world as a stable and predictable place; the panicky questioning about one’s ability to cope; the intensity and lability of emotions; death anxiety (“Will my dad actually die?” “Could I die too?”); separation anxiety; and the intrusive thoughts and images continually replenished by yet more exposure to graphic stimuli” (p. 169). The loss of the vital parent compounded with exposure to the dying body, free-floating anxiety, anger, fear and sense of responsibility can create fertile grounds for physical and psychological reactions if the child lacks support systems. When children are uninformed and feel isolated, their fears and imagination fill in the missing information, and they often feel responsible and guilty about a medical condition. This was exemplified for the author when a 13-year-old girl shared her guilt, fear and sense of responsibility for her mother’s relapse. She harbored these feelings, expressing them only when encouraged to write and tell her story. This creative process permitted the teen to describe how she was hastening her mother’s death. “I stress her all the time. I can’t help it but we fight and my mother yells, ‘You are stressing me and making me sick.’” Later the mother and daughter came together with the child life specialist to clarify misconceptions and enrich communication. The meeting served to educate parent and child about normal teen development, which includes arguing to assert opinions in an effort to define identity and independence. They both saw that the disagreements and appropriate stress did not create or fuel the growth of cancer cells. They discussed the cancer and the sadness evoked by the many disruptions it brought in their lives. The conversation allowed the girl to express feeling loss and love for her mother. Ultimately, the experience was healing and invaluable for mother and daughter.

It is therefore useful for the child life specialist to encourage a dialogue between children and adults. Adult patients can be confused and unaware of precisely what they are conveying about their illness or anticipated death. “The ability to handle a traumatic situation without being overwhelmed depends upon a person’s coping skills, life experience, perceptions of the event and emotional stability” (Brooks, 1996, p. 10). One means of facilitating positive coping and assisting communication among family members is to encourage children to visit their hospitalized parent. Child life specialists help prepare and structure visits for children with planned activities to enrich understanding and coping, and decrease stress.

**Supporting Through Family-Centered Care**

The first sentence of the American Academy of Pediatrics Policy Statement on Child Life Services describes how child life programs serve to “address the psychosocial concerns that accompany hospitalization and other health care experiences” (p. 1757). In psychosocial services, a central issue is family-centered care. The basic premise of family-centered care acknowledges that patients and family members function as a unit. Optimizing the family’s ability to help the patient impacts the patient’s sense of well-being. The healing process in turn, has a positive relationship to the patient’s functioning within the medical setting. Family support is invaluable and visits can be beneficial for all involved.

Child visitation with adult patients poses challenges and may expose children to stressful stimuli. Some key ways to maximize coping for children of cancer patients include “maintaining a child’s daily routines and activities, maximizing age-appropriate child-centered family time, and facilitating parent-to-child and child-to-parent communication” (Journal of Supportive Oncology, 2006, p. 75). Opportunities for children to visit hospitalized loved ones offer the time and space for family communication and support to occur. Children can better understand the situation by experiencing it firsthand, which can demystify images held when a visit has not occurred. Additionally, visits can lift patients’ spirits by giving them time to spend with their children, allowing them to maintain the healthy role of a parent and not just a patient. The mutual pleasure gained from time spent together as a family is essential during times of crisis.

But managing visits can present challenges. Travel arrangements, finances, job disruptions, schedule changes and other factors are obstacles that are particularly challenging when a family is emotionally drained. Parents are known to question the benefits of visitations. Some worry about the ways that a declining physical state may frighten their children. Children may have limited attention spans, may lack structure, and can act out their anxiety in the unfamiliar environment. Hospital rooms rarely have age-appropriate activities that will hold interest or be a source of comfort to children. Some parents have limited energy and emotional resources, and find visitations stressful and overwhelming. Studies report that bereaved children have memories of anxiety and disappointment while interacting with the ill parent. These memories remain painful and disturbing during the first year after death (Christ & Christ, 2006). Child life specialists can help before, during, and after visits. By coordinating with medical staff, they can minimize exposure to traumatic material, and provide age-appropriate information and meaningful activities, which help children work through their experiences.

The author worked with a family anticipating the death of a woman from an alcohol-related disease. She had a 6-year-old daughter and a 9-year-old son. Their father was receptive to the recommended interventions and brought the children for bi-weekly visits for a four-week period. Years of alcohol abuse had left the patient with severe neurological damage resulting in thrashing and moaning behavior. The physician reported...
that her physiological reactions were not painful to her, but could be disturbing for others to witness. The child life specialist contacted the patient’s nurses for collaborative planning. In preparation for the visit a request for additional sedation was made to quiet the mother before and during the visit.

Prior to seeing their mother the children spent much of their time drawing cards to leave in her room. This process was calming and allowed them to artistically express positive memories of their mother. Upon entering the room, they saw their mother sedated. Both touched and kissed her and placed their cards around the room. Although the patient was non-responsive, the children embraced her and were pleased to have time with their mother. The structured visit minimized disturbing images or events and began preparing the children for the parent’s inevitable death. The mother’s critical condition was described and the children witnessed it during the visit. Nonetheless, their wish to see her was granted, and they seemed content to share stories about their mother when she was alive. The children were told about their mother’s anticipated death in a timeframe appropriate to their ages, six and nine, which was hours before it occurred. They understood the doctors could not save their mother and that her body had stopped working. Creating art during each visit helped calm and center them by providing a vehicle for self-expression and leaving images as tokens of care for their mother. The positive communication and planning between the father, child life and nursing staff presented a safe space and minimized the potential for traumatic experiences and memories.

In handling these difficult situations, the child life specialist assesses environmental factors and medical conditions, educates other caretakers, and presents psychosocial and therapeutic interventions to the medical team. One myth to dispel is that children cannot cope with the situation and that discussing fears will overwhelm them with anxiety. In cases of anticipatory grief, time is taken to explore and encourage expression of the child’s thoughts and feelings. One means of exploring children’s experiences is simply to ask them to draw two pictures: first, their fear and second, their wish. This non-verbal form of communication gives children of any age the distance, time, and creative means of expression, often difficult to provide through talking.

The author encouraged a 13-year-old boy whose dying brother was in the intensive care unit to share his experience through art. The teen’s pencil drawing illustrated a boy with his head lowered and holding flowers over a tomb stone. An arrow was drawn pointing from this image to the rear of an ambulance. Later he described anticipating his brother’s death and a clear understanding of the situation. He expressed concern regarding his mother’s mental health and feared she would require hospitalization after her attempted suicide. He was encouraged to share his concerns with his parents and the attending social worker who discussed and arranged for additional support for the mother. In the second part of the process, drawing a wish, the brother depicted the annual family reunion. By expressing hope, the boy was comforted with memories of the family united. Hope is a useful way for people to cope. The art fostered the expression

**COMMUNICATING BAD NEWS TO CHILDREN**

**ENVIRONMENT FOR BREAKING BAD NEWS**

- Find a space and time with few distractions and disruptions, ideally a quiet room
- Sit down, maintain eye contact and say there is bad news
- Provide information in a sensitive, direct, honest and age-appropriate level
- Use concrete examples, descriptive language and include drawings or diagrams
- Engage in discussion to understand child’s awareness of the situation, alleviate misconceptions, and encourage mutual support
- Listen even to the silence: let 2 – 3 minutes pass without words; this “pregnant pause” is filled with vital thoughts and feelings - quiet allows reflection
- Be empathic and flexible with children, if they need to fidget, let them, if they want to draw while listening, let them. As long as they are in the room, the information can continue to be shared
- Follow up

**INDIVIDUALIZED CARE PLAN FOR FAMILY**

- Support parent or guardian in making a plan to discuss bad news with child, offering support from specialist who can take the lead and model for parents
- Educate and decide upon timing with parent or guardian to provide an open, honest and informative exchange of information
- Explore, incorporate and respect family values, beliefs and cultural background
- Encourage contact with child on an ongoing basis through visiting, calling or sending letters and self-made gifts

**ASSESSING AND INCORPORATING FAMILY STRENGTHS**

- Observe and assess family relationships; identify members who can advocate for children
- Identify if family had previous crises and if so, what coping mechanisms were successful
- Encourage family visitation and enable family to have a positive visit with adequate preparation for children, appropriate materials for children to use during the visit, with a realistic length of stay and a plans for a smooth separation

**INCLUDE CHILDREN IN A CARETAKING ROLE**

- Children enjoy expressing their concern
- Encourage children to create or bring gifts or items to share during visits
- At visitation children can be guided to help the patient with small tasks such as bringing water, pillows or dimming the lights
- Share memories by viewing photographs
of immediate concerns along with expression of hopes and memories.

This type of activity presents an opportunity for child life specialists to educate adults and children, to support the family, and to advocate for the inclusion of children in the process of anticipatory grief or grieving together. In certain situations the child life specialist’s role may extend to facilitating the communication of “bad news” which requires an atmosphere conducive to learning and sharing information about the upcoming death. This abstract information must be translated into concrete terms for comprehension. It requires an understanding of child and personality development, family dynamics, coping styles, and levels of cultural competence.

In an emergency room, a father was pronounced dead on arrival, and the author initially met with the mother. After an introduction of the role of a child life specialist, the weeping mother said, “I don’t know what to do. I don’t know what to tell the children.” The author reassured her by saying, “I have helped many other families and will help you.” The first goal was to educate and support the mother by reassuring her that we would tell the children the truth and they could cope with her love and support. She was asked about her 7-year-old daughter and 10-year-old son’s conceptions of death. The mother said the children’s uncle recently died, and she could say their father is now with him. The mother was calmed once she had organized her thoughts. She had a plan for talking to her children, and then shared with staff the following sequence of events: the family had been home and the father was not feeling well and took a nap. During his nap he made unusual noises and his wife woke him twice to check on him; he told her he was just tired. Then the children heard their mother screaming and directing them to go to their grandmother upstairs as she dialed 911. The children were brought to the hospital by their grandmother after the mother had arrived with her husband in the ambulance.

The child life specialist accompanied the mother into the waiting room where the children sat with their grandmother. The mother immediately sat down and said, “Daddy is with your uncle” and the children sobbed. It was a heartbreaking experience to witness the children’s grief. The adults did an excellent job of allowing the children to express themselves without interference. They held and comforted them with reassuring words. They were asked to think about questions they had about the death. Their three most important questions were: How did my father die? Would he have lived if the ambulance came sooner? Could I have done anything to help prevent my father’s death?” This immediate intervention allowed the children to receive answers from a nurse and child life specialist. This multi-disciplinary approach facilitated greater understanding of the sequence of events, physiological changes and a guilt-free grieving period. Art materials were provided for the children to create a memory box about their father. They worked peacefully, shared memories and felt support from arriving family members. These arrangements helped ground the children with a concrete and tangible activity that they could share and feel connected to their deceased father. The mother was willing to trust the staff, to integrate recommendations and to witness the work of the child life staff; this willingness enabled the child life specialist to support both the surviving parent and children. This spearheaded communication in a safe and nurturing environment which the family can always reference.

The surviving parent or adult caretaker takes on a pivotal role before, during and after a death. Parents who have difficulty initiating communication, or who feel their children are “fine” may be struggling to cope themselves. “The inability of these parents actively to assess their child’s reactions likely testifies to just how much parents needed to think that their children could cope, and cope moreover, without adult intervention. This ‘no news is good news’ style of parenting speaks, as well, to the unfortunate fact that it is easier to overlook the plight of children who internalize distress” (Saldinger, Cain & Porterfield, 2003, p. 175). Situations like...

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**One means of exploring children’s experiences is simply to ask them to draw two pictures: first, their fear and second, their wish.**

**This non-verbal form of communication gives children of any age the distance, time, and creative means of expression, often difficult to provide through talking.**

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**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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Grief and Development

Six to Nine Years Old

Children are better able to understand the concept of death. They readily express feelings of sadness upon being informed of the death and later express the sadness in short spurts or share pleasurable memories. The separation is experienced as going to heaven or another place. They are often concerned about who will care for them and their safety. Their thinking is concrete and information they seek is comforting by giving them a sense of control.

Recommendations: It is helpful to encourage and answer questions in a clear and honest manner. A detailed explanation of death and what happened to the deceased body may be requested, which is typical and appropriate for this age. It is helpful to give the information as well as emotional support. Children can be given a choice to participate in funeral arrangements and attend the funeral.

Ten to Twelve Years Old

Abstract thinking is developing and death is understood as universal. The questions about death and what happens to the body when it is dying are an expression of the need to master the concept and understand the full impact. There is developing sense of moral awareness which might lead to the perception that death is a punishment. Children’s ability to clearly express themselves can help adults explore and demystify thoughts about death.

Recommendations: Clarify that death could not be prevented by the child. Simply put, sometimes things happen for which there are no answers. Encourage sharing feelings and memories.

Thirteen to Eighteen Years Old

Most adolescents have a full understanding of death. They begin to integrate a spiritual approach and conceptualize the abstract components of dying and death. Developmentally, adolescents may be experiencing feelings of immortality, often taking risks, romanticizing death and exploring their own limits and boundaries. The reality of death is overwhelming, shattering their idealized and safe world. It is not unusual for teens in this age group to deny the impact of death and avoid direct conversation about the death. Nevertheless, it is helpful to share feelings and memories. Teens can be given the choice about involvement in funeral arrangements; adults should, remain aware that adolescents may choose not to participate. In this stage of life adolescents are developing their identity, and for some, being identified as the “kid who is grieving” can be disheartening. Encourage expression of feelings without expectations, force, or pushing. Adults can provide comfort, mutual exchanges, respect and understanding.

Recommendations: Be prepared for deepest conversations to occur at unexpected times; driving in the car, getting ready for school and other spontaneous moments. In this type of relaxed communication, the contact can be brief and meaningful at the same time. It is not pressured and the adolescent does not feel confronted. It is highly recommended the adolescent find ways of memorializing his/her loved one through creative expression, participating in family events and rituals, which connect to the deceased.

Complicated and Traumatic Grief

Complicated grief involves many prior issues such as other deaths, losses, emotional vulnerability, or multiple deaths at one time. Traumatic grief results from sudden, unexpected, violent, or catastrophic death. The following behaviors are signs for concern when displayed over a period of more than one month after the death. They suggest the need for professional advice and bereavement counseling.

- shift in school performance
- shift in play patterns
- shift in expression of feelings
- shift in eating patterns
- inability to separate
- shift in school performance

* Adapted from Leewenburgh and Goldring, 2006, Why did you die?

How children experience grief changes with their developmental stages. Although individual children vary, there are characteristics typical of each stage. This chart describes those characteristics and offers recommendations to help children cope.

Two and Under

Children in this age group readily identify their parents, siblings, and caretakers, and most often have established these relationships. They are profoundly aware of change, and separation from a primary caregiver creates stress. This is observed in distress responses, night terrors and irritability.

Recommendations: Use basic language, tell the child that the loved one has died and will not come back. Talk in simple terms about events related to death. Be aware that familiar items are important and try to minimize changes in the environment. Photographs of the deceased and shirts or pillows with the loved one’s scent can be comforting. Encourage sharing memories.

Three to Five Years Old

Children have not developed abstract thinking and do not understand death is permanent. They frequently ask where or when the deceased is coming back, which is an attempt to master the concept and understand. Children in this group have short attention spans and will not participate in long, emotionally intense discussions. They deal with their sadness and grief using play, frequently expressing sadness when disappointed, when experiencing the loss of an object or whenever behavioral limits are set.

Recommendations: There is a need for concrete, simple and descriptive information to explain death (e.g., the body stopped working). Children must be reassured death is not caused by their behavior or thoughts, as “magical thinking” is typical of children at this age. Try to reestablish routines and schedules with loving limit setting. Photographs and sharing memories can be encouraged.

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- shift in eating patterns
- inability to separate
- shift in school performance

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this challenge child life specialists to sensitive-ly and creatively educate parents about chil-dren anticipating the death or the grieving process. As adult family members experience grief, they are understandably confused, dis-oriented and have difficulty making deci-sions. Child life specialists can support the grieving parents by providing resource materi-al and modeling ways to communicate. “Bereaved parents may have difficulty dealing with their feelings and grief issues, which will
impair their ability to parent their children. These children may then have to deal with major psychiatric problems and social dysfunction in their childhood and possibly throughout their adult lives” (Kirwin & Hamrin, 2005, p. 62). The child life specialist’s keen awareness of child development can be shared with adults to help them address the immediate crisis and to prevent future unresolved issues that may compromise children’s well-being and development.

**DEVELOPMENTAL STAGES OF UNDERSTANDING DEATH**

Parents can be reassured that children overcome adversity and continue to thrive in their development with proper communication and support, despite the death of a parent or close family member. It is essential for parents to be aware that children grieve differently from adults as they pass through each developmental stage. “This simple fact is imperative for adults to remember when observing a grieving child. The child’s behavior should not be interpreted with an adult’s frame of reference. A child can play with family or friends at the funeral and still be in the midst of grieving” (Leeuwenburgh & Goldring, 2005, p. xi). Parents’ awareness of children’s grief and their ability to have realistic expectations will strengthen the child’s coping ability by offering greater support.

**RESILIENCY OF BEREAVED CHILDREN**

Parents can foster growth and resiliency in their children. Resiliency is a strengths-based approach used in education, prevention and other human services. Resiliency is an innate capacity of humans. We are born with internal assets, strengths and characteristics; when nurtured we will thrive, and when neglected, our assets are undeveloped and remain dormant. “Resilience means the ability to jump (or bounce) back, thus implying an ability to return to an original form after being bent, compressed, or stretched, as well as being able to rise above adversity and survive stress” (Greef, 2004, p 28). Resiliency can be developed by tapping into and fortifying qualities such as social competency, problem solving, autonomy and sense of purpose. Resiliency research illustrates protective factors which “buffer the effect of adversity and enable development to proceed, appear to predict positive outcomes in anywhere from 50-80 percent of a high-risk population” (Benard, 2004, p. 8).

Resiliency has been studied with bereaved families and some studies have identified how children recover from the crisis of the death of a family member. The common factor found in families making successful recoveries was a sense of “coherence” defined as, “a global orientation to life as comprehensible, manageable and meaningful” (Greef, 2004, p. 29). The basis of the coherence is an ongoing process of communicating and sharing in an honest manner. “Sharing the experience of death, dying, and loss can promote both immediate and long-term adaptation for family members, strengthening the family as a functional unit” (Greef, 2004, p. 29). The family strengths are found in communicating feelings, problem solving, finding and maintaining rituals or belief systems that support connections with each other and the deceased.

**CONCLUSION**

Resiliency is a strengths-based perspective which fits well with what our profession advocates. Child life professionals help to buffer adversity for children and enable development to progress. We foster resiliency by enhancing pediatric patients’ personal strengths. We present opportunities for our patients to experience autonomy; by being active participants in their care, making choices when possible, and controlling aspects of their environment. Family-centered care involves family members in problem solving; planning visits, using critical thinking and gathering insights. Child life staff bring together team members and families in order to facilitate communication with children, which enhances social competence and trust. In addition, they tailor communication to meet the developmental needs of children, incorporating verbal and non-verbal communication. Demonstrations with dolls, medical play and creative arts therapy all readily access children’s ability to understand and express themselves. Children can learn about illnesses, negotiate painful...
experiences, and find positive means of coping with our support. We transform experiences of devastating loss by advocating, educating, and supporting growth, which simultaneously evokes a sense of meaning, hope, and purpose.

Child life specialists contribute to ending “death denying” attitudes with children and promote respectful and honest support for children coping with the death of a loved one. Our success in developing evidence-based practices within our psychosocial support services continues. We have identified this at-risk population and can spearhead innovative approaches for treatment. Child life specialists advocate in medical centers lacking services by initially examining ways children are cared for within the adult units. Staff education begins with the unit’s nurse manager by exploring conceptions about this population. It is essential for staff to facilitate positive visiting experiences for these children. This invaluable support integrates child life services within a multidisciplinary team to provide family-centered care.

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REGISTER NOW FOR THE CLC ANNUAL CONFERENCE AND 25TH ANNIVERSARY CELEBRATION

Child Life Council has an extraordinary conference planned from June 7-10, 2007 at beautiful Disney’s Coronado Springs Resort in Lake Buena Vista, Florida. Registration is well underway for the Annual Conference on Professional Issues and 25th Anniversary Celebration, and we encourage you to join us for a joyful gathering of your peers. It’s time to celebrate 25 years of making a difference in the lives of children and families! Take advantage of a diverse array of high-quality, timely and relevant educational opportunities with offerings for professionals at all levels of experience.

For more information, or to register for the conference, please visit the CLC Web site:
http://www.childlife.org/Conferences/Annual_Conference/index.htm
FROM THE EXECUTIVE DIRECTOR

As an active member of the premier organization for association professionals, the American Society of Association Executives (ASAE) and the Center for Association Leadership, I am part of a community of association executives linked by a common belief and a common passion. We believe that associations have the power to transform society for the better. ASAE helps association professionals to achieve high levels of performance in nurturing the communities of members that they serve. As a group, we see our role as helping to connect great ideas and great people. My membership in this wonderful organization provides all of us on the CLC staff with resources that assist us in continually improving your member experience.

I’d like to share excerpts from a recent article written by Susan Sarfati, CAE, president and CEO of The Center for Association Leadership and executive vice president of ASAE. I found it particularly inspiring, and she has given me permission to reprint it here. I welcome your thoughts and reactions; email me at skrug@childlife.org.

The Dream of Associations

Making a Difference

by Susan Sarfati, CAE

This article has been condensed from its original form from the December 2006 issue of ASSOCIATIONS NOW Magazine. Reprinted with permission.

I have long felt passionate about social involvement, but on February 3, 2006, the intensity of the flame flared up. Bono, best known as the megastar lead singer of U2, showed the other side of his life, as one of his generation’s great humanitarians, at ASAE & The Center’s Nation’s Capital Distinguished Speakers Series. He spoke about the power one person can have. He said that social responsibility was not about causes, nor even about doing the right thing. Much more than that, doing something about the social depravities in this world is about justice. Simple, elegant, and powerful: It’s about justice.

INSPIRATION GROWS

Earlier that day, several staff and volunteer leaders from ASAE & The Center entered into a dialogue with some incredible thinkers at a meeting of ASAE & The Center’s Thought Leaders Council. Frances Hesselbein, long-time leader of the Girl Scouts of the USA and later of the Leader to Leader Institute, set the stage for the meeting by quoting the late Peter Drucker: “It is not business. It is not government. It is the social sector that may yet save this society.” The discussion then flowed about how associations as an important and influential part of the social sector could work toward this awesome charge and what was holding us back. ASAE & The Center and its members and its members’ members represent more than 280 million people. The question looms very, very big to me: Are we maximizing our enormous, untapped potential to improve the world around us?

It’s probably true that every generation throughout time thinks it is on the verge of a major breakthrough that will change society forever, but I believe now more than ever we are at that tipping point where we can influence the world to make responsible decisions, that we can create the “justice” that Bono spoke of. I believe in the power of one person. And I believe in the power of one person interacting with another person. And I certainly believe in the power of 280 million people. If we as an association community can find a way to mobilize ourselves, then we can create a tremendous difference in eliminating human suffering. And if not us, who? No one else has the power of numbers and the influence to reach into every sector of every industry and profession and cause.

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Show your support for your profession and the children and families you serve by joining the CLC Executive Board in an anniversary drive to benefit Child Life Council initiatives.

“Imagine the Possibilities for Child Life”

Imagine if we had the additional revenue needed to realize our dreams for:

- Evidence-Based Research
- Conference Scholarships
- Child Life Promotional Materials
- Parent Tools & Resources
- Leadership Development Opportunities

Imagine the impact child life can make. Imagine the children and families we can help.

In order to embark upon a successful fundraising campaign with foundations and corporations, we must first start from within. Support from our members and friends will help us convince potential partners that we believe in ourselves and the importance of child life.

The CLC Executive Board is proud to have made a 100% commitment to this anniversary fundraising appeal. In celebration of 25 years, we now ask you, our valued and supportive members, to join us in this exciting effort to raise $25,000 to benefit Child Life Council initiatives.

Friends, family, and colleagues can support your profession and your passion by making a gift in your honor to this anniversary campaign.

Donors will be acknowledged at the annual conference and on the Web site.

Suggested donation is $25 per member.

Donations may be made online at www.childlife.org or checks may be sent to the CLC office, Attention: 25 for 25.

Child Life Council is a 501(c)3 nonprofit organization. Donations to CLC are fully tax-deductible as allowed by law.
Child Life as Teacher of Ethics

continued from page 1

sation, support, and play. The same skills that are used to prepare a child for a medical procedure may be useful to prepare a child to participate in an ethical decision about his or her care.

The ability to wrestle with ethical issues serves as a ‘learner’s permit’ for decision-making, enabling children and adolescents to gradually assume autonomy to make their own decisions about care options (Kuther, 2003). Respect for the autonomy of children requires health care professionals to involve children and adolescents in decisions about their treatment. A developmental understanding of autonomy suggests that as minors mature they have an increasing ability to have a say in decisions about their care. The American Academy of Pediatrics states, “as children develop, they should gradually become the primary guardians of personal health and the primary partners in medical decision-making, assuming responsibility from their parents” (Committee on Bioethics, 1995, p.316).

Child life specialists may be called upon to assist a child to make decisions about current and future care options. Around the age of 7 years, children develop an increasing capacity to understand, process, and make decisions about their care (Burns & Troug, 1997, p.74). “Determining whether a patient lacks capacity to make a particular health care decision requires assessing the patient's capability to understand information relevant to the decision, to communicate with caregivers about it, and to reason about relevant alternatives against a background of reasonably stable personal values and life goals” (The President's Commission for the Study of Ethical Problems in Medicine, 1983, p.121). The child life specialist can explore the patient’s ability to understand medical information, consider alternatives, and communicate wishes to family and health care professionals.

The child life specialist often uses expertise about Piaget’s stages of cognitive development to inform the interdisciplinary team about how the child understands his or her illness, and the values, communication, and preferences of this child’s family. However, reliance on Piagetian models of development to understand ethical development in children is not without controversy. Bioethics in the care of children is still dominated by Piagetian age-stage theories of child development that tend to emphasize the inability to make truly informed autonomous decisions, as if the mind and conscience grow as slowly as the body” (Alderson, Sutcliffe, & Curtis, 2006, p. 25).

Additionally, a Piagetian view of ethical development requires health care providers to wait for the child to move to the next stage of cognitive development. But children with chronic and life-threatening illness often cannot wait. They need to learn ethical decision-making skills to confront immediate and very personal ethical dilemmas.

This essay suggests that child life specialists may accelerate ethical decision-making skills by proactively teaching children about ethics. Vygotsky’s developmental theory suggests that teaching provided at an appropriate developmental level can help children advance their reasoning skills and understand better complex concepts such as ethics and illness (Vygotsky, 1962). When we teach about ethical principles and help children explore alternatives, we are entering into the zone of proximal ethical development. We are teaching skills that promote positive coping, enhance control over one’s illness, and facilitate family-centered involvement in care.

What might teaching ethics in child life look like? Role-playing might give children and adolescents the opportunity to try on various ethical needs and language of children. Vygotsky’s developmental theory suggests - in effect, being part of a conversation about matters of personal significance (p.936). The child life specialist can actively facilitate ethical decision-making by listening carefully to a child’s ethical concerns, helping the child express these concerns through play and words, and helping the team consider the child’s perspective about matters of personal significance.

References


Making a Difference

continued from page 5

A START

How can you possibly mobilize 280 million people to act on social callings? The only place I know to start is with conversation. Beginning last spring, I’ve had many conversations on this topic. ASAE & The Center’s annual meeting offered a venue to make several connections, and Jon Hockman, founder of Dream Dare Do, and I led three learning lab conversations. Here’s what I’ve learned:

• People who participate in such conversations are often inspired, though some people are uncomfortable simply engaging in conversation, especially when the outcome is not a conclusion or action plan of some kind.

• There can be a real energy around doing something purposeful. When people are touched, they respond.

• It may be difficult to pick a specific focus, such as eradicating hunger or ending persecution. People have widely varying notions of what social responsibility is and how to go about practicing it.

• We need patience. This idea is not anything that will happen overnight. The purpose now is to seed the idea and begin to build momentum.

I will continue to have these conversations. If the idea of mobilizing associations to think and act for the purpose of social responsibility is to become a movement, it will be partly because of the caring and passionate early conversations. In Turning to One Another, Margaret Wheatley wrote, “When a community of people discovers that they share a concern, change begins. There is no power equal to a community discovering what it cares about.”

THE ROADBLOCKS

Talking about uncomfortable issues is important to building that future. The thought leaders noted that innovation comes from considering and acting on ideas far outside your comfort zone. It’s too easy for association leaders to do everything possible to avoid being uncomfortable, from avoiding difficult conversations to avoiding the obvious elephant on the table.

Another roadblock is the scope that an organization chooses to define for itself. Many association executives will say that, sure, no one likes war or poverty or hunger, but their organizations’ missions are focused solely on the industries, professions, or causes that they serve, that their scope does not extend to saving society. I think we need the courage to see the tremendous opportunity we have and to make our scope extend to society as a whole. Yes, you need to work hard to develop a strong organization that serves your members, but coming up with plans and budgets and metrics isn’t that hard when you think about it. When you look inside association boardrooms across the country, you can see an incredible wealth of knowledge and talent. What a shame if that braintrust focuses solely on budgets and metrics and not at all about their role in society.

NEXT

I don’t know what the endgame looks like or even what to expect as the conversation expands. My wish is that as part of their overall strategic objective, every association would have an emphasis on the role their members have in social responsibility. It is likely that I can’t even imagine what the massive association network could do or how it would act when mobilized. I’d love for forward-thinking association leaders to have a conversation with Jack Welch or Bill and Melinda Gates or Bill Clinton or Bono. I’d love to talk with them about what it could mean to mobilize 280 million people. I think it’s possible that while a single cause may not be the answer, a partnership with joint interests and pooled resources could be.

I do believe we are at a tipping point. I was inspired by Bono, and there have been dozens of equally inspirational people I’ve had the good fortune to meet and hear through the Distinguished Speakers Series and other venues, and there is a lesson from them that comes through loud and clear. Most of these world-renowned leaders say they are ordinary people who work hard to accomplish extraordinary things: Talent is not enough; perseverance and passion must be its steadfast partners.

ASAE & The Center produce more than 75 learning experiences each year, publish Associations Now Magazine and the Journal of Association Leadership, provide thousands of web-based tools and resources, conduct future-focused and market research, and act as the voice for and advocate of the association profession.

2007 CLC ELECTION INFORMATION AND CANDIDATE PROFILES AVAILABLE ONLINE

To access the 2007 CLC Executive Board leadership candidate profiles, along with information about proposed bylaw changes up for vote, visit the Members Only section of the CLC Web site.


The Nominating Committee is pleased to present to the membership the slate of candidates for the positions of President-Elect, Treasurer, Member-at-Large (Member Care), Member-at-Large (Professionalism), and Child Life Certifying Committee Chair. The profiles on the CLC Web site highlight the candidates’ qualifications, and include their responses to four questions about serving on the Executive Board.

The 2007 Elections will take place at the 25th Annual Conference on Professional Issues in Orlando, Florida.

HOW TO VOTE:

Option 1 – By Absentee Ballot: Professional, Associate and Lifetime members can vote in the 2007 CLC elections by requesting an absentee ballot before April 23. To obtain a ballot, contact Genevieve Thomas, Manager of Communications at 1-800-CLC-4515, ext. 12 or email marketing@childlife.org. Complete the ballot and return it by mail, postmarked no later than May 11.

Option 2 – At Annual Conference: Professional, Associate and Lifetime members attending the 25th Annual Conference June 7-10 in Orlando, Florida can vote in person at the voting booth in the Exhibit Hall.

REMEMBER, EVERY VOTE COUNTS!
CLC Welcomes Shari Rager

CLC is pleased to welcome Shari Rager, who recently joined the CLC staff team. She has taken the project lead in the final stages of testing and implementation of the Association Management System (AMS) and is providing oversight for the new Web site development project.

Shari brings more than eight years of experience in event planning, nonprofit management and development. Most recently, Shari served as Director of Meetings & Sponsorship for the Institute for Family-Centered Care (IFCC).

For more information about Shari and the rest of the team at Child Life Council Headquarters, please visit the Staff section of the CLC Web site:

http://www.childlife.org/About/about_staff.htm