CHILD LIFE COUNCIL
Bulletin

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Meeting the Needs of the Patient Population: Reevaluating the Holiday Donation Process

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During the winter season, child life programs commonly play the role of "holiday helpers," delivering donated toys to patients to foster normalcy, create positive memories, and facilitate play—all objectives that align with general child life goals. In preparation for an upcoming holiday season, The NYC Health + Hospitals/Elmhurst Child Life Program staff noticed areas of concern in the way they distributed donations and were compelled to reevaluate and ultimately change the process.

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G is for Grant Funding

Teresa Schoell, MA, CCLS
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With many thanks to Carol Fisher, BSN, mentor and friend, who wrote the grants that launched our child life services program, and taught me so much about the world of grant funding.

Many child life programs suffer from a significant imbalance between great projects and the money needed to fund them. Whether looking to launch a new child life program, increase current staffing, make over a playroom, or launch a thousand other worthy projects, advocating for the value of the undertaking and demonstrating its worth through evidence-based practice and other means is often much easier than coming up with the funds to make it happen. Once facility allies buy in to the idea, funding must still be secured. Oftentimes, child life professionals face the sentiment, "We love the idea, but there's no money for it." Fortunately, grant opportunities can sometimes fill this funding gap.

One of the most common funding gaps is salary. Whether expanding a program into a new clinical area or introducing child life services to a facility for the first time, the need for salary funding is central. After all, the greatest value in child life is the *staff*, not the *stuff*. Always keep in mind, though, that unlike hospital budgets that renew each year, grants are typically one-time offerings, meant to address a specific and finite need. Grant-giving organizations very rarely provide grants to cover salary – the quintessential, ever-present, self-renewing need.

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INSIDE

In *Focus*:

President's Perspective

The Momentum Continues . . .

Kristin Maier, MS, CCLS

My first months in the role of president have been filled with activity, and I'm honored to share a glimpse into some of the hard work that is underway in several arenas. I've always known that this is an incredible organization, but I'm even more inspired by the work carried out by CLC's many volunteers and dedicated staff this summer.

As you may be aware, the Child Life Council hosted its second Academic Summit in early August. The forward movement in the profession as a result of the initial Academic Summit, held nine years ago, has been astounding. The path to certification as a child life specialist is more standardized and rigorous. Internship accreditation launched in January with the goal of all child life internship programs being accredited within five years. We expect to have 36 internship programs reviewed by the end of the year, and invite programs interested in undergoing the accreditation process to submit letter of intent in early 2017. (Visit the internship accreditation page on the CLC website for more information on the accreditation process.) Continuing the process of defining and elevating our standards for educating and training new professionals, the undergraduate endorsement program will be launched later this year. Changes in the standards for certification have been progressing; the educational prerequisites for sitting for the exam move from one course covering six topics to 10 courses in seven content areas in 2019, and then to a graduate degree in 2022.

The pace of change has been swift but measured, and this year was an opportune time to assess our progress and map our future. This summer's summit brought together academic and clinical professionals to step back and examine how far we've come and to collaborate to create a process to move forward to ensure that we provide a comprehensive and effective training program for the future of our field. The steering group that planned the summit included representatives of the five committees involved in the education and training of child life professionals—Child Life Certifying, Education and Training, Internship Accreditation Oversight, Undergraduate Endorsement, and Graduate Accreditation—who identified and invited 60 academic and clinical child life professionals representing undergraduate and graduate programs and internships, taking care to include various-sized programs based in numerous regions of the U.S. and Canada; traditional and online educational programs; and small, large, and co-op internship programs. This focused group discussed such topics as the child life practicum, the internship application process, the relation of undergraduate to graduate programs, and other issues related to the future of child life education and training. Representatives of the five CLC committees are charged with taking the results of the weekend of brainstorming and discussion back to their committees to incorporate into their activities and recommendations for the CLC Board of Directors.

Another current focus of our organization has been on the international front. Our work in Southeast Asia to advance pediatric psychosocial care has been completed. As a result of this project, a team of experts implemented three training workshops in Bangkok, Thailand; Jakarta, Indonesia; and Kuala Lumpur, Malaysia. This train-the-trainer program was successfully delivered to over 30 senior pediatric psychosocial medical personnel in each region. These participants were trained to teach other relevant professionals about the basic universal best practices in pediatric psychosocial care and were made aware of child life best practices in the US.

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For information on advertising in the *Bulletin*, please refer to the Advertising Opportunities section of the CLC Website. *Bulletin* advertising is accepted in accordance to the CLC Relationship Policies and Advertising Guidelines.

from the Executive Editor

Who Do I Think I Am?

Katherine L. Bennett, MEd, CCLS

I recently stumped an Apple support "Genius" (a.k.a. customer service representative). She was speechless and I was surprised when she went "off script" and confessed that she honestly did not know what to do to resolve my issue. We spent a meaningful, mentally challenging 45 minutes on the phone working together to figure out how to change, of all things, my identity with the company. My Apple ID was the key to everything, it seemed: music, communication via phone and email, applications, my calendar, and my ability to interface with the outside world. Okay, that last item may be an exaggeration, but you get my point. My phone had been threatening me for days with words like "shut down," "locked," and "no access." I had passed the point of effectively using denial as a coping strategy for this situation. My resources to handle this stressor were not sufficient.

This all started when I changed my personal email address. This sounds so mundane. How could changing something as "daily" as an email address cause such confusion? I have had the same personal email address for over 14 years. It is based on a combination of my maiden name and married name and very simple to remember. I use this email address for everything outside of work: my children's schools, my community, my university, shopping, friends, and relatives. It was not until I attempted to change this email address, which was also attached to my Apple ID, that I realized how much this "name" was a part of my identity.

"Identity" is defined as "sameness of essential or generic character in different instances" (Merriam-Webster, n.d.). More commonly, many would define identity as "who someone is." My identity, I discovered on a long phone call with an Apple Genius one Saturday afternoon, was very important. It was something to keep secure. It wasn't something to be changed on a whim. Defining it (and changing the definition of it) required a massive amount of thought, verification, and many, many steps. Changing my electronic identity was not something that came easily. In fact, it had been less work to change my legal name than to change this particular manifestation of my identity. This struck me as slightly absurd, but relatable to other aspects of my life.

As we grow and develop, we continue to re-evaluate and shape our identities. Adolescents have the major developmental task of figuring out and establishing their identities or risking long term confusion about who they really are. I contend that this is a task that humans continue to revisit throughout life. There are situations in life that often cause me to ask myself "Who do I think I am?" The situations may be seemingly major (marriage, job change, becoming a parent, losing a loved one to death), or they may seem more minor (work schedule changes, children going to school, an acute injury, a construction project at home). Regardless of the challenge of the situation, thinking about your identity can be unsettling. If my identity is too attached to things that shift, I may be more easily shaken. I risk having no consistent identity or predictability in myself, which could make my actions untrustworthy for others. However, if my identity is grounded in more consistent things, I will be more stable and dependable.

In this issue's Focus article, Katie Krog challenges us to think about the potential for heavy emotional labor in our profession that can impact our lives both inside and outside the professional environment. While we may recognize that our work has emotional challenges, the evidence presented in Katie's article suggests that we may not yet be clear on what effectively decreases the negative impact of our work. According to the evidence presented, finding effective ways of preventing negative emotional impact is still very much a process with a high level of individual variability. That is, what works for one person, may not work for another. What self-care practices fit best with your own professional (and personal) identity? Who you are may impact what helps you cope.

In the Point/Counterpoint column, some leaders in the academic realm of child life practice present some insightful points about not only different learning environments, but also a deeper level of reflection about what types of learners and topics fit best into diverse academic settings. Even when choosing an academic path, it is important to know your identity as a learner. What do you already know? What do you still need to learn? Where are you strong and where do you struggle?

Finally, as the idea of identity was in my mind, I couldn't help but think about our professional organization as a whole. We are in the midst of a rebranding process, which continues to challenge us to re-evaluate our identities, both as individuals and as a group of child life professionals. In fact, some of the words in the organization's current strategic plan are relevant to the idea of how our profession defines itself and is perceived by others: credibility, reputation, and brand. The major points of our mission and vision include phrases like "why we exist," "what we do," "where we're headed," and "what we believe."

Even though you may be past the developmental stage of adolescence and have a good handle on your online identity, I hope the ideas in this issue will cause you to think about what you can change about your professional identity to be relevant and what needs to remain consistent to maintain credibility. Regardless of what defines your identity, I challenge you to reflect upon your own work and clearly articulate for yourself the answer to the question "Who do I think I am?"

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CEO Shares...

Strategic Drivers and the Work We Do

James Gandorf, CAE

With every *Bulletin* issue, this column seems to have a theme: We are working on many projects to enhance this organization, promote the reputation of the profession, and support the work of child life specialists. Although the projects I share in this space are disparate, in actuality, everything we do is in the service of the three Strategic Drivers of our organization's 2015-2018 Strategic Plan: *Professional Credibility, Member Experience,* and *Organizational Strength*.

You've heard a lot over the past year about the rebranding of our organization, one of the activities under the *Professional Credibility* umbrella. In addition to the new organization name and logo that we'll begin using later this year, the certification program now has its own logo, which was recently unveiled. This sub logo is reflective of the overall organization's new logo and will be featured on materials used to communicate about issues of the certification, maintenance, and recertification process. In addition, a small "brand extension logo" has been developed that will be made available for use by Certified Child Life Specialists on business cards, websites, and other materials to indicate their certification in the field. View the logos and learn more about the development process on our website's rebranding page.

Another focus of *Professional Credibility* has been our work to establish key partnerships with allied organizations with the intention of expanding awareness of the field of child life and engaging stakeholders in our work. We've been actively cultivating relationships with organizations such as CHA (Children's Hospital Association); the American Academy of Pediatrics, where we continue to have a representative on the Committee on Hospital Care; the Association for Play Therapy; the Beryl Institute; and the Institute for Patient- and Family-Centered Care, just to name a few. These relationships with varied organizations will open new doors and provide new opportunities for child life, and I look forward to sharing developments that result from these partnerships in future columns.

In support of the *Member Experience* strategic driver, the largest and most obvious recent activity was the conference held in Orlando in May. The excitement all weekend was contagious, and in addition to connecting with each other and attending fabulous workshops, attendees raved about the the new logo "reveal" and accompanying balloon drop at the opening general session, and the social media challenge at the closing general session! Other *Member Experience* initiatives are smaller in scope, but still meaningful: One goal we have is to respond to member requests for new services whenever possible, and recently, we were able to do just that. CLC staff has taken a look at the options for shipping items that are purchased from the bookstore on our website, and we're thrilled to be able to offer lower rates to send items out to you. Browse the offerings in the bookstore and take advantage of the savings!

Another focus within *Member Experience* is the widely anticipated launch of the updated website, which will happen later this year. Without giving away too much, I can promise you a clean, new look and improved functionality. Expect a website where you'll want to spend time poking around and exploring the resources and content—one that you'll be proud to share with colleagues and families, as it will contain sections specific to their needs. With the launch of the website comes the official change to our organization's new name, the Association of Child Life Professionals (ACLP), and the retirement of the old Child Life Council name and logo.

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The Scope of Perinatal Bereavement Care: An Emerging Area for Child Life Involvement

Heather Eppelheimer, CCLS
Texas Children's Hospital, Houston, TX

In recent years, the field of bereavement care has begun to shift greater focus onto two aspects of perinatal bereavement: perinatal hospice and bereavement services for pregnancy loss. Perinatal hospice services are provided to families given a fatal diagnosis prenatally. These families know during their pregnancy that they are carrying a baby who will not survive long after birth, and may not even go home from hospital. In contrast, perinatal bereavement refers to services provided to families experiencing an unexpected loss at any point in their pregnancy journey. These families expect a healthy baby, but due to unforeseen problems, the pregnancy does not come to term or the baby is stillborn.

PERINATAL PALLIATIVE ADVANCED CARE TEAM

As a Certified Child Life Specialist at the Pavilion For Women (PFW) at Texas Children's Hospital, I am a member of the Perinatal Palliative Advanced Care Team (PPACT), which provides support to families who have chosen to focus on comfort care for their infant. In addition to child life, the multidisciplinary PPACT group includes a palliative care physician, a neonatologist, a neonatology response nurse, a social worker, a genetic counselor and a care coordinator. This team meets with families who have been given a diagnosis which indicates that their child will likely have a very limited lifespan or will not survive outside the womb (i.e. anencephaly, alobar holoprosencephaly, renal agenesis, etc.), and thus can ethically be offered the option of comfort care or palliative care. This concept of "comfort care" refers to care that does not include any resuscitative measures at birth and includes pain medications and potential coordination with home hospice services if the infant survives until the mother's discharge. Palliative care includes the aspects of comfort care, but also allows for curative measures to be taken if appropriate and desired.

The mission of PPACT is "to provide the highest standard of comprehensive, compassionate, family-centered palliative care to infants with a life limiting diagnosis that preserves dignity and enhances quality of life for both baby and family" (Texas Children's Hospital, 2011). PPACT typically has two to three meetings with the family prior to the birth of their child to formulate a birth plan, which reviews many aspects of the care the mother and child will receive while they are patients. The birth plan is thoughtfully created by asking specific questions, so that once these families arrive to deliver their child, the focus can be on comfort, bonding, and memory making. Some of the points included on the birth plan include questions regarding who the family wants to be present at the delivery, what funeral home the family will be working with, their religious preferences and wishes for their child, and what specific types of memory-making activities (e.g., ink prints, hand molds, photographs) the family would like.

As a part of PPACT, child life focuses on memory making and sibling support. We encourage families to bring special items from home if they want to dress their child in a certain outfit, hat, or blanket. We work closely to coordinate requested services with the family, such as facilitating a special photographer who will be present before, during, or after the birth. Child life also has the capability of taking photographs for a family during more intimate moments

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if desired. Following the delivery, child life assists families in creating personalized art projects, such as family handprints on canvas or multiple copies of their child's prints for extended family members.

Sibling support is also an important part of PPACT services, and child life can help parents find developmentally appropriate language to discuss the life-limiting condition(s) of their baby with their other children. Once these difficult discussions take place, child life can meet one-on-one with siblings to help identify what their needs may be during the delivery and bereavement process. Child life facilitates sibling visits and prepares the children for what they may see, feel, or hear in the hospital, and creates a safe space for them to be able to express emotions and participate in memory-making activities. For some children, the most meaningful interaction may be to hold their brother or sister and take a photograph; for others, it is to help with hand and foot molds or create a personalized memory box for the special items we make together. Such interventions may lead to conversations with siblings about what their brother or sister's funeral might be like, allowing an opportunity to provide preparation and encourage coping skills.

PERINATAL BEREAVEMENT SERVICES

Within the scope of perinatal bereavement services, there are a growing number of opportunities for child life specialists to provide psychosocial support to families facing losses that occur across the spectrum of pregnancy. PFW offers a variety of keepsakes and has memory boxes for this purpose, with items based on gestational age and gender. The child life team, in collaboration with hospital leadership, has created an evidence-based practice statement to describe the use and benefit of these services, with the primary focus being the provision of a healing environment for families experiencing perinatal and fetal loss. As research shows, "bereaved mothers who had not spent as much time with their baby after stillbirth as they wished experienced a seven times greater risk of developing depressive symptoms" (Limbo et al., p. 318); therefore an emphasis is placed on allowing unlimited time for the infant to stay with the family, as well as time for the creation of mementos. Perinatal

UPCOMING CLC WEBINARS

There are a few remaining opportunities to earn PDUs through CLC webinars this year, and the topics are diverse and exciting! For details of each session and to register for a webinar, see the webinar page on the CLC website. Check back often, as the schedule will be updated as new sessions are added!

Unless otherwise noted, CLC webinars are scheduled on Wednesday afternoons from 2:30 to 4:00 pm Eastern time. Attendees earn 1.5 PDUs for each webinar. Individual and group rates are available.

For your convenience, several OnDemand webinars are now available! See the CLC website for details.

October 5—Life After Dying: A Model of Grief, Loss, and Death Anxiety for Survivors of Life-Threatening Diagnoses
October 12—Child Life Without Borders: Serving on Medical Mission Trips
October 19—Embodying Self-Care: Why Mindfulness Matters
October 26—Constructing the Play Lady: Child Life and the Female Human Identity
November 2—Play is the Work of Children AND of the Child Life Specialist: Making Play a Vital Part of Your Day and Theirs

loss can be especially difficult for families to process because all of the hopes and dreams they have for their unborn child are taken away very suddenly. These children are not issued a birth certificate since they die in utero; however, to honor their child's life, one of the memory-making items we offer families is a Certificate of Life, which are available commercially. Similarly, some states will also issue a "Certificate of Birth Resulting in Stillbirth" for families.

First trimester loss is also a recognized and honored loss within PFW, and memory-making activities can be modified and provided to these families should they request or accept child life services. Although services during the first twelve weeks of pregnancy are offered, loss at this stage of pregnancy may mean traditional memory-making items like molds or ink prints are not possible. However, modified memory-making services can still be beneficial when provided for families, and child life works closely with the PFW staff to identify families who wish for such keepsakes. The keepsakes offered for first trimester losses may include a ceramic heart stone with a generic handprint on it, a small infant hat, an infant blanket, a card to place the name of the baby and date of their birth, or an infant ring, which are placed within a heart-shaped memory box. We can also offer handprints and ink prints once there are formed hands and skin integrity is appropriate. These memory items can be gender neutral if the infant's sex is not yet known, traditionally gender-specific colors like pink and blue, or based on the colors the family planned for a nursery. We also include a bag with multiple resources on pregnancy and infant loss, including local support groups. Heley and Schott speak to the importance of mementos to these families stating, "Physical items connected with their baby may help to confirm the reality of his or her short existence and provide comfort as well as a focus for their grief in the longer term" (Henley & Schott, 2008, p. 327).

The other type of loss encountered within a perinatal institution is intrauterine fetal demise, or stillbirth. Memory-making items for this population include hand and foot ink prints, impressions of the hands and feet, clothing items, locks of hair, and photographs. We find that mementos are crucial with these types of losses based on research that affirms that "mothers feel appreciative when providers engage in meaningful acts of ritualization with them, often expressing gratitude for microrituals such as taking photographs, holding the baby, and collecting mementos" (Cacciatore, 2013, p. 72).

Sibling support and preparation is also a significant component of perinatal bereavement services, as siblings are generally excited for the arrival of their new brother or sister. Limbo and colleagues found that "literature continues to support widely accepted clinical practices such as inviting parents to spend time with their baby; facilitating legacy creation, ritual, or photography; and including surviving siblings in the baby's living and dying" (Limbo et al., 2010, p. 318). When speaking with parents experiencing a loss, we encourage openness, honesty, and receptiveness to questions—often the best way to start these difficult dialogues. Child life can help facilitate developmentally appropriate conversations and offer to be present during such moments. Sibling visits to see the baby who has died are also facilitated and supported by child life. Siblings are prepared for what they will see in the room and are given positive choices about how they will experience the visit with their deceased brother or sister. Siblings can choose when to look at the baby, if they want to touch or hold their sibling, and when they want to leave the room. Siblings can be offered opportunities to participate in memory-making activities, such as creating their own memory boxes, taking photos, helping with ink prints, or helping to stir molds.

Overall, the support provided to families helps to build trust, increase bonding, and build positive lifelong coping skills. All of the families experiencing a loss within the PFW are provided follow up grief support through phone calls from child life and bereavement cards signed by staff that are sent out one month, six months, and a year after the loss of their child. As Cacciatore states,

> The death of a baby to stillbirth is the ultimate paradox for providers and patients — the convergence of life and death and the fundamental contradiction it represents — with proper care and compassion, families stand a better chance in the face of such indescribable loss and they need not suffer alone. (Cacciatore, 2013, p. 76)

Conclusion

When working with families experiencing perinatal loss, child life focuses on providing their infant the respect, dignity, and honor all children deserve. Patients and families can often be in such shock that they are uncertain if they want to even see their child after the delivery experience. In such situations, as a child life specialist, I can begin to gently introduce bereavement services by asking if I can dress their child and wrap them in personalized clothing items. Such conversations help build rapport in a delicate space with these families. If a family is unsure or not ready for services, child life can

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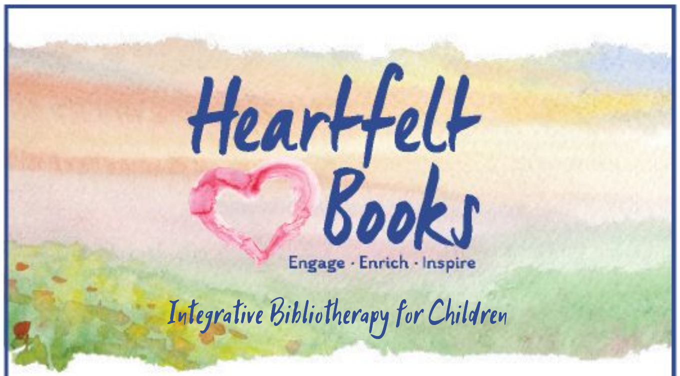

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provide the opportunity for a family to think about the services and have services initiated at any point in their hospitalization. In fetal/perinatal bereavement, Henley and Schott explain that "[Parents] value those staff who remember that their baby is a person and who respect and care for him or her as a precious individual who matters" (Henley & Schott, 2008, p. 325). Providing these bereavement services in a slow and respectful manner allows psychosocial support for these families and helps them honor their child.

Working as part of a psychosocial team with spiritual care and social work allows a multidisciplinary approach to supporting these families. Social work can offer help with funeral arrangements and financial and grief support services in the community. Spiritual care offers baptisms, blessings, naming ceremonies, and helps the family connect with members of their faith group. Although our work is predominantly with parents more than siblings or pediatric patients, one can see that these interventions are very much relevant to the Child Life Council's Mission statement, which states: "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, n.d., para. 1).

Overall, there is something sacred about supporting these families in this very special space as they prepare for their child to come into the world and pass away at the same time. When families are given the option of PPACT, it signifies that the family has likely been through a battery of tests, doctors' visits, and heavy discussions regarding their unborn child. Often families describe the experience as being a paradox of being the worst day of their life, but having the best experiences and opportunities to bond, build memories, and be a family with their child because of the birth plan and the support of PPACT. It's truly an honor to be a member of this team and be present during this journey with these families.

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Milestones

The child life community lost a longtime leader as **LeeAnn Derbyshire Fenn, MSc, CCLS**, passed away in August. LeeAnn began working as a child life specialist at McMaster Children's Hospital in Hamilton, Ontario, in 1976, and after a 31-year career encompassing clinical work, teaching, researching, presenting, and consulting, retired in 2007 from McMaster University, also in Hamilton. LeeAnn was an active member of both the Child Life Council and the Canadian Association of Child Life Leaders. Her many contributions to CLC include her service as a board member, committee member and chair, and her leadership through many of the changes that strengthened the association as well as the profession. In the 1990s, LeeAnn chaired the group that developed CLC's Mission, Vision, Values Statement, she chaired the committee that revised the official documents in 2000-2001, and she participated in the Vision-to-Action strategic planning process that guided CLC into the 21st century. For her dedication to the profession, LeeAnn was awarded CLC's Distinguished Service Award in 2008. Her many contributions to child life are rivaled by the impact she had on those who knew her, who will remember her as a dear friend and mentor with a kind spirit, visionary wisdom, and wonderful sense of humour.

Learned Optimism: A Guide to Thinking and Assessing Positive Thoughts

A Review of Seligman, M. (2006). *Learned optimism: How to change your mind and your life*. New York: Vintage Books.

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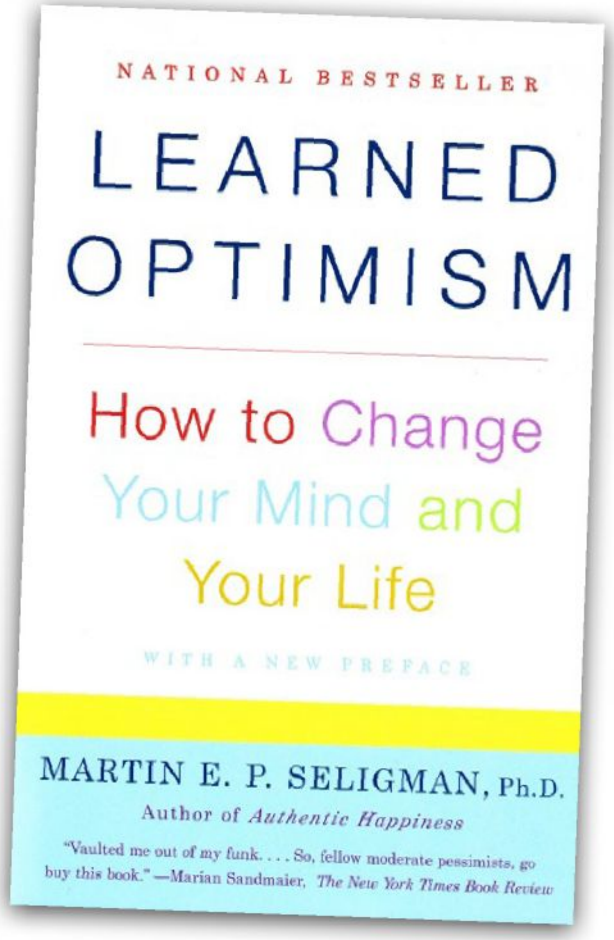

Dr. Martin Seligman's term *learned helplessness* is well known to most child life professionals as a core reason to consistently provide mastery experiences for pediatric patients. In the child life realm, learned helplessness results from a child's experience of inescapable and uncontrollable negative situations (such as a medical procedure). Feelings of helplessness could lead to a lack of motivation to change subsequent similar situations due to the child's perceived lack of control to change those negative experience. Seligman, as founder of Positive Psychology, focuses his research on understanding the effects of positive and negative thought processes, as demonstrated in his book, *Learned Optimism: How to Change Your Mind and Your Life*. For readers, Seligman's theoretical concepts give rise to a new understanding of learned optimism, the ability to engage in more positive thinking when dealing with setbacks.

Learned Optimism is broken into three parts. The first focuses on previous research to provide evidence of the existence of learned and unlearned helplessness. This included canine animal models, the extinguishing of behaviors perceived as futile, and the connection between children's perceived loss of control and possible resulting passive behaviors. Child life specialists will most appreciate this section's discussion of preventative and assessment tools, along with an ABC (adversity, belief, consequences) model that the author presents to show children more ways to comprehend and retain positive thinking patterns. In the second section, Seligman introduces the application of learned optimism to different realms of everyday life, including the importance of social support and optimistic thinking for children's health, becoming more conscious of positive and negative feelings, and the interpretation of failure. Child life specialists will want to pay specific attention to this section's exploration of the role of children's negative thinking patterns, as they lead to permanent beliefs of inefficacy and a giving up response.

In the third section, the most applicable to child life specialists, the author examines ways to create positive behavior changes, using a variety of techniques, including verbal disputation and reframing setbacks. Verbal disputation is a good example of one of these techniques, as it helps children to better understand how to explain setbacks and involves changing a giving up reaction to a more positive response. By reframing setbacks as temporary, specific to the situation, and not under personal control, children can externalize the perceived failure, rather than internalizing it. Martin Seligman demonstrates that externalizing negative perceptions can change them and lead to an understanding that obstacles do not define the results of future endeavors.

Some chapters of *Learned Optimism* hold less relevance for the child life field, such as the extensive history of psychology. Though *Learned Optimism* provides interesting historical background, it is not required for a reader seeking to teach optimism. The sections specific to adult success in the work world, politics, religion, and culture hold less relevance to child life practice as well, though may provide some beneficial personal insight. The specific sections pertaining to the cognitive well-being of children, however, are of particular value to child life professionals, especially those that relate to how children cope with emotional trauma due to loss or other significant life events.

In providing detailed descriptions of learned optimism methods, Seligman captures the importance of perceived personal control and its role in combatting learned helplessness. In his efforts to determine ways of changing thought patterns, Seligman ties in many relevant and crucial elements pertaining to child life assessments. These crucial elements include patient and parental anxiety, patient comprehension, coping skills, and the rate at which a child returns to baseline. In *Learned Optimism*, the elements relating to children's anxiety provide a more in-depth understanding of how to teach optimism in efforts to promote positive thinking and healthier coping.

POINT/COUNTERPOINT

The editors of *Bulletin* are proud to present this Point/CounterPoint piece, featuring opinions by four experienced educators espousing two different teaching and learning environments that potential child life students may consider. Each has its benefits and drawbacks, and each is appropriate for some students but not others. As potential students weigh the options for undergraduate or graduate study, it is important to take into account personal preferences and learning style when deciding whether to invest in a traditional classroom or online program. However, in addition to that, it is also wise for students to have a solid understanding of the skills necessary to become a child life specialist. An honest self-inventory may be necessary when deciding which type of program could best address individual areas of strength as well as weakness.

POINT: Face-to-Face Instruction: Interactively Engaging Students to Master Child Life Competencies

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INTRODUCTION

Communication is at the core of the child life profession's Care of Infants, Children, Youth and Families Competencies (Child Life Council, 2010), and is essential to successful child life practice. In this exploration of the benefits of face-to-face academic preparation for child life students, supporting literature and examples will be partnered with each Child Life Council (CLC) competency to illustrate advantages of this teaching style. Learning occurs through interactions with others in a social environment (Vygotsky, 1962, cited in Levin, He, & Robbins, 2006). For example, in the classroom setting, learning occurs through interactions and discussion between the instructor and students, and peer-to-peer support is encouraged. The instructor scaffolds students' learning using the following methods: role play, case study discussion, small and large group discussion and interaction, and simulation.

Competency A: The ability to assess and meaningfully interact with infants, children, youth and families.

Effective communication, collaboration, and problem-solving skills are expected competencies for students to be successful in the complex health care arena (Marken, Zimmerman, Kennedy, Schremmer & Smith, 2010). These skills may be learned in a variety of ways, one of which is role play. When introducing role play, an instructor demonstrates a specific competency using a mock example for the class, followed by discussion to clarify students' interpretations. Peer role play is low cost (Bosse et al., 2010) and low risk (Marken et al., 2010) and per the skills outlined in the CLC competency, students match interactions with the developmental and emotional level of the child. Students benefit from rich discussion and timely processing of the role play experience during subsequent real-time feedback sessions with both the instructor and peers. Role play moves students from passive to active learners (Paquette, 2012). Communication skills gained with each role play situation are refined and mastered as students build confidence.

Competency B: The ability to provide a safe, therapeutic and healing environment for infants, children, youth and families.

Safe, therapeutic and healing environments are not only physical, but also relational. Affective dimensions of learning are especially important in human service professions (Hughes, Ventura & Dando 2007; Martin 1989, as cited in Reilly, Gallegher-Lepak, & Killion, 2012). Based on the collective professional experiences of the authors, affective skills can best be understood and mastered in direct communication with others. Through hands-on learning, students build, rehearse, and evaluate affective skills, a domain of *Bloom's Taxonomy of Educational Objectives* (Anderson & Krathwohl, 2001) that addresses feelings and emotions. The affective domain (Anderson & Krathwohl, 2001) is comprised of ways in which we connect with others by listening and reacting, and relating and synthesizing values. A personal values system is understood and modified when an individual is exposed to others who have differing values. Child life instructors model attitudes, values, and emotions that are consistent with the child life specialist's role as a therapeutic agent (Martin, 1989, as cited in Reilly, et al., 2012).

Competency C: The ability to assist infants, children, youth and families in coping with potentially stressful events.

When responding to a child in distress during a health care role play, students demonstrate normalization play (developmental play), separation play (therapeutic play), and play with medical equipment (health care play) by applying what they have learned in lecture (Hollon & Resler, 2013). The natural anxieties of students are addressed when they video record themselves in simulation situations; they learn that mistakes are expected, accepted, and supported as their skills improve. These learned skills have natural transfer to real-world annual competency and skills demonstrations as might be experienced during employment in a child life department.

Competency D: The ability to provide teaching, specific to the populations served, including psychological preparation for potentially stressful experiences with infants, children, youth and families.

During practice preparation sessions in the classroom in which students portray alternating roles of a child, parent, or child life specialist, the student 'child' participant manipulates preparation materials, asks questions, and expresses concerns or fears likely experienced by children at different developmental stages. Regardless of the medical procedure, the key elements of effective preparation are reinforced during these simulations: 1) provision of developmentally appropriate information; 2) encouragement of emotional expression; and, 3) formation of a trusting relationship with a health care professional, (Koller, 2007). These key elements are reinforced as students

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POINT/COUNTERPOINT

COUNTERPOINT: Distance Education: A Dynamic Learning Community

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Distance education, or online learning, offers students access to education that may otherwise be unavailable. Today's students—millennials, parents, full-time professionals, and career changers—are looking for options to earn a degree or advance a career that don't require one to uproot a family, leave a job, or pay additional housing costs in a new city. In order to achieve a master's degree in child life, many students might need to move to a city that offers a brick and mortar child life academic program, limiting who can attend degree programs. Distance education eliminates the potential costs of relocating, while allowing students to maintain living arrangements, employment, and access to their support systems. Creating an online child life degree increases accessibility, thus allowing for a more diverse body of students to pursue child life, potentially creating a more diverse workforce.

Distance education may bring to mind the commercial of the hard working parent, up late watching learning modules in solitude, and MOOCs (massive open online courses) enrolling hundreds of students, many who never complete the course. However, modern tools of technology and trends in distance education have moved beyond the early models, recognizing that "transformational teaching is about recognizing how humans learn, how reflection and prereflection aid in learning, and how metacognition embeds learning" (Wolpert-Gawan, 2015, para. 5). Distance education can engage students by making use of active learning principles that allow students to fully engage in the material being presented, with other students in the courses, and with faculty, creating a dynamic learning community.

Studies have shown that online courses are more successful when multiple engagement, communication, and interaction strategies are utilized (Dennen, Darabi, & Smith, 2007; Dixson, 2010; Goertzen & Kristjansson, 2007; Gosmire, Morrison, & Van Osdel, 2009; Hughes, 2008; Kehrwald, 2008; Shea, Li, & Pickett, 2006). An online course can be a combination of teaching modalities: hybrid programs, a combination of both brick and mortar and online sessions; synchronous sessions where students meet virtually in real time; asynchronous sessions, where students complete assignments on their own schedules; or a combination of synchronous and asynchronous formats.

Regardless of pedagogy, higher education requires the professor to use concepts of reflection, discussion, and community to support student learning (Thompson, 2006). Developing a distance learning program requires the examination and dissection of the science of teaching, taking a hard look at methods and asking, "What is it that we want our students to experience and know about this work?" The experienced educator harnesses technology to provide a robust multidimensional learning opportunity for all students, creating interactive, hands-on courses that are not driven by the digital tools, but by the consideration of student learning and the developmental interaction approach. Thus, students have the ability to develop and explore complex issues that foster discussion and deep reflection when able to contemplate and share ideas within a community.

"I liked to see how the conversation developed and my viewpoint changed while concurrently learning new facts and information," said a student as she explained how she "listened" to the thoughts of others posted on a class discussion board, analyzed and synthesized new information, and built her understanding of the material while scaffolding new knowledge. Discussion boards in an online course provide students with the conversation and community that is present in a brick and mortar educational setting. Offering opportunities that allow students to explain their thinking influences the thinking by the class and leads to greater discourse (Kelly, 2015). Online discussion boards are no longer limited to a narrative, but make use of other modalities, such as video, slides, and pictures to express ideas and foster engagement. In an online discussion, the instructor must deconstruct the process by requiring the students to focus on understanding thought processes rather than just the correct answer (Kelly, 2015). Using a prompt or a reading, students in small groups share thoughts, ask questions, and offer ideas. The instructor has the opportunity to observe each group's discussion, offer alternative suggestions or ideas, refer additional materials, or present a different viewpoint, leading to discussion boards being student led, yet instructor facilitated.

Students clearly benefit from the insights and support of fellow students. As one student noted, "This week's discussion topic was so enlightening. Not only did I learn a lot from the class discussion, I learned a lot about myself by watching the (assigned) video. I was nervous to click play on that video because I was afraid of my reaction to watching a child have a seizure. Then I read and participated in the discussion and was able to go back and look at the video again from a more informed perspective." If critical thinking and rethinking are central goals of liberal education, discussion is essential to support the process of allowing ideas to evolve (Gallagher, 2006). It is less about the environment in which we teach and more about how we choose to create an environment that supports critical thinking, inquiry, and discourse. According to seminal research in this area, three types of interactions affect the experiences of students: interactions with course content, interactions with instructors, and interactions with peers (Moore, 1989; Moore, 1993). Students are clearly looking for an opportunity to engage with their peers, instructors, and content in a meaningful manner that deepens their engagement and knowledge of the field of study, while taking advantage of the flexibility that distance education offers.

An integral component of training child life specialists is group

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perform sequencing events from beginning to end, understand another's point of view, become aware of their communication style through interactive processing of the experience, and give feedback to peers.

In-class case studies, examined in small and large group discussion format, afford students a broadening of their understanding of child life work. Case studies "promote perspective-taking and developing critical reflection, and help [students] make connections between theory and practice" (Lundeberg & Levin, 2003, as cited in Levin et al., 2006). Student presentations exploring the impact of a diagnosis or procedure on children elicit peer discussion; their understanding is further deepened through the instructor's facilitation. Guest lectures from content experts can be added to the curriculum, allowing for question and answer interchange throughout the presentation, as "lectures that promote discussion, critical thinking and group activities help to develop independent thinking skills" (Hollon & Resler, 2013, p.9).

Competency E: The ability to continuously engage in self-reflective professional child life practice.

In the face-to-face class format, "expert instructors become astute in recognizing the emotional state of students through observation of facial expression, gestures, eye contact and speech" (Reilly, Gallagher-Lepak, & Killion, 2012, p. 100). Synchronous teaching—real-time instruction—increases discussion, supporting students with their preferred method for immediate feedback and inspiration gained from peer responses (Levin et al., 2006). Exposure to difficult topics in the classroom, such as dying and death, demands self-exploration and response to others grappling with this challenging subject (Marken et al., 2010). Marken et al. (2010) found debriefing to be a positive classroom process and feedback allowed students to understand how to better approach families in emotional situations.

Competency F: The ability to function as a member of the services team.

Simulation, an interactive technique with guided experiences that replicate the real world, "can be used to help learners acquire new knowledge and better understand conceptual relations and dynamics" (Gaba, 2007, p. 128). The simulation facilitator gives real-time guidance and feedback. Students learn to work with others, including those with backgrounds and experiences different from themselves and whom they might never otherwise encounter (Weimer, 2013), gaining empathy in the process. As Gaba (2007) further states, "simulation is applicable to clinicians throughout their careers to support lifelong learning" (p. 129). For example, in a university's poverty simulation (Kidd et al., 2015) or in a hospital's trauma center, students and child life specialists can improve clinical skills and family-centered care practices through simulation participation (Woodward, 2016). Simulation techniques offer child life students, while still novices, an interactive, guided experience to practice applying child life skills. Participation in simulation has boosted students' self-confidence when they enter an actual clinical setting (Yoder & Hochevar, 2005).

CONCLUSION

Face-to-face academic instruction is beneficial for increasing child life students' social and communication skills as they develop child life specialist competencies and learn to work with others. Face-to-face learning offers students higher levels of satisfaction and interest, instructor interaction, the development of student friendships, improved attendance, immediate feedback (Hirshchheim, 2005, as cited in Okech, Barner, Segoshi, & Carney, 2014), and better understanding of the materials presented (Rovai, 2007, in Okech et al., 2014) The communication skills students develop through face-to-face learning and demonstration are fundamental for emerging child life professionals.

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Counterpoint

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work. Through the use of shared documents, video chatting, and email, students can readily collaborate and work together online regardless of location and time. Students learn to share, edit, and work as a team. "We were able to bounce off ideas from one another. We did not take on a job and then just check in with each other; we worked collaboratively," commented a student, reflecting on how the group work prepared her for work as a Certified Child Life Specialist. Students recognize that, although a course is online, they learn valuable skills they will eventually need in a professional setting. According to a student, "I also think this is good practice for working in the hospital, and we have to collaborate with other members of the team. We fed off of each other's ideas, and each did our part into adding information to each section of the assignment."

Through the use of Google Education Apps and other digital resources such as Twitter, podcasts, blog posts, and webinars, students are able to engage with information, teachers, and each other. Creating an environment that is driven by inquiry leads to a sense of ownership that further improves the educational outcomes and understanding of content. Students become the teachers and the instructor becomes the facilitator. Instructors support students as they become independent and self-reliant, equipped to operate consciously rather than passively or reflexively. Students become masters of their fates and are empowered by the process (Gallagher, 2006). Online students cannot hide behind more vocal participants, since each student must find their own voice to share thoughts and ideas using tools that go beyond the virtual walls of the course. Students' projects created using digital tools are easily saved online and built upon as they progress in their courses, and can become a digital portfolio that can be used to assess growth and understanding throughout the program. Later, the digital portfolio can be part of the professional package when the student applies for internships or professional jobs.

As Nicholson and Galguera explain, specific skills learned through online courses are invaluable for future success:

> As the Internet is increasingly becoming the defining technology for literacy and learning with the majority of the world expected to be online in the next fifteen years, developing skills, knowledge and dispositions to engage in the new literacies or the Internet are essential for successful engagement in education work and democratic participation. (2013, p. 7).

The skills learned mastering "netiquette," defined by Merriam-Webster as "the rules about the proper and polite way to communicate with other people when using the internet" (n.d., para. 1), along with collaboration and teamwork will only enhance students' professional package as they become Certified Child Life Specialists and participants in the global field of health care.

Creating an online course using the brick and mortar course as a foundation, rather than as a replacement, drives the process leading to curriculum mapping, instructor collaboration, and consistent assessment of student feedback. By incorporating intense faculty preparation and including an emphasis on research-based educational design principles which faculty put into practice, the online program becomes a deep and rich experience. Schedules, learning styles, location, and time changes can be a thing of the past. By removing obstacles that may make getting a child life degree impossible, online programs may also lead to a more diverse workforce. In distance learning, students choose where they engage, when to engage, how often to engage, and what modality to engage with, leading to thoughtful discussions that are driven by students who chose to participate rather than merely attend.

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Introducing the 2016 Research Recognition Award Recipients

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The Research and Scholarship Committee is excited to introduce winners for both the inaugural Student Research Recognition Award and the Professional Research Recognition Award. Kayleigh McQuaid, MS, CCLS and Laurie Wagerman, BA, who completed their research as graduate students at Towson University, are the inaugural winners of the Student Research Recognition Award. Their research was detailed in an unpublished paper, *GBMC and Child Life*. Katherine Bennett, MEd, CCLS, is the child life specialist awarded the professional award. She and her research team, which included nurses, professors, child life students and statisticians, published "The Effect of Directed Medical Play on Young Children's Pain and Distress During Burn Wound Care" (Moore, Bennett, Dietrich, & Wells, 2015) in the *Journal of Pediatric Health Care*. This article was also reprinted in *Child Life Focus* in 2015.

Amy Curry, MS, CCLS (right), Chair of the Research and Scholarship Committee, presents the Student Research Recognition Award to Laurie Wagerman (left) and Kayleigh McQuaid.

In their study, Kayleigh and Laurie took their passion for child life outside of the classroom and explored ways to improve the delivery of health care in their community with the addition of child life services. *GBMC and Child Life* explored the perceived need for the addition of child life services in the combined pediatric care unit at Greater Baltimore Medical Center (GBMC), a community hospital in Towson, Maryland. With support from a physician at GBMC and numerous others within their academic community at Towson University, the researchers sought to specifically research parent and professional perspectives on the delivery of pediatric care at this and other institutions by collecting data on what aspects required improvement. Their data was used to inform the need for the consistent provision of child life services.

Their mixed methods approach included utilizing a comprehensive literature review, printed and electronic surveys, and focus groups. Of note, three different surveys were created and disseminated: one for medical professionals at GBMC; another for families of children who encountered medical care at GBMC; and a third for child life professionals to gather information on how existing child life programs were started and what they considered essential for a new program. Two focus groups were created, a family focus group for parents of children who were previously hospitalized at GBMC (6 initial participants), and a professional focus group comprised of interdisciplinary staff members from the pediatric combined care unit (4 initial participants). Transcripts from each focus group were reviewed to identify recurring themes within responses. The data collected from pediatric patients and their parents as well as medical staff was used to identify areas of stress faced by children and families during hospitalization. "Responses indicated a need for services that could aid children in coping with their fears and stress; distraction techniques; teaching materials such as dolls to demonstrate procedures; medical play opportunities; developmentally appropriate toys/activities and alternative restraint methods" (McQuaid & Wagerman, 2015).

This research project was chosen for the inaugural student award in part because the format of the research could be replicated in other settings and have implications for introducing child life services in other community hospitals. This research project was part of a larger movement toward providing child life services at Greater Baltimore Medical Center, which came to fruition in 2016. It is the hope of the award reviewers that Kayleigh and Laurie, along with other child life graduate students completing research, will pursue publishing their research so that others may more fully benefit from results of their labor.

Katherine Bennett, the recipient of the Professional Research Recognition Award, is currently a child life specialist working in the educator role for Child Life and Volunteer Services at Monroe Carell Jr. Children's Hospital at Vanderbilt. She completed her undergraduate studies at Freed-Hardeman University and graduate work at Peabody College at Vanderbilt University. Katherine remembers having an interest in completing research in the field of child life as early as her internship and feels strongly about the importance of research to validate child life interventions. While she had been a part of a number of quality improvement research projects previously, this article is her first published research.

Katherine credits the multidisciplinary team, including seasoned researchers Nancy Well, DNSc, RN, FAAN, and Elizabeth "Bette" Moore, PhD, RN, for the success of this five-year project. They used their expertise in conducting research to mentor Katherine, a less experienced researcher, while still letting her do much of the work. The experiential learning that took place helped enrich the project and highlights the value of collaboration. The researchers began with a literature review, which highlighted gaps in use of play in health care settings and a lack of research specific to burn care. To address these gaps, the team hypothesized that children in the burn clinic who participated in medical play would experience less pain and distress than those who received standard care, which was preparation for the dressing change by a clinic nurse. The study also sought to understand the role of medical play as a potential mitigator of parental distress. The research design was quasi-experimental, with participants being assigned to the intervention or control groups based on the day of their burn clinic appointment. Parents' anxiety

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You Can't Pour from an Empty Bucket: Stress and Self-Care in the Child Life Profession

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Abstract

Certified Child Life Specialists play an essential role in providing emotional and psychosocial support to pediatric patients and families (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014), but providing this support may come at a steep psychological and emotional price for the specialists themselves. Research has demonstrated that while individuals in helping or caregiving professions are likely to develop compassion satisfaction as a result of their work (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010), these same professionals are also at risk for compassion fatigue, vicarious traumatization, secondary traumatic stress, and burnout (Brinson, 2012; Fisackerly, Sira, Desai, & McCammon, 2015.) Although self-care is often advised for caregiving professionals, research on its efficacy is limited (Salloum, Kondrat, Johnco, & Olson, 2015), and current practice in the field of child life does not necessarily align with research findings (Fisackerly, 2011; Sansó et al., 2015). This paper discusses the concepts of compassion fatigue, burnout, and compassion satisfaction in detail, along with stressors relevant to the child life profession. This paper also defines self-care and reviews research on its efficacy in promoting compassion satisfaction and decreasing compassion fatigue and burnout. Suggestions for future research and practice are discussed.

Self-care: Most of us have heard the term, and most of us have probably attended presentations, read articles, or received handouts on the subject. Child life is a caregiving profession, an essential element of psychosocial care in the hospital (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014), and we, as child life specialists, encounter the stress of hospitalization alongside the children and families we serve. How can we make sure that as we care for others, we do not lose ourselves in the process? This article explores the research regarding the stresses of child life work in the hospital, the risks we face as a caring profession, and the role self-care plays in our jobs and our lives. Finally, recommendations will be provided for future practice and research.

STRESSORS

Before we can discuss self-care, it is important to understand the stressors within child life work. Hospitalized children and families are at risk for various forms of traumatization, and witnessing this can be stressful for everyone involved, including Certified Child Life Specialists (CCLSs; Meadors & Lamson, 2008; Osofsky, 2009). Because of the stress inherent in hospitalization, patients and families may need high levels of emotional and psychosocial support (Coyne, 2006; Meadors, Lamson, Swanson, White, & Sira, 2009; Osofsky, 2009; Wray, 2011). In the process of providing emotional support and opportunities for emotional expression, CCLSs may learn details of past trauma or abuse in the lives of patients or families. Additionally, CCLSs may be called upon to report incidences of trauma or abuse or to testify in court regarding a child's experiences in health care settings. CCLSs are present for many different aspects of children's hospitalization, including painful or stressful procedures, and therefore directly witness human suffering. CCLSs are also often called upon to provide bereavement support for patients and families.

Brown (2009) writes:

> Even in cases where the family may not have previous familiarity, such as in an emergency department, the sensitivity, skills, and non-medical role assumed by the child life specialist provide for effective and welcome assistance at the time of death and beyond. (p. 238)

Because CCLSs directly witness suffering, it is important to consider the potential stressors related to intervening during a stressful event as opposed to intervening afterwards. In their study on residential childcare workers, Eastwood and Ecklund (2008) distinguish between professionals who intervene with children following the development of psychological and behavioral issues and those who work with those children as issues are developing. In a similar vein, it may be important to distinguish between professionals such as therapists who intervene after traumatization has occurred and CCLSs, who are often present throughout hospitalization and thus may witness traumatization as it initially occurs or develops. Witnessing the suffering, grief, or death of children adds an extra dimension to the stress experienced by staff, as the death or suffering of a child may be viewed as unfair or may create feelings of vulnerability in staff who are themselves parents (Brown, 2009).

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COMPASSION FATIGUE AND RELATED TERMS

In the literature surrounding the need for self-care, one of the most important related concepts is compassion fatigue, although its definition is still a subject of debate. The earliest documented use of the term was by United States Senator Alan K. Simpson, who used it in reference to accepting immigrants and defined it as a "potential unwillingness to respond to others" (Administration's Proposal on Immigration and Refugee Policy, 1981, p. 3). Joinson (1992) first used the term to describe the emotional cost of working in a caregiving profession and applied the term specifically to nurses. Figley (1995) expanded the concept to other professions and linked it both to burnout and to preoccupation with a patient or client or the trauma that individual had experienced. The PROQOL (Professional Quality of Life) manual defines compassion fatigue as encompassing burnout and secondary traumatic stress (STS; Stamm, 2010). Additionally, some researchers have defined compassion fatigue synonymously with vicarious traumatization (VT) and STS (Harr, 2013; Jenkins & Baird, 2002). VT encompasses symptomology of post-traumatic stress disorder (PTSD), including emotional disturbance, preoccupation with trauma, and avoidance of reminders of trauma (McCann & Pearlman, 1990; Tabor, 2011), and is often conceptualized as resulting from working with survivors of abuse and violent trauma (Dunkley & Whelan, 2006). STS is similar to VT in symptomology, but is due to repeated exposure to a singular trauma (e.g. through testifying about abuse in court) and results from a practitioner directly experiencing or witnessing a traumatic event (Dunkley & Whelan, 2006; Tabor, 2011). Compassion fatigue has been found to lead to PTSD symptomology (Harr 2013; see Figure 1) and may be conceptualized as the emotional cost of empathizing with human suffering, regardless of whether the suffering is due to trauma (Tabor, 2011; Tunajek, 2006). Therefore, compassion fatigue, VT, and STS may be seen as being different causes of the same or similar PTSD-symptomology (see Figure 2). For example, VT may be caused by learning about an instance of child abuse, while watching a child die and then explaining the death to siblings may lead to STS. Compassion fatigue, a result of general empathy for suffering, may be caused by either of these examples or by working with a child with a chronic illness. (Examples are the author's, based on theory from Dunkley & Whelan, 2006; Tabor, 2011; & Tunajek, 2006).

Decreased self-esteem
Apathy
Difficulty concentrating
Preoccupation with trauma
Perfectionism
Rigidity
Thoughts of self-harm or harming others
Emotional disturbance
Other behavioral disturbances (e.g. sleep disruption)

Figure 1. Symptoms of Compassion Fatigue (Harr, 2013).

Research on compassion fatigue within the child life profession is limited, but so far the research suggests that compassion fatigue is an incredibly relevant issue to child life. In a survey of 154 CCLSs, Fisackerly et al. (2015) found that the risk of compassion fatigue among CCLSs is comparable to that incurred by other caregiving professions. Brinson (2012) found that 47% of CCLSs were at risk for compassion fatigue and

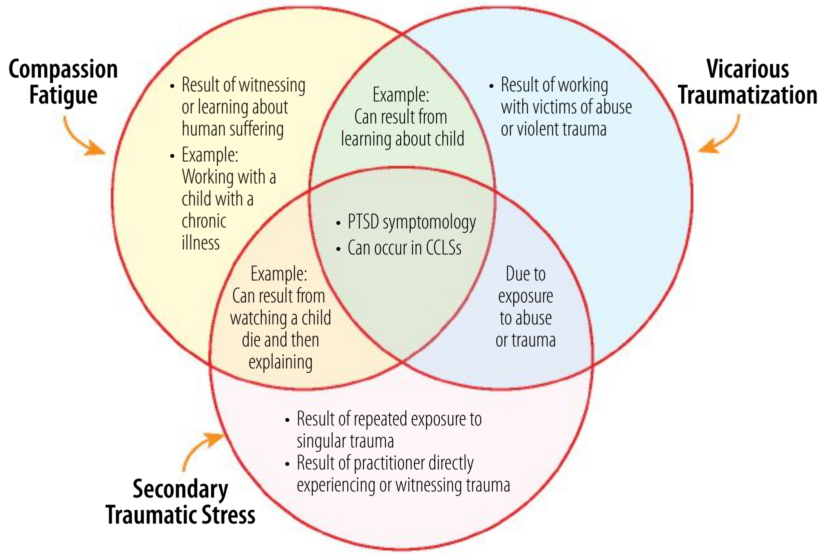

Figure 2. Comparison of compassion fatigue, vicarious traumatization, and secondary traumatic stress.

About the Views Expressed in *Focus*

concluded that CCLSs are at high risk for compassion fatigue. Not all research has found a high risk of compassion fatigue among CCLSs, however. Meadors and colleagues (2009) reported a prevalence rate of only 7.9% for high levels of compassion fatigue in a sample of pediatric health care workers. It is important to note that although more than half of the sample in this study was composed of CCLSs, other health care workers, including chaplains and physicians, were also included. According to Meadors et al. (2009), the risk of compassion fatigue is higher if the health care worker has recently experienced the death of a patient. Even though research is limited within the child life profession, research with other professions has found that overall, 25% of caregiving professionals are at high risk for developing compassion fatigue and another 50% are at moderate risk (Stamm, 2010). Professionals who have been found to have a high risk of compassion fatigue include nurses (Abendroth & Flannery, 2006; Potter et al., 2010; Hooper et al., 2010), social workers (Bride, Radey, & Figley, 2007), child welfare workers (Van Hook & Rothenberg, 2009), and family physicians (El-Bar, Levy, Wald, & Biderman, 2013). Recently, research has identified many different risk factors for developing compassion fatigue (see Figure 3) and has identified factors that protect against compassion fatigue (see Figure 4). Due to the similarities in symptomology and theory of compassion fatigue, VT, and STS, risk factors for developing VT or STS (see Figure 5) and protective factors against these conditions (see Figure 6) are also presented for consideration. As can be seen in Figures 1-6, symptoms, risk factors, and protective factors overlap greatly for compassion fatigue, VT, and STS, so further disambiguation of these concepts is needed.

Working with traumatized individuals (Meadors & Lamson, 2008; Van Hook & Rothenberg, 2009)
Occupational stress (Li, Early, Mahrer, Klaristenfeld, & Gold, 2014; Badger, Royse, & Craig, 2008; Eastwood & Ecklund, 2008)
Pre-existing trauma or PTSD symptomology (Li et al., 2014)
Youth (Hunsaker, Chen, & Maughan, 2015; Van Hook & Rothenberg, 2009)
Personal stress (Meadors & Lamson, 2008; Rossi et al., 2012)
Burnout (Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013)
Providing psychosocial support to patients and families (Slocum-Gori et al., 2013)
Providing emotional support to other staff members (Slocum-Gori et al., 2013)
Being female (Baum, Rahav, & Sharon, 2014; Rossi et al., 2012)
Working with patients with chronic illnesses or conditions (Maytum, Heiman, & Garwick, 2004)

Figure 3. Risk factors for developing compassion fatigue.

Perceived interpersonal support from co-workers or supervisors (Hunsaker, Chen, Marghan, & Heaston, 2015; Conrad & Kellar-Guenther, 2006; Adams, Figley, & Boscarino, 2008)
Compassion satisfaction (Conrad & Kellar-Guenther, 2006; Burtson & Stichler, 2010; Van Hook & Rothenberg, 2009)
Job satisfaction (Burtson & Stichler, 2010; Adams et al., 2008)
Beliefs about self-competency (Burtson & Stichler, 2010; Adams et al., 2008)
Emotional separation (Badger, Royse, & Craig, 2008)
Working part-time (Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013)
Higher levels of experience (Burtson & Stichler, 2010)
Interpersonal support outside of work (Eastwood & Ecklund, 2008)

Figure 4. Protective factors against compassion fatigue.

Working with traumatized individuals[1] (Bober & Regehr, 2006; Cunningham, 2003) [1] Devilly et al. (2009) found that STS and VT in mental health professionals correlated with workplace stressors but not with exposure to patients' traumatic material.
Occupational Stress (Devilly, Wright, & Varker, 2009; Badger, Royse, & Craig, 2008)
Pre-existing trauma or PTSD symptomatology (Sabin-Farrell & Turpin, 2003; Bell, 2003)
More years in direct service[2] (Robins, Meltzer, & Zelikovsky, 2009; Bober & Regehr, 2006) [2] Devilly et al. (2009) found that fewer years in direct service was a risk factor for developing STS or VT. Blurring of caregiver boundaries (Robins et al., 2009)
Burnout (Devilly et al., 2009)
Working in an intensive care unit or hematology/oncology clinic (Fisackerly, Sira, Desai, & McCammon, 2015)

Figure 5. Risk factors for developing secondary traumatic stress [STS] or vicarious traumatization [VT].

Perceived interpersonal support from co-workers or supervisors (Devilly, Wright, & Varker, 2009)
Beliefs about personal safety in work environment (Devilly et al., 2009)
Resolution of personal trauma (Bell, 2003)
Positive coping role models (Bell, 2003)
Personal beliefs that provide hope (Bell, 2003)
Positive beliefs about coping abilities (Bell, 2003)

Figure 6. Protective factors against secondary traumatic stress [STS] or vicarious traumatization [VT].

Burnout

In addition to compassion fatigue, burnout is a possible effect of working in the child life profession. Maslach, Schaufeli, and Leiter (2001) define burnout as "a prolonged response to chronic emotional and interpersonal stressors on the job" (p. 397), and state that it is composed of exhaustion, cynicism, and inefficacy. The same study found that burnout leads to lowered job performance and productivity, higher turnover rates, and mental health issues such as depression or anxiety. Research has found a variety of risk factors for developing burnout, including a lack of social support, role ambiguity, and work overload (see Figure 7). Research has also found factors that protect against burnout, including group identification with co-workers and feedback and support from supervisors (see Figure 8).

Although burnout and compassion fatigue are sometimes conceptualized as part of the same model or as aspects of each other (Figley, 2002; Joinson, 1992; Stamm, 2010), burnout and compassion fatigue have multiple important differences (see Figure 9). First, the main components of burnout are exhaustion, feelings of cynicism and detachment, and a sense of ineffectiveness or lack of accomplishment (Maslach, Schaufeli, & Leiter, 2001), whereas compassion fatigue involves a broad array of PTSD symptomology, ranging from apathy and a preoccupation with trauma to thoughts of self-harm or harming others (Harr, 2013). Secondly, burnout is the result of demanding interpersonal situations, psychological strain, and a lack of support, while compassion fatigue is the result of secondary traumatization or witnessing suffering (Harr, 2013; Jenkins & Baird, 2002). More simply put, compassion fatigue is due to exposure to another person's trauma or suffering, and while burnout can be influenced by trauma exposure, its main causes are stressful work conditions. Finally, burnout can occur in any profession, whereas compassion

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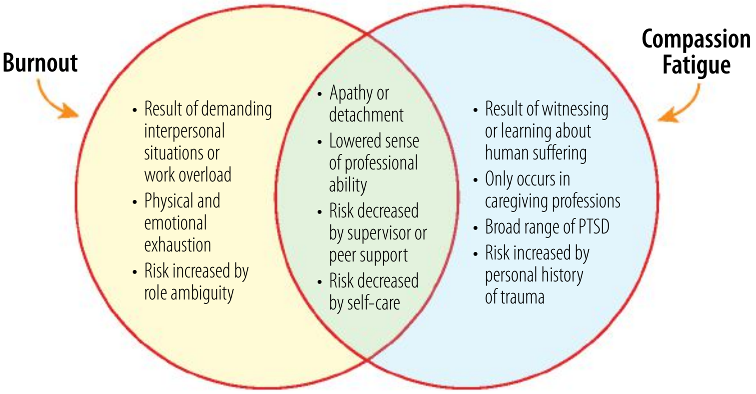

Figure 9. Key differences and similarities between burnout and compassion fatigue.

fatigue is specific to helping or caregiving professions (Alkema, Linton, & Davies, 2008). Although they are separate concepts, it is important to recognize that burnout overlaps moderately with compassion fatigue, as both can result from emotionally demanding work relationships or situations (Jenkins & Baird, 2002).

Although the research on burnout within the child life profession is still limited, there have been some important studies on the subject. Munn, Barber, and Fitz (1996) explored burnout among CCLSs and concluded that role ambiguity contributes to stress and burnout and that supervisor support is an important buffer against stress and burnout. Cole, Diener, Wright, and Gaynard (2001) also found a high prevalence of role ambiguity in child life. Another study by Brinson (2012) found a high risk of burnout (27%) among CCLSs, with a moderate correlation between burnout and compassion fatigue.

Compassion Satisfaction

Though working with hospitalized children and families can be difficult, there are many positive effects of working in a caregiving profession. For example, CCLSs can experience joy or gratification from helping others. In the literature, this joy is called compassion satisfaction, and it can serve as a buffer against the negative impacts of working with traumatized or ill persons (Hooper et al., 2010). Research has found many factors which promote compassion satisfaction, including practicing self-care, having high levels of managerial support, and having high levels of group cohesion in the workplace (see Figure 10). Research has also found some factors that decrease or limit compassion satisfaction, including PTSD symptoms (Li et al., 2014), stress exposure (Li, Early, Mahrer, & Klaristenfeld, 2014), burnout (El-bar et al., 2013), and years of professional experience (Salloum et al., 2015).

Lack of social support (Maslach, Schaufeli, & Leiter, 2001)
Role ambiguity and role conflict (Maslach et al., 2001)
Work overload (Maslach, et al., 2001; Bride, Radey, & Figley, 2007)
Younger age of professional (Augsberger, Schudrich, McGowan, & Auerbach, 2012; Boyas, Wind, & Kang, 2012; Hamama, 2012)
Fewer years of professional experience (Hamama, 2012; Sprang, Clark, & Whitt-Woosley, 2007)
External locus of control (Maslach et al., 2001)
Being female (Baum, Rahav, & Sharon, 2014; Sprang et al., 2007; Van Hook & Rothenberg, 2009)

Figure 7. Risk factors for developing burnout.

Group identification with co-workers (Topa, Fernández, & Palací, 2006)
Compassion satisfaction (Conrad & Kellar-Guenther, 2006; Fisackerly, Sira, Desai, & McCammon, 2015)
Feedback and support from supervisors (Maslach, Schaufeli, & Leiter, 2001; Bakker, Demerouti, & Euwema, 2005; Bride, Radley, & Figley, 2007; Brinson, 2012)
Being married (Maslach, Schaufeli, & Leiter, 2001)

Figure 8. Protective factors against developing burnout.

Self-care practices (Sansó, Galiana, Oliver, Pascual, Sinclair, & Benito, 2015; Salloum, Kondrat, Johnco, & Olson, 2015; Alkema, Linton, & Davies, 2008; Radley & Figley, 2007)
High levels of managerial support (Hunsaker, Chen, Maughan, & Heaston, 2015)
Organizational commitment (Li, Early, Mahrer, Klaristenfeld, & Gold, 2014)
Group cohesion[1] (Li et al., 2014) [1] Li et al. (2014) found that group cohesion moderated the effect of PTSD symptoms and stress exposure on compassion satisfaction.
Self-awareness (Sansó et al., 2015)
Positive coping with death (Sansó et al., 2015)
Work-related quality of life (Sansó et al., 2015)
Holding management positions[2] (El-bar, Levy, Wald, & Biderman, 2013) [2] See Salloum et al. (2015) for a refutation of this finding.
Teaching students (El-bar et al., 2013)
Being female (Salloum et al., 2015)
Internal locus of control (Killian, 2008)
Optimism (Radley & Figley, 2007)
Social support (Radley & Figley, 2007)
Having a patient recover (Fisackerly, Sira, Desai, & McCammon, 2015)

Figure 10. Factors that promote compassion satisfaction.

Although the names compassion satisfaction and compassion fatigue appear to be opposites and have been found by multiple studies to be inversely related (Alkema et al., 2008; Rossi et al., 2012), not all researchers agree that the two conditions are necessarily mutually exclusive (Hooper et al., 2010). In fact, Sansó et al. (2015) found no significant negative correlation between compassion satisfaction and compassion fatigue. One possible explanation for this discrepancy is that it may be possible for a professional to experience stress or compassion fatigue due to one experience or element of work and to be satisfied with their performance or coping abilities in other areas.

Self-care

It is evident from the research available that burnout and compassion fatigue pose a real threat to child life professionals. Self-care is frequently advocated as the antidote to this threat (Maslach et al., 2001; Newell & MacNeil, 2010) and self-care strategies have been found by some researchers to be associated with lower levels of burnout and compassion fatigue and higher levels of compassion satisfaction (Alkema et al., 2008; Radley & Figley, 2007; Salloum et al., 2015; Sansó et al., 2015). However, empirical data on the effectiveness of specific self-care strategies is limited (Salloum et al., 2015). The Self-Care Assessment Worksheet

(SCAW; Saakvitne & Pearlman, 1996) delineates six different types of self-care (see Figure 11), and these types have been referenced and explored by multiple studies (Alkema et al., 2008; Fisackerly, 2011).

Research has found some self-care activities to be effective at decreasing compassion fatigue or its symptoms (see Figure 12) and has also found that some self-care activities are effective at decreasing burnout or its symptoms, including all six types of self-care delineated by the SCAW (Alkema et al., 2008) and Trauma-Informed Self-Care (TISC; Salloum et al., 2015). TISC is a specific approach to self-care that involves emotional self-awareness, participating in trauma education, seeking teammate and supervisor support, and maintaining work-life balance (Salloum et al., 2015). Additionally, Alkema et al. (2008) found that emotional, spiritual, and "balance" self-care are effective at increasing compassion satisfaction.

Physical (e.g. getting enough sleep)
Psychological (e.g. practicing receiving from others)
Emotional (e.g. staying in contact with family or friends)
Spiritual (e.g. experiencing awe)
Professional Workplace (e.g. taking breaks during workday)
Maintaining balance between home and work

Figure 11. Types of self-care (as delineated by the Self-Care Assessment Worksheet [SCAW]). Examples are drawn from Fisackerly (2011).

Although most research and literature suggests that self-care is effective and necessary among caregiving professionals, some research and theory argues against self-care. Bober and Regehr (2006) found that therapists believe in the efficacy of leisure time, self-care activities, and supervision for reducing stress, but that time spent engaging in these activities does not correlate with reduced traumatization or stress. It can easily be argued, however, that far from disproving the validity of self-care, this study demonstrates the importance of prioritizing quality over quantity. Bober and Regehr (2006) also argue that advocating for self-care may be victim-blaming, since it suggests that traumatization is the fault of the professional for failing to balance work and family life effectively. On the other hand, encouraging self-care can be seen as empowering. Self-care is a learned skill, and just as no one should blame a child who does not instinctively know how to cope with an unfamiliar procedure, CCLSs should not blame themselves for needing to learn self-care strategies. Additionally, Salloum et al. (2015) found no relationship between TISC and secondary trauma. However, this is a single study and it examined a very specific program of self-care; therefore, its findings cannot be easily generalized to all self-care strategies. Finally, Topa, Fernández, and Palací (2006) argue that social identity plays a powerful role in job satisfaction and burnout and that, therefore, burnout cannot be viewed merely as an individual problem. This suggests that rather than merely focusing on encouraging individualistic self-care activities, supervisors should focus on fostering social support and a sense of belonging within a department to improve job satisfaction and reduce stress and burnout in the group as a whole.

Mindfulness - A mindfulness practice program decreased stress and rumination among counseling graduate students (Shapiro, Brown, & Biegel, 2007)
Inner and social self-care practices buffer against compassion fatigue (Sansó, Galiana, Oliver, Pascual, Sinclair, & Benito, 2015)
Leisure activities – Engaging in hobbies, reading for pleasure, and taking vacations provide significant protection against compassion fatigue (Eastwood & Ecklund, 2008)
Learned skills to promote resiliency, including optimism and clinical mastery (Brinson, 2012)

Figure 12. Self-care activities found to be effective at decreasing compassion fatigue or its symptoms.

Advocating for self-care is a common practice in the child life field, but specific recommendations vary. In a 2004 Focus article, Gottlieb, Hennessy, and Squires provided a list of ways to recognize burnout and a list of self-care practices. Most of the article's suggested practices focused on emotional or spiritual well-being or on finding a balance between work and personal aspects of life, and emphasis was placed on individualizing self-care ("…each of us knows what best meets our own needs…" [p. 3]). Additionally, the Child Life Council website provides information on some recent articles and resources regarding self-care and compassion fatigue, and the Council maintains a Pinterest board devoted to self-care ideas. One resource listed on the Child Life Council website is the Resource Center for Compassion Fatigue, a website dedicated to disseminating information regarding compassion fatigue and self-care to CCLSs. With regard to current self-care practices among individual CCLSs, Fisackerly (2011) reported the following ranking of types of self-care strategies, based on self report by CCLSs regarding the effectiveness of different strategies:

1. Maintaining balance between home and work
2. Physical self-care
3. Emotional self-care
4. Workplace/professional self-care
5. Spiritual self-care
6. Psychological self-care

CONCLUSIONS

Although physical self-care appears to be among the most commonly practiced self-care techniques among CCLSs (Fisackerly, 2011) and may be effective at reducing burnout (Alkema et al., 2008), there is little evidence so far suggesting that it is effective at reducing compassion fatigue (Sansó et al., 2015). In the field of child life, where compassion fatigue appears to be a greater risk than burnout (Brinson, 2012), recommendations should emphasize other types of self-care to reduce the risk of compassion fatigue. Accepting support from supervisors (and to a lesser extent, peers) is one such type of self-care that has been demonstrated by multiple studies to be effective at reducing compassion fatigue and burnout while increasing compassion satisfaction (Adams, Figley, & Boscarino, 2008; Conrad & Kellar-Guenther, 2006; Hunsaker, Chen, Maughan, & Heaston, 2015; Li et al., 2014). Therefore, effective supervision and support, including training for supervisors on dealing with compassion fatigue and related issues, should be a high priority in child life departments.

Further research is needed in a variety of areas, including the prevalence of compassion fatigue and the specific risk factors in its development, especially within the child life profession. Additionally, further research is needed on the types of effective self-care practices. Special attention should be given to whether different types of self-care may be more effective for different individuals or professions. Given the argument of Topa et al. (2006) that self-care needs to be rooted in social identity, it may be worth exploring whether departmental, institutional, or cultural factors modulate the efficacy

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of different types of self-care activities. Currently, the SCAW is often used as the standard for delineating and assessing different types of self-care (Alkema et al., 2008; Fisackerly, 2011). If the SCAW is to continue to be used in this way, careful attention must be given by researchers and practitioners to proper categorization of self-care activities. In addition to categorization of self-care within domains, research is needed on the effect of practicing self-care from multiple domains. Rather than picking between types of self-care, it may be important to practice a variety of self-care practices from different domains.

As research is conducted, researchers should take into consideration the pre-existing personalities and personal histories of people entering the field of child life. Given evidence that personal history of traumatization and pre-existing personal beliefs can impact compassion fatigue, it is worth investigating the prevalence and impact of these factors within the child life profession. Finally, education is needed, not merely on the importance of self-care, but on the reasons for self-care, which types of self-care are most effective, and the best ways for supervisors to support staff. Educational material will need to be edited to incorporate further research as it becomes available.

Child life specialists provide essential support services to patients and families, and this support can leave specialists emotionally, psychologically, and physically drained. As the field continues to develop new ways of helping children and families, we must not forget to care for ourselves in the process. With continued research on self-care and related concepts, we will be better equipped to predict and prevent the negative impacts of working in the child life profession, and we will be able to more fully experience the joy and satisfaction of serving others.

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Research Awards

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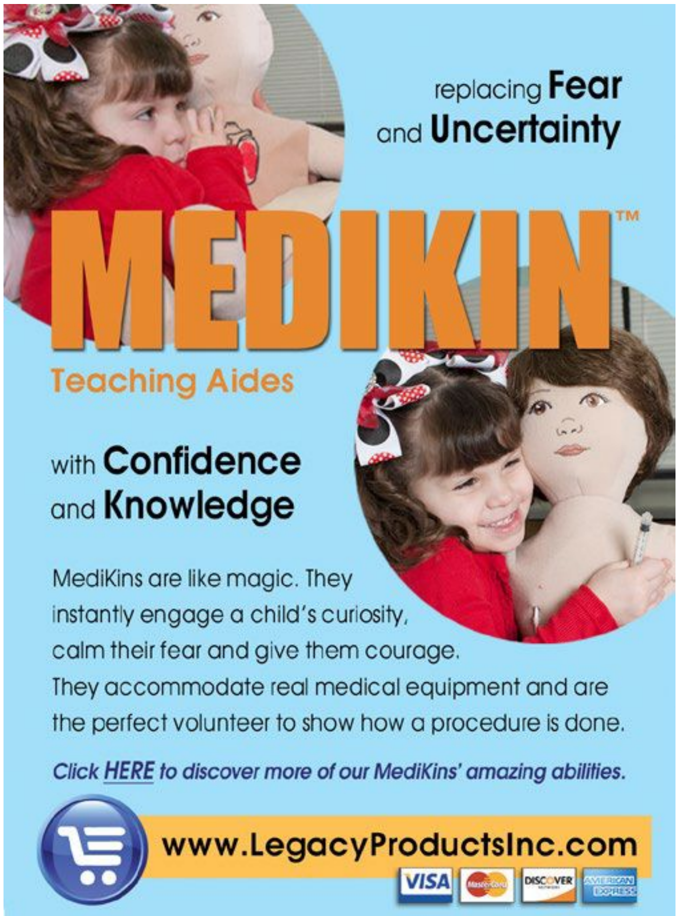
and satisfaction were measured at the beginning and conclusion of each visit. Children in each group rated their pain before and after the dressing change, and each child's pain and distress behaviors were scored by a trained observer during the dressing change. Children in the intervention group participated in medical play led by a child life specialist. While medical play sessions followed a standard script with the same medical equipment available each time, the child life specialist could still adjust to meet the needs of each child. Although none of the findings were statistically significant due to the small samples size, all findings were in the hypothesized direction and were clinically significant. According to Katherine, while the project "took a long time and had lots of bumps in the road, the consistency of the research design and literature review were the foundations that made a big difference."

This research project was chosen for the professional award because it met so many of the qualities of a good research project. It addressed an actual gap in existing research uncovered in the preliminary literature review. It worked around a dilemma that child life specialists often struggle with: the fear of withholding interventions in order to create a control group. In providing child intervention in a new setting, the design of this project demonstrated one way in which this concern can be ethically addressed. Finally, the implementation and data analysis were strong, and along with the design, could be replicated in other settings. It is the hope of the award reviewers that other child life specialists will follow Katherine's example of collaborating with the multidisciplinary team members to research the efficacy of child life interventions to improve outcomes for patients and their families.

From left to right, Katherine Bennett, MEd, CCLS (project manager/content expert); Nancy Wells, DNSc, RN, FAAN (nursing researcher); Mary Dietrich, MS, PhD (statistician); and Elizabeth (Bette) Moore, PhD, RN, IBCLC (principal investigator, nursing researcher).



The Professional Research Recognition Award honors significant work by a child life specialist and the Student Research Recognition Award acknowledges significant work conducted by a student. Both awards celebrate research initiatives that contribute to theory and practice within the field of child life. To be eligible for consideration for the awards, research had to have been IRB-approved, and submissions for the professional award had to have been published in a peer reviewed journal within the last two years. Research teams had to include at least one CLC member or child life student, and research had to address a facet of child life. Applications were evaluated on how well the research demonstrated the value and effectiveness of child life, increased knowledge, improved techniques, or advanced the field of child life. In addition, the research design, implementation, and analysis were carefully evaluated.

We encourage Child Life Council members to spread the news about both awards to individuals who may be interested in applying for next year's awards. Information about the 2017 Research Awards will be available on the CLC website.

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Specialized Resources

Specialized Resources is a column designed to share books, websites, apps, and other resources that may be helpful for child life specialists working with a specific population.

This column represents only the personal views of the author, and the Child Life Council does not endorse or sponsor the products or services mentioned. In addition, the authors of this column verify that they have no affiliation with the companies or organizations related to the products and services mentioned in this article, unless specifically disclosed.

Resources for Autism Spectrum Disorder (ASD)

Camilla Sutter, MA, CCLS
Newton-Wellesley Hospital, Newton, MA

Autism spectrum disorder (ASD) is a title for a broad range of disorders of brain development. People with ASD have difficulties with social interactions and communications, as well as restricted repetitive behaviors, interests, and activities. Prior to the revision of the DSM (Diagnostic and Statistical Manual of Mental Disorders [American Psychiatric Association, 2013]) in 2013, these disorders were known individually by their types: autistic disorder, childhood disintegrative disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS), and Asperger syndrome. The U.S. Centers for Disease Control and Prevention (CDC) identifies around 1 in 68 American children as being on the autism spectrum.

Explanations for Children

Preschool: Some children have a different way of talking and making friends than you. Some things scare them that may not be scary to you.

School age: According to Jessica Watson,

> Autism is a disorder that makes it hard for a person to deal with the world around them. A sound like the school bell ringing, which may not bother most kids, may sound like nails on a chalkboard to a child with autism. A tag in a T-shirt might feel like a terribly itchy sweater. The sunlight outside might feel like a flashlight has been just shined into their eyes. Autism is like walking around with your nails cut too short and your shoes on the wrong feet. (Watson, 2013, para. 4)

Teen: Autism spectrum disorders are a set of developmental disorders that often make it difficult to communicate and relate to others. With autism, the brain handles information differently. It is not contagious.

Books helpful to child life specialists working with this population

Baker, J. (2008). *No More Meltdowns: Positive Strategies for Managing and Preventing Out-Of-Control Behavior*. Arlington, TX: Future Horizons. [A clinical psychologist reviews behaviors in those with ASD and techniques to reduce meltdowns, as well as behaviors we can change around these patients.]

Chalfant, A. M. (2011). *Managing Anxiety in People With Autism: A Treatment Guide for Parents, Teachers and Mental Health Professionals*. Bethesda, MD: Woodbine House. [Many programs developed to reduce anxiety are not effective with patients with ASD. This book assists in understanding anxiety in ASD and looks closely at effective practical treatment approaches.]

Hudson, J. (2006). *Prescription For Success: Supporting Children with Autism Spectrum Disorders in the Medical Environment*. Lenexa, KS: Autism Asperger Publishing. [Authored by a child life specialist, this book is well written with outstanding summary pages as well as direct hospital-based interventions. A classic that should be in all child life collections]

Lawson, W. (2001). *Understanding and Working with the Spectrum of Autism: An Insider's View*. London, UK: Kingsley. [The author, a woman with ASD, analyzes ASD characteristics and examines interventions for dealing with social skills, anger management, and self-esteem. She also explores stress in these patients and their families.]

Tools for teaching others in the hospital about ASD care:

Guide for phlebotomists and anyone doing procedures on patients with ASD:
vkc.mc.vanderbilt.edu/asdbloodwork/pdfs/ProviderGuide.pdf

Guide for EMT and emergency providers:
http://www.autismems.net/media/abcs$20of$20autism.pdf

Guide for dental visits:
https://www.autismspeaks.org/science/resources-programs/autism-treatment-network/tools-you-can-use/dental

Simulations for educating yourself and others:

Five simulations to help you, your volunteers and interns get a better sense of sensory issues: http://mashable.com/2014/04/23/autism-simulations/#NrWK.hNq9uqa

Very simple simulation of a playground as seen from the eyes of an autistic child with auditory hypersensitivity: http://gamejolt.com/games/auti-sim/12761

Guides to phrases that are often used with this population:

In-depth definitions of autism-related terms: https://www.autismspeaks.org/docs/d_200710_Glossary_of_Terms.pdf

An extensive list of words that may be included in materials about autism: http://www.emedicinehealth.com/autism/glossary_em.htm

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Camilla Sutter has been a child life specialist for 28 years, and for the past four years has made this population a special focus. Cam can be reached at csutter@partners.org if you would like further information on any of these resources.

Finding the Best Resources for Your Practice

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Finding resources to educate yourself about a new topic or to share with patients and families, volunteers, and interns can seem daunting. Although each of these audiences is different and will likely be provided with different types of information, the process to select strong resources is the same. Below are a few tips on how to filter through the plethora of books, articles, and websites available on topics pertaining to child life.

FINDING RESOURCES

Despite living in the Internet age, don't trust a quick Google search to find the best information. Google will tend to lead you to sponsored or generic sites (e.g. WebMD), which may be biased or have commercial agendas. Instead, try digging a little deeper. Some ideas include:

- Explore the Child Life Resource Library. Updated frequently, resources are sorted by topic and are prescreened by other child life specialists.
- Look for resource lists within a disease/illness-specific website (e.g., www.gikids.org) for prescreened and subject-specific resources.
- Explore the support forums for specific conditions or illnesses (e.g., www.healingwell.com/ibd).
- Check in with the resource library within your hospital, which is different than a medical library. Often staff there are trained to help find the exact resource you need.
- Search the CLC Forum for topics that have already been posted. Thousands of great postings may include or review topics that you are looking for.

BOOKS FOR PATIENTS AND FAMILIES

First and foremost, always read a book before you recommend it to a patient or family. Although you don't necessarily have to do a cover-to-cover read, you need to be able to assess the following:

- Is it an enjoyable read? The parent of a patient is not likely to want to read a fat textbook, nor something written for clinical specialists. Ensure that the tone of the book is appropriate for your audience.
- Is the book visually appealing? Are the pictures outdated or scary? Do the illustrations (particularly in children's books) make you cringe? If so, find an alternative.
- Does the author have special knowledge or experience in the field? Something written by the caregiver of a child with an illness is often as informative as something by the leading expert in the field, but can be biased, so be careful with content that is not neutrally presented.
- How old is it? Although old isn't bad, some material does become dated. Books on leukemia treatments, for instance, that were published in the early 2000s should be recycled, as there has been so much progress since then. In comparison, a book like *The Fall of Freddy the Leaf* is considered a classic for discussing death with children, yet it was published in 1982.

WEBSITES

When searching on the web, there are two great websites you may want to start with:

- medlineplus.gov is sponsored by the National Library of Medicine, which is part of the National Institutes of Health (NIH).
- healthfinder.gov is sponsored by the Office of Disease Prevention and Health Promotion in the U.S. Department of Health and Human Services.

A few features to think about when looking at and reviewing websites:

- Is there a bias? Who runs the website? Avoid sites that are clearly ads for a product. One exception to this rule is that a pharmaceutical company that produces a specific drug for an illness may have an outstanding educational website. The website www.crohnsandcolitisinfo.com, for example, is sponsored by the company that makes a biologic medicine for Crohn's Disease, yet is an excellent site with little or no ad content.
- Are there valid sources for the information shared? Are references and links included to show you where the authors got their material or to go to for further information?

TABLE 1. SAMPLE WEBSITE COMPARISON

Website owner	Website url	Evaluation	Grade
Stanford Children's Hospital	http://www.stanfordchildrens.org/en/topic/default?id=coarctation-of-the-aorta-90-P01770&sid=33168	Well-written, minimal ads and self-promotion, written for parents of children, good illustrations.	A-
American Heart Association	http://www.heart.org/HEARTORG/Conditions/CongenitalHeartDefects/AboutCongenitalHeartDefects/Coarctation-of-the-Aorta-CoA_UCM_307022_Article.jsp	Minimal information, graphics are poor.	C
Mayo Clinic	http://www.mayoclinic.org/diseases-conditions/coarctation-of-the-aorta/basics/definition/con-20031772	Too many ads and links for appointments, but best diagrams.	B
Cincinnati Children's Hospital	http://www.cincinnatichildrens.org/health/c/coarctation/	Good video, simple language, great diagram of the surgical repair, ads optional at the end.	A
Wikipedia	https://en.wikipedia.org/wiki/Coarctation_of_the_aorta	Too technical with many medical terms. Poor graphics.	D
Centers for Disease Control	http://www.cdc.gov/ncbddd/heartdefects/coarctationofaorta.html	Neutral, no ads, pretty good content.	B
Emedicine	http://emedicine.medscape.com/article/895502-overview	Too technical, with medical school-type phrases and diagrams.	F
KidsHealth	http://kidshealth.org/en/parents/coa.html#	Simple illustrations, date of update, name of author, good language. Links to article in Spanish.	B

- Is it evidence-based? Keep in mind that testimonials, anecdotes, unsupported claims, and opinions aren't the same as objective, evidence-based information.
- Is it visually appealing? Are there ads everywhere? Are the diagrams easy to read?

To illustrate the wide variety of content generated from a simple Google search, included in Table 1 is an author-generated chart rating the first eight websites that appear for the phrase "coarctation of the aorta." The evaluation as well as the grades are subjective, but serve as an example of how to compare the vast range of material available with a simple Google search.

Clearly, there is a full range of information available to you and your patient. Screen it with a critical eye and try to offer the best resources in your clinical opinion.

RESOURCES FOR YOUR PRACTICE

You may also be searching for resources for your own use. Teaching tools, educational games, applications, and support information are ever changing. Again, a critical eye is important. A few areas to explore:

- Teachers' supply stores will have hands-on materials for teaching, such as anatomy aprons, puppets, and doctor's kits.
- The CLC App Catalog has a strong catalog of apps to use for education, teaching, and preparation.
- Pinterest has thousands of creative ideas for making your own resources. A simple search for "child life" yields creative ways to address education and coping with patients.
- Craft stores: Rather than purchasing an expensive model, try making your own. For example, with a few supplies, you can make your own sample of the different cells in blood http://www.icanteachmychild.com/what-is-blood-made-of/

It is important to remember to always screen what you use. Use your skills to assess whether materials are child or family friendly, and trust your instincts if a resource seems "not right." There are amazing things we can offer children and families to supplement our work with them, so have fun exploring!

CEO Shares

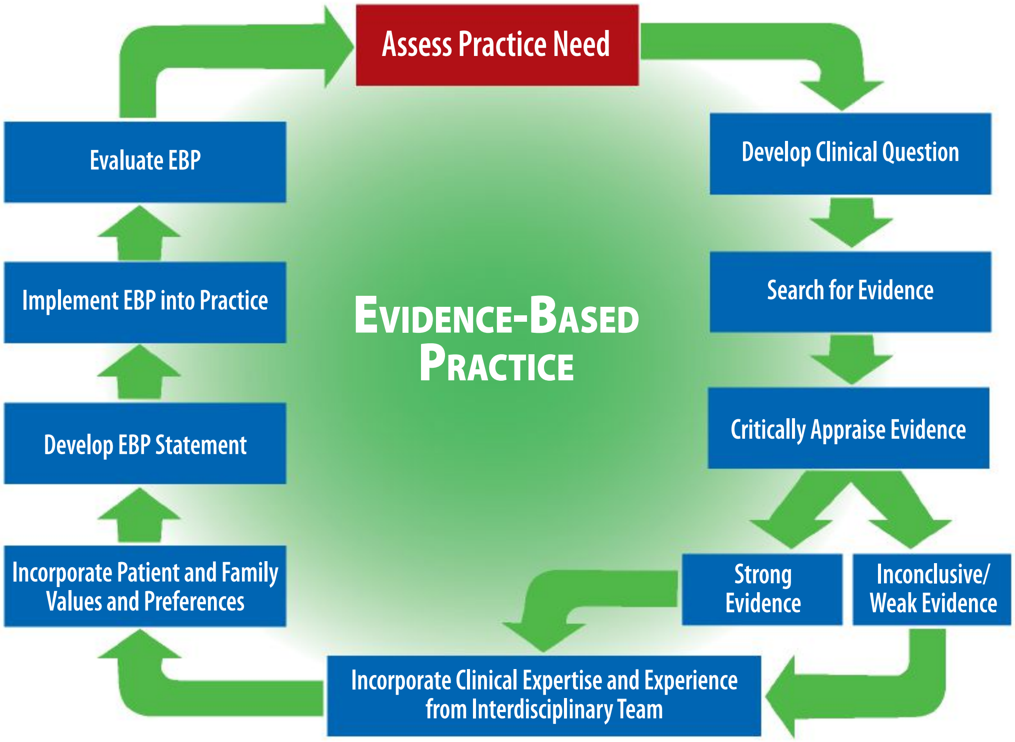
continued from page 4

As you can see, framing our work within our organization's strategic plan allow us to measure our progress as we make strides toward the vision of our organization: that every child and family has access to comprehensive services provided by a child life professional as an integral part of their health care experience.

Click on the picture to see a video highlighting some of the lighter moments of CLC's Annual Conference.

EBP, One Step at a Time

In May, 2011, the Child Life Council Board of Directors approved a step-by-step model for engaging in evidence-based practice (EBP) that was created by the Evidence-Based Practice Committee. In this new series, written by members of the EBI/QI Awareness and Networking Subcommittee of the Research Committee, readers can gain an in-depth understanding of each individual step in the Evidence-Based Practice Model in Child Life. Taking EBP one small step at a time can lead to changed outcomes for patients, families, and staff at your organization.



Step 1 – Assess Practice Need

Emily Jones, MS, MEd, CCLS
Annette Bonjour, CCLS
Cincinnati Children's Hospital Medical Center, Cincinnati, OH

Evidence-based practice (EBP) begins with identifying an area for improvement. This could mean a change in current practice, such as starting a facility dog program, or finding support for a core child life intervention, such as comfort positioning for young children receiving injections. It is important to use evidence whether you are implementing a new program or validating a current intervention. Simply put, EBP substantiates why we do what we do.

Assessing a practice need begins with **evaluating current practice**. As an initial step, it is important to understand the culture and existing policies and procedures in your organization, as well as what resources are available. For example, if you want to implement a facility dog program, it would be important to understand current infection control policies. You would also want to check to see if other departments are working on the same or a similar initiative, and if you could form a partnership with them. Connecting with an EBP or research council at your institution can also be a great place to start, as they can help guide you through the EBP process. If one doesn't exist within the department of child life, partnering with a nursing council would be a logical step.

After evaluating current practice, **let the brainstorming begin**. Identify ideas for change and incorporate the suggestions of others. Ask colleagues on your unit or within your department for feedback on areas of improvement. Aligning your ideas with your organization's strategic plan, mission and vision, or current goals is important in gaining support for your project. It is also necessary **to clarify the outcome(s)** you are hoping to achieve. If implementing a facility dog program, goals could include improving patient satisfaction, decreasing length of time to walk after surgery, minimizing distress, and maximizing coping. Clearly articulating your goals can help narrow the focus so that it becomes a manageable project and can help **gain buy-in from key stakeholders**. Stakeholders for a new facility dog program should include infection control and unit leadership; however, you could also partner with disciplines such as occupational and physical therapy (OT/PT). A targeted outcome of helping patients meet post-operative goals such as getting out of bed, ambulating, and increasing activity level could be a great way to gain buy-in from groups like OT/PT. In your brainstorming, it is important to **consider how your desired improvement will positively impact the work of other disciplines and lead to better outcomes for patients and families**.

Once brainstorming is complete and you and your identified stakeholders have finalized a clear goal, you are ready to move into step 2 – developing a clinical question. Our next *Bulletin* article will explore this step.

Continue to follow this series as we dig deeper into each step of the EBP process!

President's Perspective

continued from page 2

Finally, you may have noticed a change in the organization of CLC's volunteer committees this year. This new structure groups subcommittees by mission, combining those with similar focus into larger committees. We are confident that this streamlining will result in enhanced communication and collaboration and enable the organization to best support its members. This new structure is arranged so that groups supporting students and emerging professionals are connected (see Figure 1), committees working to enhance the leadership skills of members are linked together (see Figure 2), and those supporting professional development are associated (see Figure 3). You'll be hearing more from some of these committees soon, as we have exciting developments to share.

While I am involved in many facets of the extensive work of this volunteer organization, I am always aware that it is our members, and the children and families they work tirelessly to support, who must ultimately benefit from our work. Thank you for all you do to keep CLC and the child life profession moving forward.

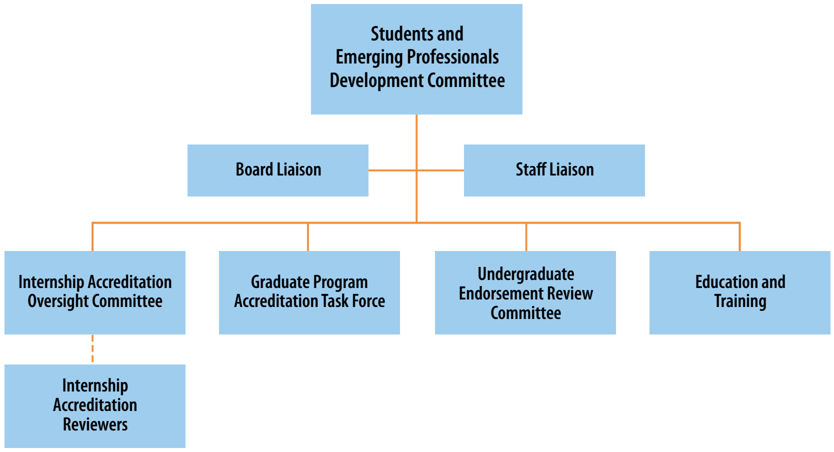


Figure 1. Students and Emerging Professionals Development Committee Organizational Chart

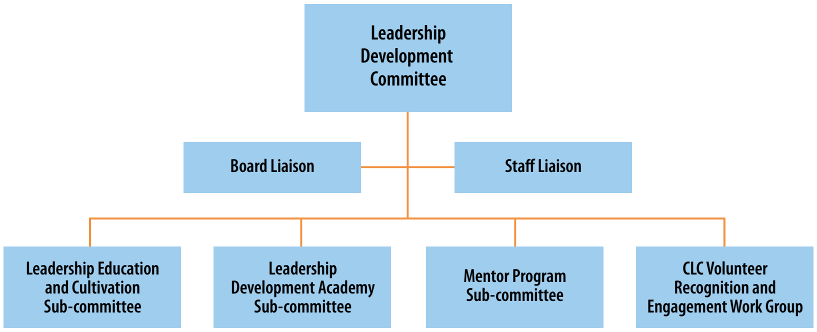


Figure 2. Leadership Development Committee Organizational Chart

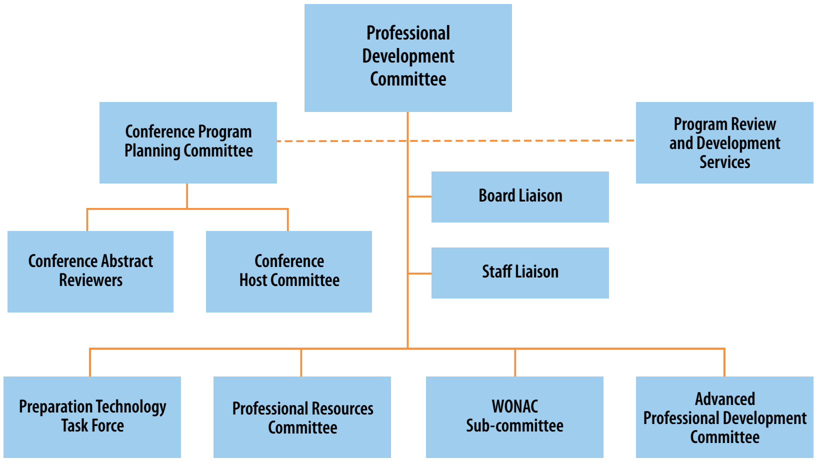


Figure 3. Professional Development Committee Organizational Chart

Academic Summit Stress Relievers

The Academic Summit was a weekend packed with information sharing, brainstorming, and the hard work of mapping the future of child life education and training. As "good" child life professionals, attendees understood the importance of self care and participated in stress-relieving teambuilding activities. A few of the activities that helped participants stay grounded included:

- **Rock-Paper-Scissors Tournament**—Participants played Rock-Paper-Scissors with partners. Winners moved on to subsequent rounds until a champion was crowned.
- **Heads or Tails**—The whole room picked heads or tails. When a coin was flipped, those who lost sat down, and the game was repeated until one winner, who had guessed correctly in every round, was left standing.
- **Caption This**—Everyone wrote creative captions for a series of amusing photos. The winning caption was selected for each, and participants got a good laugh when the slide show of winning captions was displayed.
- **Beach Ball**—The object of this game was to get people up and moving, keeping a beach ball off the ground while everyone tapped the ball over their heads.

Holiday Donation Process

continued from page 1

After breaking down the donation process, looking at child life clinical care, patient population, efficiency, donors, and time management, the program identified three disadvantages in the system:

- ***Child life clinical care:*** Scheduling and escorting multiple donors through the hospital often required designated hours, making other child life services including preparation, procedural support, and therapeutic play unavailable. As these responsibilities were handled solely by the two-person child life program, clinical care was not only decreased, but entirely unavailable at times.
- ***Specific needs of the hospital patient population and surrounding community:*** Donations were only reaching pediatric inpatient units and fewer than ten outpatient families annually. The surrounding community of Elmhurst contains 45.5% of individuals living in poverty, and with an increase in outpatient care appointments, it was clear that the donation process was not reaching a large population of families in need: those receiving outpatient care who could not afford gifts for their children during the holiday season.
- ***Relationships with dedicated donors:*** Donors were escorted through the pediatric units, visited each room, and chose the gift to give each child, an experience that often left donors with a sense of fulfillment. Although this led to many returning donors, it was not family-centered.

After finding disadvantages within the donation process, the child life program surveyed five other hospitals in New York City to find out how they handled holiday donations. Four main donation processes were identified, and the advantages and disadvantages of each were noted (see Figure 1). Incorporating some aspects of these methods, the child life program at NYC Health + Hospitals/ Elmhurst created a process that better suited its patients' needs: a Winter Wonderland Shopping Event. The intended goals of the event were to increase caregiver involvement in the gift giving process, relieve the stress of shopping during a hospital admission, and provide a dignified opportunity for caregivers from outpatient units to shop for their children. The idea was presented to the child life program supervisor who advised that a short proposal be created and shared with overall hospital administration to explain the rationale and advocate for the proposed change. Upon proposal review, the Winter Wonderland Shopping Event was well received by administration and quickly approved, without further questions.

After hospital staff were educated on the new process, social workers and other interdisciplinary staff were given referral guidelines to identify outpatient families who would be invited to the event. A large number of referrals were made based on social workers' psychosocial assessments of families' financial and/or emotional needs. Due to the potential stressors families may experience while being admitted to the hospital, caregivers from the pediatric inpatient unit,

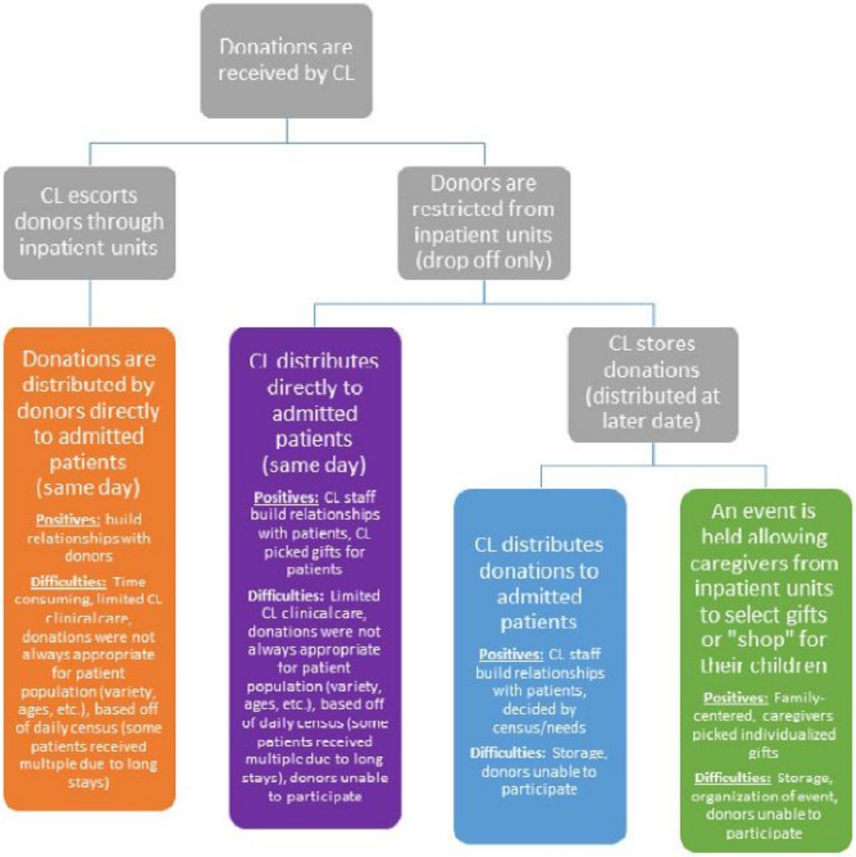


Figure 1. Four main donation processes identified through benchmarking.

pediatric intensive care unit, and the neonatal intensive care unit were automatically invited.

Volunteer staff members, hospital volunteers, and donors continued to play a vital role in the gift distribution, helping set up the room, checking in families, wrapping gifts, and escorting families through the room. Volunteers who were not available the day of the event were utilized to help organize donations prior to the event.

To best prepare for the event, the following steps were taken:

PRIOR TO EVENT:

- Collected referral list with family names, ages of children, and referral source
- Organized donations by developmental age group and assigned each group a color
- Determined how many toys each child could receive based on number of donations
- Prepared for non-referred families requesting admission - families were welcomed back at the end of the event to receive gifts on a first come, first served basis

DAY OF THE EVENT:

- Decorated the room and played music in the background
- Laid out donations by age and respective color-coded section
- Oriented hospital staff volunteers, general volunteers, and donors to their roles
- Welcomed caregivers (only 4-5 families were in the space at any given time)
  - Checked in referred families and gave color-coded cards assigned to each child's age group
  - Educated caregivers on the Winter Wonderland process to manage expectations
    - Color-coded cards and matching section
    - Number of toys a caregiver could receive per child
    - Location of wrapping station
- At the end of the event, social workers who referred families made gift bags for families who did not attend
- Welcomed families not on the referral list at the end of the event on a first come, first served basis
- Initiated breakdown

Overall, the Winter Wonderland Shopping Event was an improved way of including staff and donors, providing family-centered care by maintaining each family's dignity, and giving families the experience to "shop" for their children. Many caregivers expressed gratitude, verbalizing that they appreciated being able to participate in the event. Positive feedback was also received from volunteer staff and hospital administration, who appreciated the opportunity to escape from the stress of their daily clinical work, have more informal interactions with their patients, play a more active role in holiday gift giving, and empower families during a vulnerable time.

Additionally, the Winter Wonderland Shopping Event positively impacted Elmhurst's Child Life Program and the hospital institution as a whole:

- ***Child life clinical care:*** The event allowed child life specialists to be more flexible and efficient in their clinical care and to share donation responsibilities with other hospital staff members. Aside from the actual day of the event, child life specialists were able to adjust planning and organization of the event around their other clinical responsibilities.
- ***Specific needs of the hospital patient population and surrounding community:*** Meeting the specific patient population needs by focusing on the outpatient population, the child life program was able to report to hospital administration that the event served 46 more outpatient families in need, while still serving families admitted to the hospital. Interactions between patients, families, and their health care providers helped families to feel more comfortable in receiving medical care at Elmhurst, further strengthening the hospital-community relationship.
- ***Relationships with dedicated donors:*** Although it was a risk to allow donors to meet each other and see the number of donations received, all donors who attended the Winter Wonderland Shopping Event had a positive experience, each feeling the same sense of fulfillment and community that they obtained in the past. Many donors were already discussing how to obtain more donations for future years.

The NYC Health + Hospitals/Elmhurst Child Life Program expects this new approach of focusing on family-centered care to become the new holiday tradition. The significance of this experience was not found in the creation of Elmhurst's Winter Wonderland Shopping Event, but in the reevaluation of the donation process. At many hospitals, the donation process is often a child life tradition that is carried on year after year, where routines and procedures often stay the same. A reevaluation of the process may lead to a complete revamp or just minor changes to the donation process, but either is meaningful to ensure that not only are general child life goals met, but also the ever-changing needs of the patients and families.

G is for Grant Funding

continued from page 1

If staffing is the greatest need, though, there are ways to leverage grant funding to propel growth and expansion. It can even serve to provide much-needed financial security to a fledgling program. For example, in 2009, our hospital's grant writer secured a pair of grants that combined to provide a step-down model of funding to launch a one-person child life program. The step down occurred over a three-year period, with 100% grant funding for year one, 50% for year two, and 25% for year three. In order to access these grants, the hospital had to agree in advance to cover the balance for the second and third years. This arrangement allowed the hospital to trial child life services at minimal financial cost. It also appealed to the grant funders as a powerful use of grant funding to launch a new program that would transition to a hospital-sustained financial model over the three-year period. This was a win-win all around!

Public vs. Private Grants

Grants typically come in two primary flavors: public (also called "governmental") and private. Public grants can provide expansive funding, but often target a very narrow scope of projects. Additionally, they often carry heavy legislation – laws, rules, and regulations—as well as copious amounts of paperwork regarding how the money is used, tracked, and reported on. This means public grants have little flexibility in terms of application, use, and reporting (Gitlin & Lyons, 2014). On the upside, public grants will sometimes fund for-profit facilities, but otherwise rarely make a likely choice for child life funding needs. Private grants, on the other hand, typically prove far less complicated in the application and reporting processes, have more flexible funding interests, and offer a wider range of grant sizes. Private grants most often come from either non-profit organizations (including private foundations) looking to fund projects that align with their own mission, or corporations looking to serve their community while also improving their image and/or gaining a tax break. When non-profit organizations give grants, they must select other non-profit organizations as recipients in order to protect their non-profit status and tax benefits. Likewise, corporations giving grants for tax benefits must also select non-profit recipients. This means that child life programs in for-profit facilities are typically ineligible for private grants.

The Grant Writing Process:

Step One	Clarify the scope of the project and create an executive summary (a description of why your project is a brilliant idea, in 100 words or less).
Step Two	Obtain buy-in from key stakeholders at your facility and permission to reach out to the grant writer or development office.
Step Three	Meet with the facility's grant writer to establish a possible collaboration. If no grant writer is available, meet with the donor office instead.
Step Four	Create a portfolio of existing resources, and develop a sustainability plan.
Step Five	Clarify the application process, including deadlines.
Step Six	Reach out to the funder, if personal contact is allowed.
Step Seven	Write the application. Edit the application. Follow the directions with the concrete-thinking, literal mindedness of a preschool-aged child.
Step Eight	Send it off, wait, and hope!
Step Nine	If selected for funding, spend the money, then report back to the donor on the success of the project!

How Do I Find a Grant?

Not all projects are equally likely to land a grant. In fact, the competition is pretty stiff under the best of circumstances, with only approximately 10% of grant applications being selected for funding (Foundation Center, 2011). Most grant funders will offer a specific description of the type of projects they are open to funding. Grant givers usually gravitate towards new or innovative programs, especially those with a clear trajectory towards self-sufficiency included in the start-up plan. In child life, these programs might include the renovation of a playroom, building of a treatment room, or piloting services in a new clinical area – especially one that has expressed a willingness to take over funding following a successful pilot program. Even under the best of circumstances, though, securing grant funding can take a ponderously long time, often up to a year. When considering the use of grants for a project, always keep in mind both the low rate of funding and the lengthy "grant time" that the process can take. Fortunately, it is not only acceptable, but also genuinely advisable to apply for multiple grants for the same project. If one funder selects the project for partial funding, that information can then be shared with the other potential funders, and can increase the chance of being selected. Much like donation-matching programs offered by employers, grant givers know that they will get more "bang for their buck" in a project well funded by multiple sources.

The first step in getting a grant is finding the right match. A good match includes a proposed project that closely aligns with the funder's area of interest, has a budget that matches the funder's typical price range, is located in the funder's preferred geographic area, and is open to unsolicited proposals (some grant-givers have an "apply by invitation only" policy; Gerli, 2012a). Much of this information can be found on the funder's website, or through a web search of related news articles. When researching corporate funders, be sure to study up on the parent company as well. Public websites, such as www.guidestar.org, can provide copies of the funder's 990 tax form, which includes information about previous grants the organization has funded (Gerli, 2012b). Searchable foundation databases can help in developing a list of potential funders to research, but usually require a subscription to access. Some, like The Foundation Center, can be accessed through participating libraries (Foundation Center, 2016).

Creating a Grant Application

At some hospitals and other medical facilities, child life specialists can partner with the organization's grant writer to share the work of obtaining grants. For organizations that employ a professional grant writer, this person should be viewed as a sacrosanct gatekeeper. Never, ever, apply for a grant without including the grant writer in the process. This is the worst breech of etiquette, and can lead to irreversible damage of that grant writer's reputation, donor relationships, and good will towards the child life program. It also leaves the facility vulnerable to inadvertent "double dipping"—that is, having two grant applications come to the same funder at the same time, when only one is permitted. This is a guaranteed way to make sure neither gets funded! For those facilities without a grant writer, the child life specialist would do well to connect with the donor development department (sometimes called "foundation," "donor relations," or "sponsored research") to ensure a collaborative relationship moving forward.

Whether fortunate to partner with a grant writer or forging ahead alone, the steps of the process are much the same. First, clarify the need and scope of the project including the goals, evidence of value, and a concrete budget. Next, connect with leaders in the affected area(s) to gain buy-in, support, and approval. Then, create a portfolio of existing resources that will support the new project, such as additional funding sources, list of allies, and volunteer support. A rich assortment of supplemental resources will enhance the project's attraction for potential funders (Gerli, 2012a). Develop a sustainability plan that demonstrates how the project will continue to bring benefits or meet goals after the grant funding concludes. Finally, clarify the deadlines and process for applying. After completing all research, but before beginning the actual written application, it can be helpful to reach out to the funder with a phone call or email if the organization is open to personal contact (some are not). Have a thirty second verbal description of the project ready to share that includes a clear connection between the project goal and the funder's priorities. Ask if this sounds like a project that might appeal to the funder, and if there are any special instructions or insights for the application process that could be shared.

Each application will look different, but most include a description of the need, an outline of the project, a proposed budget, a plan for evaluating success, a plan for sustainability, and an executive summary (abstract). Whenever possible, include concrete, measureable data. This can include metric data about the relevant patient census or the specific need, as well as research data. Along with the numbers, include a story or two, to put a human face on the need. How will this project affect the life of a single child? While the numbers describe the scope of impact, the story connects it to the heart of the funder. Most applications will also require some standard forms from the requesting organization, such as the 501(c)(3) certification letter proving non-profit status, a list of board members and their affiliations, audited financials, and the requesting organization's 990 tax document (Holtzclaw, Kenner, Walden, & Kenner, 2009). Regardless of what components the application calls for, first and foremost read, and re-read, the instructions and follow them to the letter. (These instructions are often referred to as an RFP – Request For Proposal). Keep everything neatly organized, labeled, and ensure that the final product is highly polished and professional. Once the final document appears completely ready to go, ask a colleague who knows *nothing* about the project to read it, and see if it makes sense. After that, send it off (electronically, by certified mail, or track-able delivery system), and then . . . wait.

You're Funded! Now What?

Having the project selected for funding is wildly exciting, but really only the beginning of the grant's journey. Spending the money and seeing the project come to fruition can be quite gratifying, but there is still work to be done. Beyond accountability through written reports and financial statements, grant stewardship can also help build trust and reputation with the funder, leading to an increased chance of funding for future projects. For corporations seeking to improve their company's image or non-profit organizations looking to increase their support base, most grant funders appreciate, or even require, public acknowledgment of the grant (Foundation Center, 2005). Written reports, too, are standard and include financial statements and receipts, as well as a report on the use of funds and outcomes for the project. Remember that grant funds may only ever be used for the exact purpose described in the proposal. Even the slightest deviation from the plan requires written permission from the funder. While creating the report for the funder, this is a great time to include some colorful photos and the story of a child whose life was changed, or experience transformed, due to the generosity of the funder.

Organizations that give grants, and the individuals within those companies who select which proposed projects to fund, all want the same thing — to make a difference. By selecting strong potential matches through careful research, constructing a solid and persuasive application, and most importantly, putting forth a powerful and innovative project for funding, child life specialists can gain access to critical grant funds to launch, support, enhance, and expand their work. Even better, a practice of mindful stewardship and engaged reporting over a course of years can result in a strong network of funders and allies to turn to for future projects as well.

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Have You Ever Considered Writing for *Bulletin*?

Bulletin and *Focus* welcome and encourage submissions from members and provide opportunities for anyone from students to long-time professionals to share their experiences and expertise with readers. Writing for *Bulletin* or *Focus* is a great way to highlight your professional work and enhance your skills while contributing to the child life community. The variety of formats available in these publications allow for anything from short vignettes about memorable child life moments, to debates about controversial practices, to extensive research-based work.

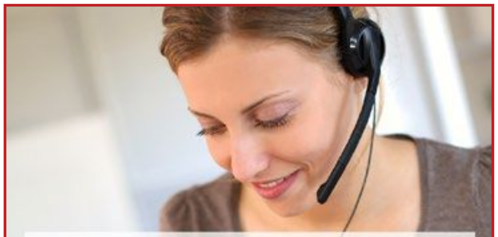
As a special incentive for *Focus* writers only, CLC has committed to awarding authors of accepted *Focus* articles with their choice of one of the following:

- one free year of CLC membership,
- 25% discount on CLC Annual Conference registration, or
- two free individual CLC webinar registrations.

In addition, *Focus* writers are eligible to earn 3 PDUs if their article is accepted and published.

Questions and ideas can be addressed to the Managing Editor at bulletin@childlife.org.

For more details on writing for *Bulletin* and *Focus*, as well as information about specific types of articles, please visit the Submission Guidelines and Instructions page of the CLC website.



There's a new way to earn PDUs—and it's free for CLC members! *Focus* articles from previously published *Bulletin* issues are available on CLC's Playback Now website, and you can earn 0.5 PDU in the Independent Learning category by reading and successfully completing the quiz accompanying each article. Please remember there is a 10 PDU limit for Independent Learning in each five-year certification cycle.

Member Price: $0

Member Bonus: With your first selection, receive a $25 off discount code to be used toward the purchase of any content on the CLC Playback Now site

Non-member Price: $15

UPCOMING EVENTS

October 10-12, 2016
14th Annual Child Life Directors Networking Conference and Retreat
Camelback Inn Marriott Resort and Spa, Scottsdale, AZ
**Please be aware that this conference is designed and intended for those with child life administration roles including child life program management and child life staff supervision. We do not encourage those in non-child life program leadership roles or one-person programs to attend.*
For more information or to be added to the mailing list for registration materials, please contact Chris Brown, MS, CCLS, at christina.brown2@nyumc.org

October 15-16, 2016
It Takes a Village: Comprehensive Collaborative Care
Children's Hospital of Philadelphia
Philadelphia, PA
CHOP is honored to host Amy Baxter, MD, creator of Buzzy™ as the Keynote Speaker. This continuing education opportunity offers a minimum of 9 PDUs. Attendees will have the opportunity to select individual breakout sessions to customize their learning experience. These sessions will focus on the multi-disciplinary approach to care at CHOP, including programming ideas, emergency department practices, bereavement interventions, mindfulness, and professional enhancement experiences.

For additional information and online registration, visit
chop.edu/childlifeconference
We look forward to seeing you in Philadelphia!
http://visitphilly.com

October 19-21 and 24-26, 2016
2nd Biennial Conference on Spirituality and Healthcare: Wholeness in Healthcare
Cape Town, South Africa: October 19-21, 2016
Pretoria, South Africa: October 24-26, 2016
For more information, visit the HospiVision website
Or contact Andre de la Porte at andred@hospivision.org.za

October 22, 2016
11th Annual Great Lakes Association of Child Life Professionals (GLACLP) Conference
Riley Hospital, Indianapolis, IN
For more information, visit the GLACLP website

November 5-6, 2016
21st Annual Midwest Child Life Conference
Lurie Children's Hospital, 225 E Chicago Ave., Chicago, IL 60611
For more information, visit the Lurie Children's website
Or contact Rebecca Meyers at 312-227-3267 or rmeyers@luriechildrens.org

November 7, 2016
Child Life of Greater New York (CLGNY) 23rd Annual Professional Development Conference
The New York Bar Association - 42 West 44th Street, New York, NY 10036
For more information, visit the CLGNY website

November 16-18, 2016
Moving Forward with Patient- and Family-Centered Care Partnerships for Quality & Safety
An Intensive Training Seminar
Wyndham San Antonio Riverwalk, San Antonio, TX
For more information, visit the IPFCC website
or contact events@ipfcc.org or 301-652-0281

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Ann Fogel, CCLS, MA

"The mobiles are fantastic! Just what we need for our infant patients for developmentally appropriate stimulation. We have searched for years for mobiles that meet our infection control standards and now we have it with Nurture Smart Mobiles. We also were thrilled that the mobiles are set for 30 minutes of music time which is the recommendation for maximum auditory stimulation at a time for infants 5 months and under."

Rita Goshert, MA, CCLS

*More Than Play is a division of PlayAbility Toys

CLC Calendar

OCTOBER

TBD	Call for nominations for CLC Board of Directors
27	Deadline to register for the November administration of the Child Life Professional Certification Exam
31	Deadline to recertify with professional development units
31	Deadline for international scholarship applications for the 35th Annual Conference on Professional Issues

NOVEMBER

1-15	Child Life Professional Certification Exam Administration testing window

DECEMBER

TBD	Announcements for Distinguished Service Award and Mary Barkey Clinical Excellence Award
31	Last day to reinstate lapsed CCLS credential

JANUARY

TBD	CLC Annual Conference registration opens
TBD	Call for committee volunteers
1	Submission deadline for *Bulletin* and *Focus* articles for consideration for the Spring 2017 issue
5	Deadline to submit internship applications for Summer 2017
1-31	Start planning your Child Life Month events and activities for March!
31	Deadline to submit 2017 Annual Certification Maintenance Fee

Moments from the past…

For many in child life, the universal tool for preparation, coping, or even imagery and distraction is now the iPad. There are so many great apps for supporting hospitalized children with the expert guidance of a Certified Child Life Specialist. But take a look at this little gem found in the Child Life Archives—it's the "Not So Scary Things" Game! The object of the game is to travel the winding path to Mount Courage. Along the way each player collects Bravery Badges by completing Scary Tasks and Courage Tasks. Every player who gets to Mount Courage wins!

Boardgamegeek.com describes the game as "the fun, acting-silly, hooray-you're-so-brave game that kids love to play again and again! [It was] created by doctors and a child psychologist to help every child develop confidence, creativity, and self-esteem."

The game was first published in 1989 by Iron Mountain Game Company. Its creators were Neil Izenberg, MD, Paul Izenberg, MD, and D'Arcy Lyness, PhD, and it was illustrated by Jude Wilson. Unfortunately, it appears that the game is no longer commercially available.

Although children and teens now have access to far more technologically sophisticated games, this photo from the Archives is a reminder that a tangible board game can still be relevant when promoting interaction and self-expression in a playful environment.