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Getting Engaged

Getting engaged was a big deal at the university I attended. It was such a big deal, in fact, that the female students had their own special ceremony to announce their engagement. Although I thought that the practice of announcing engagements in a dorm full of girls was similar across universities, when talking about this ceremony in the past, I’ve sometimes been met with disbelief that this was actually a socially acceptable “thing.” Regardless, the ceremony, called a “candlelighting,” involved, yes, a candle with an engagement ring on it being passed around a circle of girls sitting in a dark room. Usually, this dark room was the oh-so-glamorous dorm lobby. We had a curfew at my university (that’s another story) of midnight so all candlelightings happened at midnight. This guaranteed that all would be present. You didn’t want to be skulking in past curfew AND into someone’s candlelighting. The candle would be lit and passed around the room for all to “ooh” and “aah” over and speculate about whose it was. Once the candle had been passed around the full circle, it began its second trip from girl to girl. This time, it was passed faster, heightening the anticipation. Finally, the newly engaged girl would dramatically blow out the candle and everyone would squeal with excitement. What followed usually involved the retelling of the proposal, more admiration of the ring, and the entrance of the fiancé. Like I said, engagement was a big deal. Surely this was part of everyone’s college experience??

Although I never experienced my own candlelighting ceremony, I do think engagement is a pretty big deal, though not necessarily in the dramatic way that my story may imply. Engagement, more broadly, can mean far more than a commitment or promise to later marry. Engagement, in the context I think of it now, is more about paying attention and “showing up.” One of my favorite statistics to quote is that “Eighty percent of life is showing up.” Of course, I cannot back up this statistic with any empirical evidence. I can only cite the source, who frankly surprised me. No, a great orator or thinker didn’t make this statement. This statement is actually credited to Woody Allen, writer and actor. While I’ll be honest and share that I don’t look to Woody Allen for truths in guiding my life, I do think he is on to something here.

Success and accomplishment are closely related to our individual skills, strengths, and shortcomings. However, if I’m not even present, if I don’t literally show up, chances are I’m not even going to get the opportunity to succeed or accomplish or connect.

If there is so much potential in the simple act of showing up or engaging, why is it so hard to do sometimes? The first barrier to engagement, in my experience, is distraction. How much have I missed because I was looking at my phone? A conversation with a colleague, an important detail about my child’s or a friend’s day, or someone walking past me who might have needed a smile may not have my attention because I’m distracted by the device pinging and glowing in my hand. Another barrier to engagement is closely related to distraction: exhaustion. To-do lists are so long, calendars are so full, and social media feeds are so constant that there is often little time or brain power to give to other things. They all seem to be screaming (or buzzing) for our attention.

This entire issue of ACLP Bulletin represents a new opportunity for engagement. As you have probably noticed, the publication has been redesigned, and, like a shiny new engagement ring, it practically screams “notice me!”

This entire issue of ACLP Bulletin represents a new opportunity for engagement. As you have probably noticed, the publication has been redesigned, and, like a shiny new engagement ring, it practically screams “notice me!” All the details of formatting, from font selection to graphics to visual appeal, have been enhanced to support our organization in its growth and development. It is hard not to pay attention to this issue in your hands or on your screen.

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I can’t begin to express how excited I am to be writing this column as we mark the historic transition to the Association of Child Life Professionals (ACLP). After more than a year of planning and work, the transition to our new brand is complete. During the process, we’ve had many opportunities to reflect on how the professional image of child life has developed over the years. Thirty-five years ago, a major step was undertaken as the Child Life Council became the first professional organization for child life specialists. When CLC was established in 1982, it formalized the work of those who came before, those who devoted their lives to developing hospital programs to support the psychosocial needs of the children in their care. This current milestone in our organization is built upon so many years of work and the devotion of so many people who strove to professionalize what we do. Every time I get excited about the future, I look back and appreciate all who have come before, and everything they did to get us to this point.

As we continue to build our professional credibility, there are two areas of current focus that I’d like to highlight. The first is benchmarking. As child life professionals, we know that we work in diverse settings, even within hospitals, that require different types of interactions with patients and families. Such diversity makes it difficult to advocate to decision makers just how many specialists are the “right” number for a hospital with a certain number of beds. The Benchmarking Subcommittee, part of the Scientific Advancement of Professional Practice Committee, (formerly the Research Committee) has been working on creating a data center that will address metrics related to how child life programs staff and provide services. Using a foundation of evidence-based practice and outcome measures, the members of this group have focused on creating a two-phase data collection and benchmarking plan. ACLP has contracted with an organization to build a platform to capture and meaningfully analyze this data. Leadership of the committee had the opportunity to present to child life leader stakeholders at the Directors’ Conference in Phoenix, AZ, in October and met with the ACLP Board of Directors in November to share the goals, timeline, and details of the data collection project, and excitement is growing as the major benefits it will provide to the profession become clear. The first phase of data collection will be kicking off soon, and we need your help. We will be reaching out to programs and leaders, so please look for our communication and help us begin this initiative by gathering data at your site. We need each child life department—large and small—to join together, as the success of this endeavor is dependent on participation from all in the field. Additional information will be made available as the project progresses.

The second recent development that I’d like to share with you is the creation of a Patient and Family Experience Task Force. The board recently struck this task force, chaired by Carla Oliver, to build partnerships with like-minded organizations to work together toward common goals. Committee members will identify and reach out to organizations that serve pediatric patients and their families and collaborate with them to decide how we can best work toward our mutual goals. The relationships we build will help enhance our credibility and expand awareness of child life among health care professionals and administrators. We are confident that this is a step that will positively affect the field of child life and open new doors for us.

The opportunities that we have in front of us are numerous, and the steps we’re taking to build our professional credibility will position us to grow as a profession in ways we may not even yet imagine, just as the first pioneers in child life probably couldn’t have imagined the strides we’ve made since their time. The amazing dedication of our ACLP leadership and volunteers is what fuels our growth, enhances our credibility, and shapes our future.
CEO Shares
Jim Gandorf, CAE

Change, Renewal, and Continued Growth

“Wow!” I hope that’s what you’re saying as you see this issue of ACLP Bulletin! The rebranding process, announced a year ago, is finally complete. We’re now officially the Association of Child Life Professionals, known more informally as ACLP. The organization staff and volunteers who worked so hard on this project are proud to be featuring our new logo in all of our materials and publications, and we’re making the adjustments necessary, just as you are, to having the new organization name roll easily off of our tongues.

Even more exciting are the changes to the website. I hope you’re enjoying the new look and have had an opportunity to explore the exciting new features that are now available. Although the “old” website was mainly geared toward child life professionals, the updated version is more inclusive. For example, because parents and family members will be directed to our website as they seek information to help them support their children, we engaged with them in the design and made a concerted effort to tailor certain content for them. Hospital administrators are another audience, and their needs are different. Through the extensive research we did during the rebranding process, we learned, for example, that hospital CEOs and parents are interested in learning about the education and certification of child life specialists, but that different aspects of that are important to each group, so the messaging is customized on their respective pages. In addition, while health care decision makers are interested in the research that supports the use of child life, parents are less so; however, they are impressed by endorsements of child life from organizations such as the American Academy of Pediatrics and US News and World Report, so that information is featured more prominently on pages geared toward families. Realizing that this specific information about tailoring messages about child life to different audiences has use beyond the parts of the website dedicated to these groups, we have included information on member pages designed to help you tailor your own communication (your elevator speech, for example) to different people you speak with.

In another current project that addresses the strategic driver of professional credibility, ACLP leaders have been working on building key relationships that will help us achieve some of our goals. Among others, we’ve reached out to organizations that work to support video gaming for hospitalized children, and are discussing with Game Changers and Child’s Play how we can engage with each other to establish partnerships that will benefit our organization and the patients and families that our members serve. You’ll be hearing more about the beneficial partnerships we’re building as we move forward.

Finally, while you’re exploring this issue of ACLP Bulletin and the new website, I’d like to remind you that you’re now able to take advantage of a new free member benefit—you can now earn PDUs for reading the Focus article! For each article you read and successfully complete the accompanying quiz, you will earn 0.5 PDUs (up to 10 independent learning PDUs can be accumulated in each five-year certification cycle). As an added incentive for ACLP members to explore the professional development opportunities in our new online education site, with the selection of your first Focus article for PDUs you will receive a discount code for $25 to use toward the purchase of any other content on the site.

This is an exciting time to be a member of this strong organization and this proud profession. While change can be a bit stressful as we learn to navigate new waters such as the updated website and new ACLP Bulletin format, well-planned transitions like the one we’ve undertaken bring excitement and foster growth. I look forward to sharing our progress with you as we continue to make strides into the future.

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keptical was an understatement. I was actually frightened. In the center of the room was a bowl of pendulums, and written sloppily on the board were the words: Fundamentals of Hypnotherapy. What had I gotten myself into? While I expected a handful of bizarre moments during my doctoral training, I never pictured myself in a conference room surrounded by colleagues in trances. Did they think this was real? And actually therapeutic? Each day of the week-long workshop consisted of multiple practice hypnosis sessions. It was exhausting work but I left believing in the modality and eager to integrate it into my practice. Turns out, forty hours of training was convincing enough for me. Of course, this conclusion might have been subconsciously planted by a colleague while I was in trance. I will never know the truth.

**The primary goal of hypnosis is for the client to reach a trance, or an induced subconscious mental state that facilitates the acceptance of instructions or suggestions. Being in a trance feels much like being deeply absorbed in a daydream.**

Hypnosis and hypnotherapy are two different entities. Hypnosis can be empirically defined as “a social interaction in which one person, designated the subject, responds to suggestions offered by another person, designated the hypnotist, for experiences involving alterations in perception, memory, and voluntary action” (Kihlstrom, 1985, p. 385). Hypnotherapy is a treatment modality with specific therapeutic goals and techniques utilized while the patient is in a state of hypnosis (Kirsch & Lynn, 1995). The primary goal of hypnosis is for the client to reach a trance, or an induced subconscious mental state that facilitates the acceptance of instructions or suggestions. Being in a trance feels much like being deeply absorbed in a daydream. Hypnotherapy combines multiple sessions of hypnosis, typically organized into a treatment plan targeting a specific health or psychosocial concern. Consider this example of the progression of sessions: Molly* is a 20-year-old college sophomore with complex migraines and Crohn’s disease. She is anticipating an upcoming small bowel resection that will require her to miss a semester of college and move home to recover with her parents. In the past, when Molly has had GI procedures, the stress made her migraine symptoms worse and she was in constant pain. In an effort to cope with her anticipated pain, Molly seeks adjunctive hypnotherapy in addition to her weekly psychotherapy in the weeks prior to her surgery. Molly’s protocol consists of ten sessions: The first sessions target her ability to reach trance, the middle sessions aim at decreasing anxiety, and the final sessions focus on decreasing pain sensation. During this treatment course, she meets with her provider weekly and also learns how to self-hypnotize. By the time she completes treatment, she is able to self-hypnotize when experiencing migraines, post-surgical pain, or anxiety.

Once associated with circus shows and fringe science, hypnosis is now being used therapeutically under the umbrella of behavioral medicine. Behavioral medicine is an interdisciplinary field that explores the intersection of psychology and medicine (Miller, 1983). The practice of behavioral medicine includes applied psychophysiological therapies such as biofeedback, relaxation training, and hypnotherapy. Child life specialists practice behavioral medicine when facilitating guided imagery, a common relaxation strategy informed by the field. Behavioral medicine is a strong resource when considering pediatric pain. Hypnotherapy has demonstrated efficacy for relieving both acute and chronic pain in adults (Accardi & Milling, 1995). *Names were changed to respect privacy.
2009; Jensen & Patterson, 2006; Montgomery et al., 2000), and while the research on children and adolescents is less robust, the modality still demonstrates consistent value in decreasing pediatric pain (Milling & Costantino, 2000). Following a protocol of hypnotherapy, children report experiencing less distress from painful procedures (Milling & Costantino, 2000; Butler, Symons, Henderson, Shortliffe, & Spiegel, 2005), less abdominal pain such as that associated with irritable bowel disease (Vlieger, Menko-Frankenhuis, Wolfkamp, Tromp, & Benninga, 2007), and less chemotherapy-induced nausea (Richardson et al., 2007). While more research should be pursued, hypnotherapy is a promising behavioral medicine intervention for targeting pediatric pain.

Hypnosis includes three components: absorption, suggestibility, and dissociation. Clients who reach a trance are absorbed in the imagery of the hypnotic script, are dissociating—or feeling separated from—the therapy room, and are open to suggestions from others (Kihlstrom, 1985). Once in trance, clients report feeling disconnected from their bodies and their immediate surroundings (Kihlstrom, 1985). Clients also report feeling disinhibited during trance, which influences their openness to the suggestions of their therapist, coined suggestibility (Kihlstrom, 1985). One of the most promising aspects of utilizing hypnotherapy in pediatric populations is the benefit of suggestibility. Normative studies have shown that hypnotic suggestibility begins to increase starting at the age of three, peaks between the ages of 8 and 12, and declines somewhere between ages 12 and 16 (London, 1965). Thus, school-aged children might be ideally positioned for hypnotic interventions. Too, school-aged children have the benefit of their imaginations. Not everyone is hypnotizable; hypnotizability has been shown in about 75% of the general population, and the remaining 25% do not report experiencing a trance (Wood, 2015). Those who are most hypnotizable tend to be those who become more absorbed in their imaginations (Wood, 2015).

I realized child life specialists already use these techniques once the first lecture began. We support patients using their imaginations to reach relaxation when we facilitate guided imagery. While our patients are not reaching a subconscious trance-like state during guided imagery, many become so relaxed that they experience less pain or anxiety related to hospitalization. Child life specialists possess skills to build rich, creative environments for patients to explore in their minds. Research suggests that these guided imagery interventions are also efficacious for decreasing pain and distress, especially when paired with progressive muscle relaxation, another behavioral medicine modality used to release muscle tension throughout the body (Dobson & Byrne, 2014; Weydert et al., 2006). Hypnosis differentiates itself from guided imagery in two ways: trance and suggestion. Unlike guided imagery, hypnosis first starts with inducing a trance before the therapist builds imagery for their client. In addition, hypnosis ends with suggestions. Suggestions in hypnotherapy are often hopeful statements about the client’s health such as: I will have days that are less painful. When the therapist repeats these statements while the client is in trance, the client is more likely to believe in the possibility of these words. Returning to Molly’s example, suggestions embedded in her hypnotherapy script might include: I have the power to help myself feel less pain, I am capable of easing my headaches, and I have the capability to relax my gut.

Despite leaving the workshop convinced in the benefits of hypnotherapy, I have been unsuccessful in clinically implementing it. The first time I tried to hypnotize a client, a 36-year-old female with chronic migraines and generalized anxiety, she laughed in the middle of the session, stating, “Kathryn, I’m sorry, I don’t feel any different at all! I’m not in any trance!” Turns out, I’m not so hypnotic; or perhaps she falls within the 25% of the population who are incapable of reaching trance. Either way, my confidence was halted and ever since, I have not mustered the bravery to try it again with my clients. But for others, this behavioral medicine modality comes more naturally and I have witnessed trances where clients report an alleviation of pain, a decrease in symptoms of anxiety and panic, and a greater confidence in their ability to tolerate distress, all after one session of hypnosis.

Imagine the possibilities for child life specialists using hypnotherapy with pediatric patients, especially for pain. If only we could. Despite

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having similarities to guided imagery and targeting outcomes monitored by child life specialists such as pain perception, hypnotherapy is reserved for an exclusive list of clinicians, and child life specialists are not among them. Studies documenting the benefits of hypnotherapy are being published in small silos of journals related to behavioral medicine, health psychology, and pediatric psychology. Medical doctors, licensed psychologists, and social workers are among the sole professions that are able to become certified in hypnotherapy by the American Society of Clinical Hypnosis (ASCH). I left the workshop with one main, potentially controversial conclusion: Child life specialists would be ideal for exploring hypnotherapy in pediatrics. Clinically, our training in therapeutic play, cognitive development, and expressive therapies would enhance the sensory descriptions that are the base of hypnotherapy scripts. The ability to tailor hypnotherapy sessions to the child’s developmental needs only enhances treatment efficacy (Milling & Costantino, 2000). In addition to integrating hypnotherapy into our clinical cache, child life could also enhance the research on hypnotherapy. Child life has the research methods to evaluate hypnotherapy’s impact in pediatrics; in fact, we already study an efficacious behavioral medicine modality when we evaluate guided imagery. Our field could add to this empirical foundation by comparing the two treatment modalities or evaluating hypnotherapy in new populations. Between the clinical applications and research possibilities, child life could benefit from the myriad of hypnotic possibilities.

Of course there are concerns. Hypnotherapy can be perceived as paternalistic, or restricting of the patient’s autonomy, due to the suggestions embedded within the hypnotherapy script. Most often, suggestions are determined collaboratively in a patient-centered manner during the assessment process, before hypnotherapy begins. However, this is not well known throughout the mental health community. If child life were to engage in hypnotherapy, we would need to address this stigma. Too, hypnosis can be triggering for patients who have previously experienced trauma, resulting in adverse reactions during trances. Child life specialists would need to be educated on proper hypnotherapy interventions for guiding patients safely out of trance. Despite the potential benefits to our field and patient population, barriers to proper training and the stigma associated with hypnosis may thwart any possibility of child life becoming involved.

Regardless of where you fall on the issue, hypnotherapy is a growing option for families in pediatrics and many patients may already have pendulums in their pockets. Being educated on this therapeutic resource can support your practice. Since my training in hypnotherapy, I have gained more confidence in constructing and reciting guided imagery scripts for my pediatric patients. I also have a more refined foundation in teaching and promoting relaxation skills, a benefit for anyone working in pediatrics.

If you are interested in learning more about a deeper place in the subconscious mind, I encourage you to explore the website of ASCH. In addition, I encourage you to share your opinions and perspectives regarding hypnotherapy with the child life community. Where do you stand on child life’s involvement with hypnotherapy? Is it a modality we should know more about? Or one we leave for the silos of behavioral medicine? Watch for a post on the forum asking for your thoughts.

**REFERENCES**


Online Education: Earning PDUs at Your Computer

Earning PDUs is something that all child life specialists think about, plan for, and include in their budgets. Although professional development is a requirement for maintaining certification, it is more than an item on an already long to-do list. Professional development is paramount because it helps to ensure the value of the Certified Child Life Specialist designation: The professional development requirement proclaims that holders of the CCLS credential are actively updating their knowledge base, are aware of current trends in the field, and are connected with the community of child life specialists.

Fortunately, there are now more ways than ever to earn PDUs. In addition to the annual conference and traditional webinars, the Association of Child Life Professionals has recently launched an online education system to meet the needs of busy child life specialists. If you haven’t yet explored the options offered in the online system, you’ll be inspired by the selection of topics and learning opportunities and pleased with the ability to fit professional education into your schedule.

The online education system is easily accessed on the ACLP website any time that is convenient for you, and contains professional development opportunities of various types. One category of learning options included in the system is recordings of conference sessions. More than 40 presentations at the 2016 Annual Conference on Professional Issues, most ranging from 60 to 90 minutes (1 – 1.5 PDUs), were recorded live and are available in the system. You can browse through the conference sessions to choose what you’d like to learn about, or you can view the presentations by topic or presenter if that makes your search a bit easier. Access to the recording of individual sessions can be purchased, or a package price is also available for those wanting access to all sessions. If you were unable to attend last year’s conference, this is a good way to catch up on some great sessions. If you attended conference, you know that there are always tough choices to make when concurrent sessions present equally enticing topics, but with the online education system, you’re able to learn from sessions you missed. Because these recordings are considered traditional professional development, there is no limit to the number of PDUs that can be earned from these sessions.

In addition to past conference sessions, recent Focus articles are available in the online education system as an option for earning PDUs. Each Focus article earns members 0.5 PDU, and these are available at no cost to members. As an added bonus, members accessing their first free Focus article for PDUs will earn a $25 credit that can be used toward the purchase of other content in the online education system. Please note one important difference from other content in the online education system: Because Focus articles fall under the independent learning category (see the Child Life Profession Certification Maintenance and Recertification Manual for details) there is limit of 10 PDUs that can be earned in this way in each 5-year certification cycle. This differs from recorded versions of traditional professional development (conference sessions or webinars, for example), for which there is no limit to the number of PDUs that can be earned.

To earn PDUs in the online education system, child life specialists must watch the recording or read the article, and then successfully pass a quiz related to the content of the material. The quiz is a requirement put in place by the Child Life Certifying Committee to ensure each individual’s engagement with the material.

The online education system is a flexible platform, so it’s worth keeping on your radar when you’re thinking about your current professional development needs. The content will change as outdated material is removed and newer offerings are included. In fact, there are plans to add recordings of selected recent webinars, so log in soon and check back often.
Where the Spirit Meets the Bone: 
THE ROLE OF CHILD LIFE SPECIALISTS IN TROUBLING TIMES

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The morning after the 2016 election, we woke up to a new normal, which included a stark awareness about the level of bifurcation in our country. Some folks are joyously celebrating the prospect of change; some are terrified about what this change might mean for their future. There is no question that we face an enormous task in figuring out how to work for the common good when many of us have differing views of what that good should look like.

I believe that child life specialists are uniquely poised to address this rift, in all of the same ways that we are equipped to help families cope with medical challenges. We reach out from a strength-based, cooperative front, moving forward from a place of deep inquiry, witnessing and advocating for those in our care. No matter what our political beliefs, we know the value of the developmental interaction approach. We meet the needs of children and families first by asking what their needs are, then by listening and validating, and then by empowering them to find expressive outlets and coping strategies to address these needs. We facilitate children’s inner abilities to make meaning out of their individual path to healing, whatever that may look like. We do all of this while taking into account the child’s developmental needs and the family’s resources and cultural beliefs. These beliefs often conflict with our own, but we consciously choose to serve our patients with kindness and respect, despite our differences. We seek the common denominator of humanity to find common ground to work from.

We also do this side by side with medical staff, who often see things very differently than we do. We work in an interdisciplinary fashion to cooperate within the system, being positive members of the team while we gently, yet firmly, advocate for some approaches that may be outside the present medical culture. We make mistakes. We stumble and fall. But we learn from them, reflect upon them with bravery, and get up and try again.

As we seek to make room for our patients and families to share their narratives, it
When I asked people in the field about what they were seeing in hospitalized children and families the past few days, they first seemed compelled to speak about their own experiences and emotions before being able to move to sharing observations about children on their unit.

behoves us to consider creating time and space for our own conversations. If we avoid talking about our feelings and thoughts with each other, how can we create safe spaces for patients? I urge ACLP members to consider various venues for conversation: within your departments, at interdisciplinary gatherings, at places of worship, in colleges and university classrooms, and on the ACLP Forum. Not every venue is right for everyone. When approaching tough topics, it helps to set some parameters for the conversation, a protocol if you will, so that participants feel safe, respected, and cared for in one another’s presence. If we can do this, we will continue to build our empathic skills for supporting our patients and families in any conversation we find ourselves engaged.

My first thoughts about how we might structure the conversation included the following steps:

1. Guiding questions are supplied. It might take more than one conversation to address them.

2. In face-to-face or virtual conversation, participants respond to the questions, one at a time, making time for each participant. It may be necessary to impose time limits, so that airtime is evenly divided.

3. Participants agree to:
   a. Refrain from sharing personal political views.
   b. Refrain from commenting on anyone’s share—in other words, no cross talk.
   c. Stick to the questions.
   d. Use kind and inclusive language that is respectful of all, considering race, gender, sexual orientation, religion, country of origin, and culture.
   e. Observe confidentiality of our patients by not using names or identifying information.

After the past several days, however, I have been questioning the efficacy of rule “3a.” In conversations with faculty at the Bank Street College of Education, our emotions and beliefs were intricately woven in with our concerns and questions about how to best support our students. When I asked people in the field about what they were seeing in hospitalized children and families the past few days, they first seemed compelled to speak about their own experiences and emotions before being able to move to sharing observations about children on their unit. So I am wondering if we are skipping a crucial step in holding back our own stories as we seek answers for how to support children and families. We are the ones who go where angels fear to tread with children—engaging them in conversations about everything from an impending needle stick to an upcoming amputation, even loss of life. We need to be as brave with one another as we are with children. As with anything, it begins with us.

With that in mind, here are some suggested questions to guide us in respectful and kind conversation. Others may surface organically during the conversation.

1. What are some of the emotions you have been experiencing in the current social climate?

2. What are some of the questions and concerns that you have—for yourself, your loved ones, and your patients?

3. What are you observing at your worksites: in the environment, and in conversation with children and families?

4. What emotions, questions, and concerns are children and families expressing?

5. What skills, techniques, activities, and language are we drawing upon to respond to patients and families?

6. What is working?

7. What doesn’t seem to be helping?

8. What other ideas do we have about how to respond to patient concerns?

It is my deepest hope that these guidelines serve as a reminder of the toolkit we have right at hand. Our training. Our leadership skills. Our humanity. Our deep desire to serve and make the world better. Let’s make sure that every staff member we work with, every child in our care, every family member, feels safe and respected within the health care environment. Let us risk sharing who we are with one another, and then ask kids how they feel, listen to what they tell us, and provide witnessing and reassurance that we will do whatever possible to ensure that their safety and comfort, no matter their color, socioeconomic status, country of origin, religion, gender, sexual orientation, or family makeup, are protected.

I would like to end this article with the following poem:

Have compassion for everyone you meet, even if they don’t want it.
What seems conceit, bad manners, or cynicism is always a sign of things no ears have heard, no eyes have seen.
You do not know what wars are going on down there where the spirit meets the bone.

— Miller Williams, from The Ways We Touch

Resources

This was true in the case of Marco*, a father of four-year-old twins, Javier* and Juan,* both diagnosed with autism, and needing to have labs drawn in a pediatric clinic. While creating a plan for this procedure, Marco informed the child life specialist that Juan would have difficulty coping and he felt it would be best if this child had his blood work drawn first. Marco reported that Juan is very strong and when non-preferred demands are placed on him, he has the potential to become combative. Marco was given the choice of using the papoose or attempting to support his child in a comfort hold while sitting in the phlebotomy chair. The option of the papoose was strongly rejected. A bear hug hold was attempted on Marco’s lap and when this was not successful, Juan was positioned in a chest-to-chest hug. Neither position resulted in a safe, secure, or comforting hold for this child and his father. Juan was having difficulty coping and exhibited aggressive behaviors, including scratching Marco’s arms, while trying to free himself from his hold. Over 30 minutes transpired before the blood draw could be completed.

Following Juan’s difficult encounter, Marco requested the use of the papoose for Javier’s blood work. The room was set up with a DVD player playing a preferred movie on top of the papoose, which immediately attracted Javier as he entered the room and began to climb onto the exam table. Javier self-initiated lying on the papoose and was secured. The DVD player was positioned above him to provide him with an alternative focus during the procedure. At this point, Marco began to sob. The child life specialist offered to remove Javier from the papoose; however, Marco refused. He stated that his emotions were due to the fact that the papoose could provide his child with comfort that he was unable to. Javier’s positive experience enabled Marco to envision the benefits that Juan could have experienced if a different decision had been made regarding utilization of the papoose versus attempting restraint with a comfort hold.

Many children with sensory difficulties, special developmental needs, and/or behavioral challenges,

*Names were changed to respect privacy

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As child life specialists, many of us may be able to recount negative stories involving the inappropriate use of the papoose board. Improper use of the papoose board to immobilize a child during a medical procedure has a number of negative outcomes ranging from traumatization, to loss of opportunity for mastery and coping practice, to an overall sense of lack of control and increased vulnerability. Use of the papoose can be hard on caregivers, as well. In a study by Eaton, McTigue, Fields, and Beck (2005), parents were asked to rank a variety of behavior management techniques on their level of acceptableness. Of the eight techniques listed, passive restraint utilizing the papoose board was ranked as one of the least acceptable techniques by parents, coming in at number seven and followed only by the hand-over-mouth technique. These results were supported in a study by Patel, McTigue, Thikkurissy, and Fields (2016), where passive immobilization using the papoose was rated by parents as “significantly less acceptable” (p. 33) than all the other behavior management techniques described.

As child life specialists supporting patients in an outpatient dental clinic setting, a scenario that we encounter all too often is that of the patient who has been traumatized at an outside dental facility by being immobilized in a papoose as the only option offered for treatment for a painful dental procedure. Not long ago, we received a referral for a school-age child with autism who was refusing to sit in the dental chair or cooperate with any aspect of a routine cleaning and exam in our dental clinic. After reaching out to his mom to discuss a coping plan, we learned that this patient had been going to another dental facility where he had been forcefully placed in the papoose and had multiple teeth pulled. Subsequently, he was terrified of anyone coming near his mouth, even for routine oral care at home. He was even more frightened of anything to do with the dentist, which was understandable given his experience. It took much practice, rapport-building, partnership with the patient’s therapist, and many repeat minimally-invasive visits to help this patient to be able to cooperate with a basic exam and limited cleaning in the dental office. His fear in the dental clinic during those first few visits was palpable, despite the support of child life, his mother, and calm and caring dental staff willing to adapt the visit to meet his needs. It was heartbreaking to witness, particularly since it was a situation that could have been avoided altogether with appropriate supports in place for this child. While the papoose may be appropriate for certain patients and situations, there are a number of ways that it can be used incorrectly. It is preferable to give children the time and opportunity to master entering the papoose under their own volition and avoid using force. Forcing a child into the papoose creates fear of medical staff, eliminates respect for the patient’s personal boundaries, and sets the patient up for failure in future medical procedures due to mistrust. A patient given time and direction will often be able to at least sit on the papoose board to have the legs secured. A familiar caregiver can then assist the patient in lying back to have the rest of the body secured. When this does not...
have sensitivities to touch, difficulties communicating, and may struggle with keeping their bodies still for an extended time. Children with sensory processing difficulties may exhibit “flight or fight” behaviors and, like Juan, may respond aggressively in an attempt to escape from the distressing stimuli (Kuhaneck & Chisholm, 2012). Utilization of sensory adaptation techniques, including a papoose, can provide both tactile stimulation and safe physical restraint. The rationale for using a papoose is to reduce possible disruptive movements that could lead to an unsafe situation for the child or staff member when it is not possible or preferable to rely on sedation or general anesthetic (Shapiro, Sgan-Cohen, Parush, & Melmed, 2009).

While the idea of a papoose might make us cringe as child life specialists, some families self-report positive experiences regarding the anxiety-reducing effect. The papoose board provides deep pressure, which can have a stabilizing and calming effect on many children with special developmental needs (Chen, Yang, Chi, & Chen, 2014). For children who do not benefit from the pressure, the papoose may still be a safer and gentler alternative to using multiple staff members for restraint during invasive procedures or exams. Another consideration is that if the child does become upset or angry, their outburst will most likely be directed at a thing (papoose) rather than a person (caregiver or medical provider). It is also important to note that for some caregivers, a safe comfort hold may not be physiologically possible due to patient’s size in comparison to the caregiver’s size, or due to physical restrictions (i.e. recent surgery, pregnancy, etc.).

We challenge you to reimagine the utilization of the papoose. Changing the language surrounding papoose board has been beneficial for many children, including positively reframing this as a “hugger” or as wrapping the child in “friendly butterfly wings” (Shapiro et al., 2009). Presentation of the papoose in medical situations can also take away the fear and negative context. For example, consider whether or not this procedure actually needs to take place on an exam table. If the medical provider is comfortable, try changing the procedural environment. The papoose may be placed on a therapy mat and covered with a sheet while the caregiver, child life specialist, and medical staff sit beside it with preferred motivators. Utilizing a play-based approach not only brings us back to our child life foundation, but can be considerably less stressful for the patient and family experience.

To allow for the best method of safely supporting a patient during invasive exams or procedures, some basic determinants include considering sensory difficulties, if the patient may benefit from deep pressure, and whether or not restraint may lead to behavioral escalation or aggression. It is also important to address the safety of the caregiver and determine if it is feasible for them to securely and comfortably hold their child, keeping in mind the impact of any physical limitations that may exist. The papoose may not be the right choice for every situation; however, it is crucial to remove the stigma attached to it when considering its use for procedural support needs.

REFERENCES

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happen and the patient is immediately picked up and placed into the papoose, it creates a situation that is threatening and scary for the patient. Another improper use is continuing to physically restrain a patient once they are in the papoose. At times, the papoose may be an appropriate option for a patient if they are stressed by having many people in the room or by being held still by medical staff. These stressors are not eliminated if staff are still “holding the patient down” once placed in the papoose. If the papoose is used correctly, all hands should be off once it is secured. Lastly, not having the papoose set up and ready can result in another negative experience. The papoose has loud Velcro and can look intimidating when it is being set up. If a patient enters the room and the papoose is already set up, this often helps create normalcy and is less frightening for the patient.

It is inappropriate to use the papoose for patients who can safely complete procedures with suitable preparation and support, who are appropriate for a position of comfort with a caregiver, or who have had a traumatic past experience involving use of the papoose. In these cases, using the papoose may cause traumatization, loss of opportunity for mastery and coping practice, a sense of lack of control, and increased vulnerability. There is also a potential for patients to exhibit post-traumatic stress symptoms, which can impact their ability to cope with future health care experiences. It may be appropriate to use the papoose if a patient is comforted by deep pressure, is stressed by being held by an adult, and/or if caregivers and staff are unable to safely complete a necessary medical procedure using a position of comfort. In these situations, use of the papoose should be discussed with caregivers proactively, prior to patient escalation. When the papoose is used, it should be used in a positive manner, not as a restraint or as “punishment” for not being able to hold still.

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*Children’s Hospital of Philadelphia*

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Child life specialists tailor treatment goals to promote normal growth and development in hospitalized children and assist pediatric patients and their families in coping with hospitalization and illness, both in the hospital and after the child has returned home (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014).

Health care teams often struggle with integrating creativity and developmental theory into their interactions with families. Therefore, this study explores the impact of considering the concepts of normal growth and development in designing the learning environment in a summer camp organized around serving children with diagnosed asthma.

Participatory Learning:
Asthma Camp as a Learning Space for Patients and Health Care Providers

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Tell me, I’ll forget.
Show me, I’ll remember.
Involve me, I’ll understand. —CHINESE PROVERB

Child life specialists tailor treatment goals to promote normal growth and development in hospitalized children and assist pediatric patients and their families in coping with hospitalization and illness, both in the hospital and after the child has returned home (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014).

Health care teams often struggle with integrating creativity and developmental theory into their interactions with families. Therefore, this study explores the impact of considering the concepts of normal growth and development in designing the learning environment in a summer camp organized around serving children with diagnosed asthma.

ABSTRACT
Health care-focused summer camps are an effective way for patients and their health care team to learn and reinforce health education (Clark & Nwokah, 2011). The literature on health education is clear that participatory learning cements not only knowledge, but also health behavior change (Beets, Tilley, Weaver, Turner-McGrievy, & Moore, 2014). Health education is a core practice for all health disciplines in influencing health behavior change and is an especially important tool for nurses and respiratory therapists in the care of patients coping with asthma (Horner, Brown, Brown, & Rew, 2015; Turner & Fraic, 2009). In partnering with allied health professionals, child life specialists can bring interactive learning strategies to health education to improve outcomes in children (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014).

This study explores the impact of an educational intervention for children with asthma, implemented in a summer camp that uses developmentally appropriate methods adapted by a child life specialist for engaging a cohort of children 6 to 12 years of age with diagnosed asthma. The study focused on school-aged children in order to take advantage of the knowledge that this age group is highly influenced by developmentally tailored education. This study focuses on specific tools used to bridge the developmental learning styles for children and how these tools played a role in key outcomes for the participants with asthma.
Child Life Practice
Child life specialists are adept at guiding children through their health care journey using the primary tools of normalization, therapeutic play, and education. Normalization can be defined as play that is familiar and reassuring, helping to make the health care experience less intimidating and more comfortable (Child Life Council & American Academy of Pediatrics Committee on Hospital Care, 2006). Therapeutic play is the use of developmentally appropriate activities that seek to moderate children’s anxiety, encourage self-expression, and decrease the possibility that health care encounters will disrupt normal development (Child Life Council & American Academy of Pediatrics Committee on Hospital Care, 2006). Finally, education done in medical settings is the developmentally appropriate communication of accurate information about a diagnosis or upcoming events with the goals of psychological preparation and prevention of misconceptions (Bates & Broome, 1986).

Developmental Theory
Piaget’s theory of cognitive development (Piaget, 1970) places children in the 6- to 12-year age range in the stage of concrete operations, which espouses that these children think logically and rationally about their life experiences. Their thinking is developmentally limited to what they can personally see, hear, touch, and experience. Children in this stage learn best by utilizing simple, concrete language and examples. Children in the concrete operations stage are not able to readily process complex or abstract thoughts, but understand logical principles (classification, identity, reversibility, reciprocity, conservation) and are able to reason and apply their logic to concrete situations (visible, tangible, real things).

Another driving theory in developmentally appropriate interventions is Erikson’s theory of psychosocial development (Erikson, 1968), which places children in the 6- to 12-year age range in the industry vs. inferiority stage of development. In this stage, children learn to be competent and productive through the mastery of new skills, or else risk feeling inferior or incapable. The goal of mastery is the end product of grasping or understanding new skills. When they cannot meet this goal, they may otherwise feel inferior, which has the potential to impact the development of other skills. In this stage it is important to encourage a sense of control and help children attain mastery over learning topics and skills.

Summer Camp as Intervention
The use of summer camps as a nontraditional learning setting continues to grow. A recent study indicates that annually nearly 11 million children participate in a summer camp, and this finding solidifies the experience as a typical childhood rite of passage (Council on School Health, 2011). Children with complex medical needs are often unable to participate in these types of traditions due to the limitations of their disease process (American Diabetes Association, 2006; Beets et al., 2014; Cushner-Weinstein et al., 2007; Epstein, Stinson, & Stevens, 2005; Ventura & Garst, 2013), yet the literature spells out a clear benefit of a specialized medically-focused summer camp experience to normalize the illness and help educate the child about ways to best manage the disease (Buckner et al., 2007). This growing body of literature calls for continued efforts by health care systems to adapt these types of experiences (Clark & Nwokah, 2010). The goals of these nontraditional medically-based summer camps are to not only create an educational opportunity for increased knowledge of disease management, but to do so in an environment that promotes peer socialization in normative surroundings (Wu, Prout, Roberts, Parikhshak, & Amylon, 2011). Several studies indicate that campers not only gain disease-related knowledge, but many have improved self-esteem, decreased anxiety, and a better overall attitude toward their disease process as a result of attending a medical camp (Buckner et al., 2007; Buckner et al., 2005; Plante, Lobato, & Engel, 2001).

The Consortium on Children’s Asthma Camps estimates that approximately 120 separate asthma camps serve nearly 10,000 children with asthma annually. Medically oriented asthma summer camps attempt to focus on asthma education and symptom management in the milieu of typical camp activities (Welch, Carlson, Larson, & Fena, 2007). In a study conducted at the University of Southern Mississippi, “feedback from parents suggested that children seemed to be more self-sufficient, more knowledgeable about their condition, and more positive concerning their asthma after a summer camp experience than before camp” (Briery & Rabian,
The training of child life specialists, focused on developmentally appropriate language and play (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014), allows for a unique vantage point in the development of a health-related curriculum for summer camps. Child life specialists’ ability to partner with nurses and nursing students to create and deliver a participatory learning milieu is a benefit not only to direct patient care, but to the future care delivery system, as the students can adapt this into their future nursing practices. This skill set allows the child life specialist to artfully partner with the members of the multidisciplinary team of nurses and nursing students to create an asthma camp intervention that effectively conveys the key content in a child-centric way.

This camp environment allowed multiple disciplines to address family needs in asthma management with the help of a child life specialist. By addressing education for children and families, the camp aimed to improve their disease management and decrease asthma morbidity. As such, this study attempts to demonstrate that camps with developmentally tailored content, which can be skillfully designed with child life input, are beneficial for children with asthma. The outcome variable of this study is the multifactorial assessment of asthma management as measured by the Asthma Control Test (ACT). This study measured the impact that the summer camp experience, mediated by the input of the child life specialist in creating a developmentally focused intervention, had on asthma literacy and its management.

**STUDY RATIONALE**

The training of child life specialists focused on developmentally appropriate language and play (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014) allows for a unique vantage point in the development of a health-related curriculum for summer camps. Child life specialists’ ability to partner with nurses and nursing students to create and deliver a participatory learning milieu is a benefit not only to direct patient care, but to the future care delivery system, as the students can adapt this into their future nursing practices. This skill set allows the child life specialist to artfully partner with the members of the multidisciplinary team of nurses and nursing students to create an asthma camp intervention that effectively conveys the key content in a child-centric way.

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**METHODOLOGY**

**Intervention**

The Easy to Breathe (E2B) asthma day camp intervention was developed in concert with the Osceola County Public School (OCPS) system, Nemours Children’s Hospital (NCH) in Orlando, Florida, and the University of Central Florida (UCF) College of Nursing. The primary aim of the E2B camp was to create a normalized experience for children with asthma that would allow them to learn about effective ways to manage their disease in a fun and social environment. The intervention was developed using the Open Airways curriculum supplied by the American Lung Association (American Lung Association, n.d.), which offered consultative support in content delivery. In 2013, this study was piloted during a four-day asthma camp for inner-city children with asthma. Forty children between the ages of 6 and 12 years from Osceola County, Florida, were recruited to attend and participate in the camp. The camp included a full Open Airways curriculum (asthma education), nutrition activities, arts and crafts, games, community service, and visits from providers for children (e.g., zoo, puppeteers). Campers had a full schedule throughout each day, which also included breakfast, lunch, and snacks. The camp educated the children about daily management of asthma, triggers, medication, and symptoms, and included a Family Asthma Education Day with child-centered teach-back on the last day. Information provided by each child’s primary care provider was used to customize a written asthma action plan for each child.

**Subjects**

The E2B project targeted students between the ages of 6 and 12 from Osceola County, Florida, elementary and middle schools in the Kissimmee area. The E2B camp partnered with OCPS school nurses to assist with identification and recruitment of subjects. The nurses also participated in a consultative capacity in program administration. The camp was housed on the Kissimmee Middle School campus to assist families with ease of access to the camp through this neighborhood school, and to help bridge the summer learning with the school-based nursing staff who would help to reinforce the learning throughout the following school year.

A printed invitation packet to attend the free E2B camp was circulated through the school nurses, primary care offices, and NCH emergency department to targeted students with a known history of asthma. Inclusion criteria for the study ensured that candidates were on preventative asthma medication and ready to participate in an asthma camp. A total of 208 students were identified and actively recruited from 4 local schools, and a total of 40 students agreed to participate in the E2B study. However, due to logistics, access, and transportation, only 23 students participated in the E2B asthma intervention. This cohort was constituted of mostly males (68%) from a predominantly non-White ethnic background (73% Hispanic). All of the participants were recruited from schools with a high prevalence of students receiving free and reduced lunch, which stands as a proxy measure for lower socioeconomic status. Nineteen of the 23 families actively participated in a Family Asthma Education Day with child-centered teach-back on the last day of camp.

**Camp Administration**

Research protocol, registration, and consent forms were reviewed and approved by the Institutional Review Board from UCF. The camp was staffed by school nurses from OCPS, faculty and volunteers from the UCF College of Nursing, UCF nursing students, and the child life specialist from NCH. The UCF College of Nursing faculty and the child life specialist served as the E2B leadership team, as they partnered to adapt the Open Airways curriculum and present the content lesson plans during the weeklong camp (six lessons over 5 days). The child life specialist modified these lesson plans to incorporate age-appropriate terms, using simple, concrete, child-centric language which was reinforced by clear visuals to highlight knowledge and comprehension. The child life specialist and nursing faculty worked to adapt the delivery of this content into daily lesson plans within a structured schedule, dividing campers into defined groups based on age (6-8 years, 9-10 years, and 11-12 years). The leadership team engaged UCF College of Nursing students in an active discussion about camp goals, expected outcomes, and...
the daily flow. They confirmed clear timelines for the check in/check out process and timing for the daily morning medical exam with spirometer testing, and they clarified roles with meal times (breakfast/lunch), education times, experiential play times (sports, arts/crafts, outdoor activities), nutrition education, and the daily special event. Special attention was paid to engage nursing students in camp delivery as many of these students did not have a strong pediatric background. Priorities were providing children with a normative camp experience, educating about the disease process, and promoting prosocial experiences with peers challenged by the same asthma limitations.

Procedures
The E2B camp was designed to create a normative experience. The subjects engaged in summer camp activities with children their own age, but these experiences were tailored to maximize learning and increase mastery of disease management skills. The subjects were invited to learn about the disease process through a daily schedule that included checking vital signs, pulmonary function tests (PFTs), and checking peak flow. They were educated by asthma-trained student nurses in a classroom setting to address the basic knowledge of their disease process. These lessons used child life specialist-informed techniques that were engaging and developmentally appropriate, incorporated child-friendly language with visual aids to provide concrete examples, and promoted group participation.

A sampling of expressive art projects that met these goals are included in Table 1.

The study camp staff monitored each family for literacy throughout the four-day asthma intervention during their morning and afternoon transitions with campers and their families. Camp staff asked questions each day to explore families’ basic understanding of the asthma process and answered any questions that arose over the educational material given to each child as they went home from camp.

Measures
A medical history and asthma management plan were completed by the child’s medical provider prior to camp. This enabled the camp staff to analyze and evaluate clear asthma management plans for each child and document an individual asthma action plan prior to completion of camp. All participants completed a baseline demographic measure including information on age, gender, ethnicity, asthma severity, and age of asthma diagnosis. The Asthma Control Test (Schatz et al., 2006), a four-item questionnaire to assess children’s perception of their asthma control, was administered to explore perceived asthma control from the child’s perspective. Items focus on asthma indicators such as current symptoms, awakening at night with asthma symptoms, limitation of daily activities, and coughing (Schatz et al., 1999; see Appendix A). The Asthma Control Questionnaire (Juniper, Guyatt, Cox, Ferrie, & King, 1999) was administered to caregivers to assess perceived asthma control from the caregiver perspective.

TABLE 1
Developmentally Appropriate Asthma Camp Activities for Children Ages 6 to 12 Years

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>SUPPLIES</th>
<th>OVERVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goop</td>
<td>cornstarch and water</td>
<td>A hands-on art project used to create a mucous-like consistency so that children can learn about mucous as it relates to their asthma.</td>
</tr>
<tr>
<td>Fire Breathing Dragon</td>
<td>toilet paper tubes and crepe paper, basic craft supplies such as markers, googly eyes, glue</td>
<td>A craft allowing children to create a dragon-like toy with crepe paper at the end of the tube. When children blow through the tube, they are able to visualize their breath.</td>
</tr>
<tr>
<td>Cotton Ball Race</td>
<td>cotton balls, construction paper, markers</td>
<td>Children create their own race track, then blow through a straw to make cotton balls race down the track. This allows campers to better understand the power of big, strong breaths.</td>
</tr>
<tr>
<td>Balloon Lungs</td>
<td>straws, balloons, and tape</td>
<td>Children create a set of lungs by taping balloons to one end of a straw and blowing through the open end, expanding the balloons and allowing them to visualize how their lungs are working as they breathe.</td>
</tr>
</tbody>
</table>

This tool poses five questions focusing on asthma indicators such as awakening at night with asthma symptoms, limitation of daily activities, symptoms in early morning, shortness of breath, and wheezing (Juniper et al., 1999; Schatz et al., 1999; Juniper et al., 2006; Schatz et al., 2006).

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Multiple outcome measures were collected throughout the E2B asthma intervention. An asthma pre/post knowledge instrument was collected to explore baseline knowledge of asthma and evaluate the impact of the E2B asthma intervention on students’ knowledge of asthma management. This pre- and post-test was included as part of the Open Airways curriculum. Family literacy of asthma was also assessed through informal conversations to discover sustainability of knowledge gains. Additionally, a three-month follow up survey was conducted by telephone to explore retention of knowledge and the impact of the E2B asthma intervention on asthma management (including emergency room visits, hospitalizations, school days missed, and parent workdays missed). All asthma morbidity data was measured via self-report.

RESULTS
Using SPSS version 22.0, a series of correlations were performed on data derived from pre-camp questionnaires that were submitted for each camper at the onset of the camp. A significant correlation \( r = -0.593, p < .05 \) was found between age of asthma diagnosis \( (M = 40.14 \text{ months}, SD = 36.21) \) and Asthma Control Test score from the child perspective \( (M = 2.00, SD = 3.34) \), indicating a significant linear relationship between the two variables (See Table 2). When these asthma camp participants were diagnosed with asthma at a younger age, they scored higher (worse) on their Asthma Control Test.

A significant inverse correlation \( r = -0.59, p < .01 \) was found between the Asthma Control Test for children \( (M = 2.00 \text{ range } 0 - 3 \text{ per item}, SD = 3.34) \) and the scores on the Asthma Control Questionnaire filled out by their adult caregiver \( (M = 1.63 \text{ range } 0 - 6 \text{ per item}, SD = 1.61) \), indicating that adult caregivers and their children perceived the asthma severity differently (See Table 2). No significant gender differences in asthma control scores were found \( (F(1,19) = 2.80, p > .05) \).

Most excitingly, child asthma knowledge scores improved during camp with knowledge scores increasing from pretest \( (M = 2.92, SD = 0.67) \) to posttest \( (M = 3.08, SD = 0.78, p = 0.062) \). While this was not statistically significant \( r = -0.34, p > .05 \) we did find clinical significance, as families’ increased asthma knowledge was anecdotally associated with families verbalizing an increase in understanding of condition management in the daily informal literacy conversations.

Three months after camp, caregivers received a post-camp telephone call, where questions focused on child experiences and asthma symptoms post-camp, and qualitative comments on changed behaviors were collected from caregivers. No camper required emergency room or hospitalization visits in the three months following the camp experience. Two students did require missed school days within two weeks into the start of the school year. Families described and demonstrated following the child’s asthma action plan.

Some caregiver comments include “My child is now using his own inhaler when needed” and “[My child] is able to play football with the neighborhood boys without having to come inside.”

DISCUSSION
The E2B intervention was successful on many levels. This study aimed to explore the impact that an asthma camp experience, influenced by the input of the child life specialist in creating a developmentally focused intervention, had on asthma management. The campers embraced the use of child life specialist-directed art projects such as “Goop,” “Fire Breathing Dragon,” “Cotton Ball Race,” and “Balloon Lungs” as key tools to help them to see, hear, touch, experience, and master aspects of their asthma. The camp offered an engaging way for campers to better understand their asthma disease and its management. Although anecdotal, authors observed that the child life specialist contributed to family engagement through active facilitation of the Family Asthma Education Day in which the campers shared what they learned. Future studies should test this observation empirically. Further research into the direct impact that child life-specific interventions had on knowledge or behavior change related to disease management would be a benefit to the study of asthma camp outcomes.

It is clear that the data support the finding that asthma camp interventions are an important tool in improving knowledge about asthma control among the sampled cohort. This study found that when children were diagnosed with asthma at a younger age, they reported that their asthma control was worse. This may indicate the value of early intervention to educate younger children on tools for asthma management. It is imperative to note that despite the economic challenges in this sample population, more than 80% of the families actively participated in a Family Asthma Education Day with a question and answer session. Overwhelmingly, caregivers noticed a difference in children following their asthma action plan and in asthma morbidity after the E2B asthma intervention in the camp experience. This shows engagement in families with chronic asthma through interventions such as asthma summer camps may be a way to provide early education.

On the last day of camp, 19 of 23 families participated in the Family Asthma Education Day, and all families received education related to the individual asthma action plan for their child. Children whose families actively participated in the learning process on the last day of camp responded in a positive nature with feedback. Many asked for yearly camp experiences, plus intermittent educational sessions. All families provided telephone numbers for future contact. The study documented improved family engagement by active participation in child-driven

### Table 2: Perceived Asthma Control Measures

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>CHILDHOOD ASTHMA CONTROL TEST (completed by Child)</th>
<th>ASTHMA CONTROL QUESTIONNAIRE (completed by Caregiver)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>2.00</td>
<td>1.63</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>3.34</td>
<td>1.61</td>
</tr>
</tbody>
</table>

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see Appendix B). For comparison between the child and caregiver versions of the asthma control measures, item means were computed and the scores on the Asthma Control Questionnaire were adjusted to a 3-point scale and reversed. This modification allowed measures to be compared and both measures aimed in same direction, with higher scores indicating poorer control of asthma symptoms.

**TABLE 2**

**Perceived Asthma Control Measures**
the children were found to perceive a higher level of asthma severity when compared to their adult caregivers. This indicates basic understanding of home asthma management in children, and supports additional findings in which adult caregivers seem to minimize asthma symptoms when compared to the children, who evidence distress in their measured breathing. Given this finding, future efforts to promote asthma literacy would benefit from the use of developmentally appropriate language and interventions during asthma day camps to help improve children’s asthma knowledge during the course of the camp time. This knowledge gain and disease management mastery is amplified when paired with efforts to engage families actively in the learning process through child-driven teach-back techniques. Family involvement serves to improve the family’s knowledge and to reinforce the general knowledge gain observed over time with repeated exposure.

Recommendations for future research in the area of asthma camps include continued efforts to explore the role of developmentally tailored language and activities to promote knowledge and behavior change. A longitudinal design that leverages the role of the school nurse to reinforce the intervention could also add sustainability to positive outcomes found in these camp experiences.

As this study engaged nursing students, future research could explore the impact this developmentally tailored learning has on those students’ perceptions for future care or ways they would model developmentally specific interventions in their health care careers. While this study did not measure self-esteem, anxiety, or attitude, improvement was observed anecdotally. In post camp follow up, families were able to identify knowledge and behavior changes in children months after the camp experience. It would be beneficial for future research to explore the long term retention of skills and knowledge gained from asthma camp experiences such as E2B.

The study limitations center around the use of a convenience sample and the relatively small sample size of children included. The lack of a true experimental design with an identified control group limits the generalization of the study results. Finally, the blended developmental age ranges may have an impact on the curriculum, and as such future research would benefit from tighter cohorts of subjects based on age ranges that adhere to known developmental strata.

In conclusion, this E2B intervention demonstrates that an asthma camp can be a normative and educational experience for children with asthma. It suggests that including educational activities, developmentally targeted and facilitated by a child life specialist, may be a useful addition, although more research is needed to specifically study the contributions of the child life specialist to children’s knowledge and experiences. The literature offers support for the use of developmentally specific learning strategies to help reinforce gains in both knowledge and health related behaviors. It also appears that child life services can play a powerful role in improved health outcomes through developmentally tailored education and continued research in this area is warranted. Additionally, the impact of child life practices, shared with allied health care professionals such as physicians, nurses, and respiratory therapists, may serve to help bolster engagement with patients and their families. As such, future research that explores the impact of child life specialists and their training could continue to advance aims for improved health outcomes for children.

Acknowledgements: This study was financially supported from a generous gift from the Mid Florida Jeep Club.

REFERENCES


## APPENDIX A

### Childhood Asthma Control Test™
**FOR CHILDREN 4–11 YEARS OF AGE**

This short quiz will provide a score that may help your doctor determine if your child’s treatment plan is working or if it might be time for a change. Have your child complete these questions.

**1. How is your asthma today?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Very Bad</td>
</tr>
<tr>
<td>1</td>
<td>Bad</td>
</tr>
<tr>
<td>2</td>
<td>Good</td>
</tr>
<tr>
<td>3</td>
<td>Very Good</td>
</tr>
</tbody>
</table>

**Score**

**2. How much of a problem is your asthma when you run, exercise or play sports?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>It’s a big problem. I can’t do what I want to do.</td>
</tr>
<tr>
<td>1</td>
<td>It’s a problem and I don’t like it.</td>
</tr>
<tr>
<td>2</td>
<td>It’s a little problem but it’s okay.</td>
</tr>
<tr>
<td>3</td>
<td>It’s not a problem.</td>
</tr>
</tbody>
</table>

**Score**

**3. Do you cough because of your asthma?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Yes, all of the time.</td>
</tr>
<tr>
<td>1</td>
<td>Yes, most of the time.</td>
</tr>
<tr>
<td>2</td>
<td>Yes, some of the time.</td>
</tr>
<tr>
<td>3</td>
<td>No, none of the time.</td>
</tr>
</tbody>
</table>

**Score**

**4. Do you wake up during the night because of your asthma?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Yes, all of the time.</td>
</tr>
<tr>
<td>1</td>
<td>Yes, most of the time.</td>
</tr>
<tr>
<td>2</td>
<td>Yes, some of the time.</td>
</tr>
<tr>
<td>3</td>
<td>No, none of the time.</td>
</tr>
</tbody>
</table>

**Score**

## APPENDIX B

### Asthma Control Questionnaire

Please answer the best response for your child’s asthma.

**On average, during the past week, how often were you woken by your asthma during the night?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never</td>
</tr>
<tr>
<td>1</td>
<td>Hardly ever</td>
</tr>
<tr>
<td>2</td>
<td>A few times</td>
</tr>
<tr>
<td>3</td>
<td>Several times</td>
</tr>
<tr>
<td>4</td>
<td>Many times</td>
</tr>
<tr>
<td>5</td>
<td>A great many times</td>
</tr>
<tr>
<td>6</td>
<td>Unable to sleep because of asthma</td>
</tr>
</tbody>
</table>

**On average, during the past week, how bad were your asthma symptoms when you woke up in the morning?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No symptoms</td>
</tr>
<tr>
<td>1</td>
<td>Very mild symptoms</td>
</tr>
<tr>
<td>2</td>
<td>Mild symptoms</td>
</tr>
<tr>
<td>3</td>
<td>Moderate symptoms</td>
</tr>
<tr>
<td>4</td>
<td>Quite severe symptoms</td>
</tr>
<tr>
<td>5</td>
<td>Severe symptoms</td>
</tr>
<tr>
<td>6</td>
<td>Very severe symptoms</td>
</tr>
</tbody>
</table>

**In general, during the past week, how limited were you in your activities because of your asthma?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not limited at all</td>
</tr>
<tr>
<td>1</td>
<td>Very slightly limited</td>
</tr>
<tr>
<td>2</td>
<td>Slightly limited</td>
</tr>
<tr>
<td>3</td>
<td>Moderately limited</td>
</tr>
<tr>
<td>4</td>
<td>Very limited</td>
</tr>
<tr>
<td>5</td>
<td>Extremely limited</td>
</tr>
<tr>
<td>6</td>
<td>Totally limited</td>
</tr>
</tbody>
</table>

**In general, during the past week, how much shortness of breath did you experience because of your asthma?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1</td>
<td>A very little</td>
</tr>
<tr>
<td>2</td>
<td>A little</td>
</tr>
<tr>
<td>3</td>
<td>A moderate amount</td>
</tr>
<tr>
<td>4</td>
<td>Quite a lot</td>
</tr>
<tr>
<td>5</td>
<td>A great deal</td>
</tr>
<tr>
<td>6</td>
<td>A very great deal</td>
</tr>
</tbody>
</table>

**In general, during the past week, how much of the time did you wheeze?**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not at all</td>
</tr>
<tr>
<td>1</td>
<td>Hardly any of the time</td>
</tr>
<tr>
<td>2</td>
<td>A little of the time</td>
</tr>
<tr>
<td>3</td>
<td>A moderate amount of the time</td>
</tr>
<tr>
<td>4</td>
<td>A lot of the time</td>
</tr>
<tr>
<td>5</td>
<td>Most of the time</td>
</tr>
<tr>
<td>6</td>
<td>All the time</td>
</tr>
</tbody>
</table>

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The Asthma Control Questionnaire is copyrighted. Used with permission of Elizabeth Juniper.
Grief Camp: 
A REFLECTION OF MY FIRST EXPERIENCE WORKING WITH BEREAVED CHILDREN

Danielle Mollung, BA
STUDENT RESEARCH ASSISTANT, TUFTS UNIVERSITY, BOSTON, MA

Any family can be affected by loss, and children respond in a variety of ways. The opportunity to attend a grief camp allows children to express their emotions in a safe environment where they can receive emotional support from volunteers, grief counselors, cabin leaders, and their new friends. They are provided the support to develop coping strategies and they learn to honor their loved ones in developmentally appropriate ways, while feeling understood rather than alone.

In most grief camps, children participate in traditional camp activities, boosted by a component of grief education and support. Camp is transformational for campers, enhancing self-esteem and increasing hope for a positive future despite tragic losses, but I also found myself transformed by my experience as a grief camp volunteer.

As an individual seeking a future in child life, I volunteered for a weekend childhood bereavement camp, hoping to learn how children react to death and gain a sense of how they coped. I became a proud member of the Pink Fish cabin, which hosted four girls, ages 6 to 8. The Pink Fish girls understood why they were at this camp, bluntly asking each other “Who died?” and “How are they dead?” The campers shared about their losses in simple and straightforward ways, such as “My mom is dead of cancer” or “I think my dad died in a car.” I was amazed by their innocence, but also intimidated by the bluntness of their language. Professionally, my main goal was to practice my supportive skills and learn how to say the right thing about a sensitive topic. I also hoped to add more techniques to my developing child life skills in settings outside of the hospital. My camp experience opened my eyes to the many misconceptions children have about death. It is difficult for me to imagine them grasping the idea of their parent being gone permanently. I had no sense of how much they knew and I learned that the best way to support was to listen. I realized I had no need to “counsel” or directly ask questions, but that my support, presence, and comfort were enough, regardless of how much the children understood or were willing to share.

Some camp activities were traditional camp adventures while others, including a symbolic stone craft, a hand drawn pillowcase, and aromatherapy, were guided by the grief counselors. When all of the campers gathered for the first time, I could feel tension, sadness, and silence in the air. I admired the respect and support seen among the campers during the first activity, which was creating a large memory board honoring all of the campers’ loved ones. Personally, I found their stories to be an immense amount of information to hold. I wanted to cry for the boy who left hyperventilating. I wanted to hug the groups of siblings, as I could imagine their family as a whole. In the back of my mind, I feared that this weekend would be too much for me, but at the same time I wanted to give these campers my all, especially after hearing firsthand what they have been through. At first, I worried I would say the wrong thing or freeze when a child needed comfort. However, I saw the appreciation in campers’ faces when I told them their memories sounded lovely and their memories sounded lovely and their

The Pink Fish girls understood why they were at this camp, bluntly asking each other “Who died?” and “How are they dead?”

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artwork honoring their loved ones was “beautiful” and “important.” I learned how to encourage children to be open by reassuring them that they were “special” and “brave” for being present. I found myself naturally repeating these words of encouragement frequently throughout the weekend.

The most important and reflective activity of the weekend was a luminary ceremony, which featured lanterns honoring the campers’ loved ones floating around the lake. This ceremony was beautiful, and I was awestruck at the composure of the Pink Fish girls, who respectfully sat in silence and held each other’s hands while wrapped in one huge, cozy blanket. Older campers were visibly emotional, but they were quickly supported with hugs from their new friends. After such a heavy ceremony, we were able to let loose at the bonfire and dance party that followed. Dancing in the same room as the memory board created the night before was touching; it went from a room full of tension to a room of relief. Seeing the natural joy and laughter of the campers in front of the pictures of their loved ones compared to their tears and anxiety before was so therapeutic and symbolic for me. I was amazed by the children’s resilience and ability to act and be goofy like the kids they are, giving me hope that they can find a way to do so at home again, too.

Grief camp taught me how to empathize to a greater extent. It made me realize you cannot always say the right thing or fix sadness, but being present and supportive means more than anything. I had worried it would be uncomfortable to face the reality and permanence of death with these campers, especially the young girls to whom I was assigned, but I learned to not avoid the blunt, harsh words such as “dead.” Instead, I learned to redirect back to the campers and see what they had to say or how they felt about things. I found the easiest way to encourage 6- to 8-year-old campers to express their feelings or share their stories was through arts and crafts. It was easier to ask open-ended questions—who or what a drawing was of, what was taking place, why it was special—to allow the campers to reflect on the happy memories more so than the loss. I was really able to gain insight on what their losses meant to them by how they remembered their loved ones.

Since camp, I find myself more appreciative and grateful for my own family, friends, and opportunities than ever before. I value the new skills and interventions I learned and plan to use them in my own practice someday. This experience gave me insight into approaching loss in any population I end up working with in the future. I feel more confident in my ability to sit in silence, listen, and hold information regarding loss and sadness without feeling awkward or pressured to say anything. Although I may never understand what these kids are feeling or are experiencing at home, I value the short, three-day weekend we had together to try and make things a bit easier. I plan to continue volunteering at this camp and hope to be placed with older girls next year because I am curious to see how the experience affects children at other developmental stages. I wonder if it would be more difficult to sit with older kids’ stories and emotions, since they have a better understanding of the loss and permanence of death.

I feel more confident in my ability to sit in silence, listen, and hold information regarding loss and sadness without feeling awkward or pressured to say anything.

I may someday pursue working with this population, but the skills I learned at grief camp will aid me in helping children experiencing loss in any circumstance, whether they are approaching death or are experiencing loss. Having this experience as a foundation for approaching childhood bereavement and for having conversations about death will benefit me in any setting, or even with my own kids someday. Grief camp was an exceptional experience that I recommend for all those pursuing child life, as well as anyone who knows a child who has experienced loss and grief. 🌟
STEP 2: Develop Clinical Questions

Emily Jones, MS, MEd, CCLS
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CINCINNATI CHILDREN’S HOSPITAL MEDICAL CENTER, CINCINNATI, OH

Once you’ve completed the first step of the evidence-based practice (EBP) process and determined an area for improvement, the second step in the model involves refining your assessment into a clinical question. Developing a clinical question is the first step in evidence evaluation (CCHMC Evidence Collaboration, 2015). In EBP, it is important to find evidence in an expedient fashion.

A key to promoting expediency is knowing what terms to use in your search strategy, which is where the clinical question comes into play. A clinical question should follow the PICO format – Population, Intervention, Comparison, Outcome. Each of these components serves to “define the criteria for a more precise electronic literature search” (CCHMC Evidence Collaboration, 2015, p. 7). They also follow guidelines used by other medical professionals in accordance with quality evidence-based care recommendations from Appraisal of Guidelines for Research and Evaluation (AGREE) and National Guideline Clearinghouse (NGC). Below, each section of the PICO question is described in more detail.

■ When determining your Population, think about what patient group is of interest to you. Some important considerations include factors such as age, disease or condition, and setting. For example, if you have identified the need for implementing developmentally appropriate education for patients who have received a new diagnosis of diabetes, your population could be “pediatric inpatients ages 6 to 18 newly diagnosed with diabetes.”

■ Next, you need to clearly summarize your Intervention of interest. Interventions can be preventative, diagnostic, therapeutic, or encompass another health care intervention (CCHMC Evidence Collaboration, 2015). In the diabetes example, your intervention would be, “providing developmentally appropriate education regarding the origin and treatment of diabetes.”

■ If appropriate, identify an alternative Comparison to your intervention. In many cases, you may compare your treatment to current practice or “standard care.”

■ Finally, describe the desired Outcome of your intervention on your target
population. Ask yourself how your patients will be affected by your intervention. In the diabetes example, outcomes could include “improve adjustment to new diagnosis,” “improve compliance with diabetes care,” and/or “lead to more positive coping.”

Putting all of the components together, your final PICO question would be “Among pediatric inpatients ages 6-18 newly diagnosed with diabetes (P), does providing developmentally appropriate education regarding the origin and treatment of diabetes (I) compared to standard practice (C) lead to more positive coping (O)?”

After drafting your question, seek feedback from multidisciplinary team members and evaluate the components you have put together. Ensure that your question isn’t too general or too specific – either of these will negatively impact your literature search results. It is also important to make sure that your question is clinically important and warrants further research. Consider the status of existing evidence surrounding your question, the knowledge of the evidence, and the use of the evidence in your care area (CCHMC Evidence Collaboration, 2015). If there is existing evidence and/or credible expert consensus surrounding your topic, but this evidence is not being used or not being used consistently, it is important to continue with the EBP process and move toward the development of an EBP statement.

Once your clinical question is finalized, you are ready to move into step 3 – searching for evidence. You will use the key words in your PICO question, particularly related to population, intervention and outcomes, as your search terms. Our next ACLP Bulletin article will explore this step.

Continue to follow this series as we dig deeper into each step of the EBP process! Past articles are available on the ACLP website.

REFERENCES

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EBP, One Step at a Time

… it has been my experience that good things happen when I choose to show up and pay attention to the people in my life and the things I do to connect with the world.

... it has been my experience that good things happen when I choose to show up and pay attention to the people in my life and the things I do to connect with the world.
The Pips of Child Life: The Middle Years of Play Programs in Hospitals

By Joan Turner and Civita Brown

W

We have all asked the question “How did I get here?” either in our personal or professional lives. While each of us have our own unique stories, the child life history is one that binds us all. The Pips of Child Life: The Middle Years of Play Programs in Hospitals (2016) by Joan Turner, PhD, CCLS, and Civita Brown, MSEd, CCLS, captures the history of child life from the late 1970s to the late 1990s, when the field was bustling with growth, development, and professionalization. The Middle Years is the second book in a three-part series, following The Pips of Child Life: Early Play Programs in Hospitals (2014). The word “pip” means “seed”; this collection of stories helps the reader understand what exactly the seeds looked like and how they were planted to become the blooming orchard that is child life today. The pioneers of child life are described in this book in a way that transforms them from merely names in a text book to iconic role models of our profession. Turner and Brown, both Certified Child Life Specialists, have put together first-hand accounts to relay the importance of the formative years of child life. They give us a glimpse of how far child life has come as a profession while igniting a passion to build upon this groundwork for the future.

The Middle Years gives the reader the feeling of looking through an old yearbook. One might recognize a name from the ACLP Forum, an ACLP Bulletin article, or a conference presentation, but to read about the work the individual did takes it to a new level of respect and appreciation. Like a class picture, several chapters list members of original task forces and committees, highlighting these members as pioneers in child life. It is also interesting to see the multidisciplinary approach it took to bring child life to its current state. The essays in this book represent physicians, social workers, teachers, parents, patients, and child life specialists who collaborated to mold the best practice possible.

The Middle Years alternates between chapters of historical information, followed by profiles of individual visionaries in child life. Each chapter helps create a staircase in which Turner and Brown build upon different layers of the field. Behind every progression is the foundation of play created by Emma Plank that will stand strong no matter the advances in the field, and this is seen as the common thread throughout each chapter.

Reading the history of child life as a series of first-hand accounts gives the reader a different feel than could be gained through a history book. The authors of each essay were involved in the decision making that shaped child life. Beginning with the establishment of pediatrics and recognizing the need for normative play, giving way to the creation of play programs and playrooms, to creating the identity of “child life,” the reader has the opportunity to learn about all of the advocacy that went into making child life the respected profession it is today. Multiple photographs of early programs and practices also aid in understanding how child life has evolved.

Change is rarely easy, and the progress of child life is no exception. Each author narrates the hardships and struggles they experienced as they moved the field forward. Milestones such as establishing the Child Life Council, requiring certification, and creating a certification exam to acquire those credentials did not just happen; there were research studies, surveys, business meetings, and proposals involved each step of the way. Gene Stanford, PhD, is quoted many times throughout The Middle Years as asking “Will we guide the future development of child life, or do we prefer to let it just grow like topsy on its own?” (Turner & Brown, 2016, p. 20-21). The founders of child life had future generations in mind.

As a member of this new generation of child life specialists, it is hard to imagine a time when there were no child life degree programs, but it was exciting to learn about the development of them as well. Several authors retell the journey of child life education moving from a branch off of education to a more fitting subdivision of psychology, and recount the creation of more formative courses to mold students into child life professionals. They discuss the need for graduate programs which were established at four universities and now span across the United States and Canada.

Reading about the many advances made in a relatively short amount of time also gives the reader an idea of how much there is still to do. Health care is an ever-changing field, and child life must continue to keep up. The foundation, however, will not change, based on the precedents set.

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Reading the history of child life as a series of first-hand accounts gives the reader a different feel than could be gained through a history book. The authors of each essay were involved in the decision making that shaped child life.

by previous generations. As seen throughout The Middle Years, normalization and coping through play, preparation, education, support, and advocacy will remain the backbone of child life. It was a little jarring to end the book so abruptly, but it only shows there is so much left to write, and it leaves room in the series for the third book to come.

While The Middle Years may not teach a student or professional the “how” of child life, it most certainly provides the “why” behind it. The authors have put together a truly vivid picture of the hard work needed to shape the profession into what it is today. The Middle Years gives the reader a sense of pride in the field and encourages others to fulfill the expectations of those who paved the way. It reminds the reader that the work is never finished. As Linda Skinner, CCLS, is quoted in the book, “People need to remember that’s where we came from and that’s what makes a child life specialist different from everyone else” (Turner & Brown, 2016, p. 40).

Opinions about the books reviewed in ACLP Bulletin are those of the individual reviewer, and do not reflect endorsement by the Association of Child Life Specialists.

REFERENCES
Engagement in the Association of Child Life Professionals

VOICE – COMMUNITY – IMPACT

Lisa A. Ciarrocca, CCLS
THE NEXT STEP: PARTNERS IN PSYCHOSOCIAL CARE, FANWOOD, NJ

Stephanie Hopkinson, MA, CCLS
KUWAIT ASSOCIATION FOR THE CARE OF CHILDREN IN HOSPITAL, KUWAIT

Engagement—what a powerful and dynamic word! This word brings with it a diversity of thoughts, perspectives, and stories. Engagement is an opportunity to understand and be a part of something bigger than your daily, individual work. It goes beyond teaching students or other team members about the value of psychosocial services.

Engagement brings the opportunity to be connected with a larger community of child life professionals. The research informs us that there are many forms of professional engagement (Hager, 2014). Engagement can begin with being a member of a professional organization, reading journal articles, reading and responding to blogs, watching informative videos and having thought provoking dialogues, attending a national annual conference, and continues through participating on a national level through committee and board positions.

If you would like to increase your engagement with a larger circle of child life professionals, consider doing the following:

- Fill out a Volunteer Interest Form (VIF) for the 2017 Call for Volunteers
- Encourage others to submit a VIF form
- Attend the 2017 Annual Conference
- Participate in a webinar
- Apply to participate in the 2018 Mentor Program

Take a few moments to “listen” to these two volunteer leaders’ stories about their engagement in the Association of Child Life Professionals (ACLP). They represent two diverse perspectives in professional engagement. Be inspired, be motivated, and be ready to think about your own story of engagement in the child life community.

Cristie Suzukawa Clancy has worked in child life for the past 18 years and is a Child Life Specialist Lead at Children’s Hospital Los Angeles. The first time Cristie remembers becoming engaged in the greater child life community was when a child life leader encouraged her to join a Child Life Council (CLC) committee and served as a mentor to her as she stepped into this uncharted territory.

Cristie shares that she was motivated to become more engaged with CLC because “People have opinions on what should be done. In order to know more, you need to know how it works and the pieces of the puzzle. Being engaged gives you the opportunity to see the bigger picture. You have the opportunity to get involved on the other side and meet the people doing

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the work and putting the programs out. This gave me a way to become involved and a great way to have a voice.” Cristie expresses that there have been many meaningful moments in her pathway of engagement in CLC.

Engagement, to Cristie, means “becoming active and working toward the mission of CLC. As a member of CLC, it helps to know that you are a part of a larger community that shares the same challenges and triumphs. It is so nice to know you are connected to CLC. You get to know more people. You have the chance to strengthen your critical thinking, leadership, and organizational skills.” To those who want to become engaged in a committee for the first time, she offers this advice: “If there is anything on the list [on the VIF forms] you are interested in, go ahead and apply. There will be people to guide you. You have a lot to contribute and everyone’s contributions are valuable.”

Sarah Patterson, another volunteer who has benefitted from her engagement in the organization, has been in child life for over 24 years. Sarah is a full-time curriculum coordinator and professor in the McMaster University child life program and holds an ad hoc position at The Hospital for Sick Kids in Toronto, Ontario. About five or six years into Sarah’s professional work in child life, she attended a CLC conference. Describing one of her defining moments, she speaks about pausing to look around the conference room at the sea of people all there for the same reason. She witnessed great conversations, with people from everywhere, happening throughout the entire conference. This moment of inspiration was profound and encouraged Sarah to become more engaged in the child life community.

Sarah’s engagement in CLC committee work quickly began as a reviewer for Child Life Focus. As a Canadian, she was used to smaller numbers of child life professionals compared to the United States, and having the opportunity to be a part of a bigger community of child life professionals through membership in CLC was significant to her. Sarah holds the belief that being a member of ACLP is a professional responsibility. She says that “it gives you so many opportunities, helps to educate others, and moves the profession forward. It helps you become part of a network and feel connected if you are in a smaller program.” Sarah states, “Sometimes you feel like you are just another child life specialist in a hospital, but being engaged, you realize you are one of many who make up the field of child life.”

The most meaningful moment of engagement in this organization for Sarah is when she sees people in the field and then gets a chance to become engaged with those who stand out, while also having the chance to get to work alongside “pioneers” in child life. To be engaged, she says, “is to know I made a difference with my voice on a committee.” Sarah’s advice is “Just jump in. The committees are so well rounded with different levels of expertise. Try not to feel intimidated. Everyone has something to share.”

What does the volunteer selection process look like?

This brief overview of the volunteer selection process will give you an idea of what happens from the point of volunteer interest form (VIF) announcement to notifications being sent out.

- Call for volunteers goes out through an ACLP News Flash with a link to the VIF
- Committees and task forces available for volunteers are listed
- Select and rank up to three choices
- Complete your application
- Submit your form through the submission process
- Forms are compiled and distributed to the chairs of the committees/task forces
- The chairs select and submit their choices to the ACLP office
- All people who submitted VIFs will be contacted, including those who are placed on committees/task forces and those who are not

Please note that there are many ways to be engaged in ACLP; and if you are not assigned to a committee or group this time, please continue to share your experiences and passions with the association. ACLP extends profound gratitude to all who volunteer and seek to volunteer with our professional organization.

REFERENCES


Stephanie Hopkinson, MA, CCLS, is chair of the Leadership Development Committee, and Lisa Ciarrocca, CCLS, chairs the Volunteer Recognition and Engagement Subcommittee. Stephanie and Lisa invite you to learn more about volunteer opportunities by visiting the ACLP website.
ACLP Calendar

JANUARY
1-31  Start planning your Child Life Month events and activities for March!
5     Deadline to submit internship application for Summer 2017
31    Deadline to submit 2017 Annual Certification Maintenance Fee
TBD   ACLP Annual Conference registration opens
TBD   Call for committee volunteers

FEBRUARY
1-28  Continue planning your Child Life Month events and activities for March!

MARCH
1-31  Celebrate Child Life Month!
10    Deadline to apply for the March 2017 administration of the Child Life Professional Certification Exam
15    Deadline to submit internship application for Fall 2017
15-30 Child Life Professional Certification Exam Administration testing window

APRIL
1     Submission deadline for ACLP Bulletin and Focus articles for consideration for the Summer 2017 issue

MAY
25-28 35th Annual Conference on Professional Issues in Las Vegas, NV

Upcoming Events

FEBRUARY 24, 2017
Great Lakes Association of Child Life Professionals—2017 Student Symposium
Bronson Children’s Hospital, Kalamazoo, MI
For more information, visit the GLACLP website
Or contact: childlife.glaclp@gmail.com

MARCH 16-19, 2017
National Association of Pediatric Nurse Practitioners National Conference
Denver, CO
Visit the NAPNAP website for more information.

MARCH 19-24, 2017
CHA’s 2017 Quality and Safety in Children’s Health Conference
Orlando, FL
Visit the Children’s Hospital Association website for more information.

APRIL 19-21, 2017
41st Annual Association of Pediatric Oncology Social Work Conference
Chicago, IL
Visit the APOSW website for more information.

APRIL 21, 2017
Great Lakes Association of Child Life Professionals—12th Annual Child Life Assistant Summit
Helen DeVos Children’s Hospital, Grand Rapids, MI
For more information, visit the GLACLP website
Or contact: childlife.glaclp@gmail.com

OCTOBER 10-15, 2017
Association for Play Therapy 34th Annual Conference
Minneapolis, MN
Visit the APT website or email dleon@a4pt.org for more information.

2018 ACLP ANNUAL CONFERENCE CALL FOR PAPERS

The ACLP 36th Annual Conference will be held in National Harbor, Maryland, May 2-6, 2018, and it’s time now to start thinking about presenting. Do you have an innovative idea or a research project you’d like to share with your colleagues? Consider sharing your work with more than 1,000 child life professionals at the Annual Conference. It is never too early to start planning an engaging presentation on a topic of importance to your profession.

The Conference Program Committee invites you to plan now to submit an abstract in early 2017. Member and attendee feedback continues to indicate a need for presentations related to advanced-level topics, leadership, and child life in alternative settings. In addition, there is demand for topics addressing the core competencies, especially ethics and assessment.

Conference presentation formats range from posters to panels, so there is a format to fit your topic and presentation style. Participate in making the 2018 conference a rousing success!
History Repeats Itself: ORGANIZATIONAL CHANGES FOR CHILD LIFE SPECIALISTS

Lois Pearson, MEd, CCLS
ARCHIVES MANAGEMENT GROUP

The time is 1980, October to be exact. The question is “What to do with child life?” Seemingly happily settled within the multidisciplinary Association For the Care of Children in Health Care (ACCH, originally the Association for the Care of Children in Hospitals), child life workers thrived in the rich environment of nurses, physicians, social workers, psychologists, and parents. Since its inception in 1965, members focused on improving the experience of children in the health care system. Yet through the years, child life felt a strong need to begin establishing themselves as a distinct and unique profession, including defining necessary skills, educational preparation, and standards of practice.

These issues were difficult to address within the structure of the ACCH. The Child Life Position Statement in 1979 was the first official attempt to define the “profession” of child life as its own entity. Yet there were still many remaining concerns, the greatest being whether child life should stay sheltered under the umbrella of ACCH or if it was time to declare independence.

One of the child life pioneers who had the greatest impact on this discussion was Gene Stanford, and one of the treasures in the ACLP Archives is the letter he wrote to Sally Francis welcoming her to the newly organized “Ad Hoc Committee on Independent Professional Organizations.” The lengthy communication details the diversity of opinions of those on the task force, some of whom were quite strongly opposed to the idea of child life striking out on its own.

Gene writes in his letter dated October 5, 1980, “I think it would be perfectly all right to form a completely independent organization. Something like the “International Association for Child Life Specialists” or some such. There’s really no need to be linked directly to ACCH. After all, as I pointed out before, no other professional organization whose members belong to ACCH has such a link. And I believe the small fledgling group could survive and even prosper without the support of ACCH. After all, ACCH began very small.”

But if you think this mild-mannered statement was commonly accepted by the majority of recipients of this correspondence, you need to know that words like “secession,” “vigilante group,” and “paranoia” were also used! In the end, the importance of discussion and open-mindedness was emphasized, and you know “the rest of the story.”

For further reading:


CLC is now the Association of Child Life Professionals.

For more than a year, the Child Life Council has undergone a significant transformation to become the Association of Child Life Professionals—known more informally now as “ACLP.” Creating a new identity for the association had to satisfy all of the existing expectations of what our organization stands for, while simultaneously moving the brand forward.

“This current milestone in our organization is built upon so many years of work and the devotion of so many people who strove to professionalize what we do.”

Kristin Maier, MS, CCLS
PRESIDENT, 2016-2017

From the beginning of this process, the branding committee’s goals have been:

- To help grow the profession by raising awareness of the value of child life professionals
- To emphasize a family-centered care approach
- To create a sense of positive momentum for our leadership
- To support our community of child life professionals by underscoring professional standards and excellence of certification
- To strengthen our brand with a unified mark that conveys compassion, creativity, encouragement, and hope

Join us at our 35th Annual Conference as we celebrate this historic milestone!
Join More than 1,000 of your Peers in Las Vegas to Celebrate the Magic of Child Life!

ACLP 35TH ANNUAL CONFERENCE
MAY 25–28, 2017 • PARIS LAS VEGAS HOTEL • LAS VEGAS, NEVADA

The Association of Child Life Professionals’ Annual Conference is a highly-anticipated event designed by and for child life professionals. The conference provides a unique opportunity to share and expand your professional knowledge with a diverse group of peers from across the country and around the globe.

Attendees work at every level of the child life profession in hospitals, community outreach, private practice, and academic settings. Of the more than 1,000 attendees, 35% have 10 or more years of experience working in child life, 24% have 5–10 years, and 41% have 0–5 years.*

*Source: 2016 annual conference exhibitor survey

Kevin Spencer
Kevin is the Founder of the Healing of Magic program, widely considered the leading authority on the therapeutic use of magic tricks in physical and psychosocial rehabilitation. Kevin believes strongly in the power of the arts to impact the quality of people’s lives.

Register Early and Save $200!
Members of the Association of Child Life Professionals (ACLP) save $125 off full-conference registration. Register by March 31, 2017 and save an additional $200 off! Register online at www.childlife.org or call 1-800-252-4515 and ACLP staff will be happy to assist you.

Preview more exceptional educational content. The 2017 Convention program is online now!