Over time, the definition of curriculum has shifted from a focus on a syllabus or the content one wishes to transmit to a more broad definition including “all the planned learning experiences of a school or educational institution” (Prideaux, 2003, p. 268). Curriculum can be further characterized by what is planned for students, delivered to students, and the students’ experience (Prideaux, 2003). It has, therefore, moved from an input system of what will be taught, or plans that will be implemented, to what will be received or learned with the “important elements of curriculum including content; teaching and learning strategies; assessment processes; and evaluation processes” (Prideaux, 2003, p. 268). These processes of planning, acting, and evaluating are all reciprocally related and integrated into curriculum development (Grundy, 1987).

Just as the view of curriculum has changed over time, so too have the academic requirements for child life specialist certification eligibility, and these will continue to change in the near future. As a complex and unique profession, important to the health and well-being of patients and families, it will by 2022 be a requirement that all new child life certification candidates hold a master’s degree (or the international equivalent) in child life or a master’s degree with a concentration or emphasis in child life (i.e., MS in Human Development and Family Studies with a concentration in Child Life) from an academic program accredited by the Child Life Council (CLC). Then, effective in 2025, this requirement will be amended to require...

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Psychosocial Care for the Unaccompanied Hospitalized Child: Increasing Child Life Support for this Vulnerable Population

Amy McGrory, MA, CCLS
Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

Can you imagine how difficult it was for patients and families back when parents were considered “visitors” and were not allowed to stay overnight with their hospitalized child? Historically, parents were excluded due to numerous concerns, including infection control as well as a more paternalistic attitude in hospital care. The traditional models of care centered on physicians who devised the child’s plan of care without input from the family. Families were viewed as passive observers in the hospital setting. According to Roberts and Messmer (2012), this attitude began to shift after WWII. Knowing what we do now about attachment theory and child development, the added stress and anxiety that hospitalized children and families experienced prior to the 1950s must have been enormous. Eventually, the concept of family-centered care (FCC) was introduced and is now standard practice in most children’s hospitals.

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President’s Perspective

The Next Chapter Begins

Sheri A. Mosely, MS, CCLS

By the time this issue of Bulletin is published, you will probably have seen the newly developed strategic plan that was created this year. I would like to thank Carla Oliver, MSW, CCLS, for leading the effort during her year as president. She ensured that we stayed on track for the development of a new plan despite the significant change in CLC leadership that occurred and continuing work on the other important initiatives that were competing for attention. Carla, being a vested member and experienced leader, kept her sights on making this happen and did so by bringing together a group of key members and leaders who participated in a process to craft a plan that will guide our organization’s efforts through 2018. These individuals performed an important service to CLC and are commended for offering their time and thoughtful input so that we could chart our course for continued growth and opportunity.

Developing a strategic plan is a prudent activity for any organization so that decisions can be made and actions identified in order to respond to changes in the current economic, political, technologic, and business environments. In turn, a strategic plan helps organizations be more effective in serving members and customers and protects it against potential threats from the constant change and demands that exist. For CLC, a strategic plan is an important tool that not only helps shape a vision for who we are as a professional membership organization, but also provides direction for what we need to do to continue moving forward and keeps us on track to accomplish that progress. A well-thought-out plan keeps us focused on common priorities so that we can reach our goals, and helps position us for success.

The systematic approach that this group followed to develop our strategic plan was a multi-step process. The results were accomplished over the course of several days of intentional brainstorming that allowed for a healthy exchange of ideas so that we could arrive at a plan that would be relevant and sustainable. Throughout the entire planning process, we stayed grounded in our professional history, reflected on the current climate, and projected possibilities for the future. The final plan emerged from our diverse but collective knowledge, experience, and passion for child life practice. There were several components to its evolution which I will highlight here.

One of the first things we did was to establish the organizational baseline, including a situational assessment of internal and external trends that exist for CLC (e.g., member needs, organizational capacity, health care reform). From there, we held discussions regarding CLC’s business/mission, our impact/vision, as well as our beliefs/values. Next, we identified target audiences; that is, whom we serve, and the people and stakeholders for which we exist. This discussion prompted us to list the overarching strategic drivers that should be considered as priorities for CLC. In other words, we had to decide where to focus our attention for the next few years in order to move our organization forward. An important aspect throughout all of this was to review the ongoing operations that are of importance for CLC, which include things that need to continue in order for us to remain strong and of value for our target audiences. Lastly in the process, but an equally crucial component to ensure we stay on track with the priorities identified, was to develop key performance indicators (the outcomes) that will help us measure progress toward our goals.

All of this planning was done through a very interactive process that included sticky notes covering the walls to reflect ideas, small groups moving between easel boards throughout the room to hold dialogue on each topic, and then a large group “think tank” discussion at the end of each exercise to summarize common themes. We also incorporated input that was intentionally pursued prior to this planning session which came from calls made by CLC board members to some of our membership to continued on page 29
from the Executive Editor

Redefining Learning as Lived Experience

Jessika Boles, MEd, CCLS

From the moment my son was born, the running joke amidst my household, family, friends, and basically everyone we know, is that my son is the spitting image of my husband. They are carbon copies of one another in face (and belly shape), separated by 30 years and a gene here and there. At first it was cute to hear the comments like, “Oh, he looks just like his dad,” or my personal favorite from my own father, “At least you never have to go on the Maury show.” Of course my husband soaked it up, cleverly responding with, “He’s a lucky guy to have features like these!”

Even though my son looks to me for love and snuggles, chooses me for bath time and bed time, and follows me around the house babbling “mamama,” the constant emphasis on his identical appearance to his father dominated every social encounter and introduction. As someone who has never placed much emphasis on looks (and who is a feminist at heart), it hurt to hear so much importance placed on the one thing we mostly cannot control about our lives – something that is determined far before we are born. In fact, I recently read an article about how little girls are addressed by adults; primarily they are told how “pretty” they are, and compliments revolve around their clothes and hair. I found myself strangely relating, even as a “boy mom,” to the desire for my child to first be seen as smart, curious, creative, and kind.

So, I began the resistance. One Sunday afternoon, a woman at the grocery store stopped to ogle at my son in the shopping cart, gleefully saying “Well, you just got all of your looks from your daddy didn’t you?” My time had come, and I quickly retorted: “We’re just hoping he gets my smarts!” I got a quick side glance from my husband, mostly out of shock. The woman smiled and moved on. Game, set, match, and victory, in my book.

Learning has always been very important to me, which is a trait I hope to pass to my son. As a kid, I loved learning, looked forward to school, and was THAT kid in the class. I was always the child in the front row, hand permanently wiggling in the air, ready for a question or challenge. However, the same love of learning also got me in trouble a bit. For instance, when I was a kindergartener, I once found myself in the principal’s office after a public showdown: My teacher questioned my reading abilities, and I prevailed. I was only trying to answer the question that was posed, but after a brief meeting with the principal, my dad explained to me the crucial difference between “smart” and “smart-aleck” as we pulled out of the parking lot. Side note: I’m pretty sure we stopped for ice cream on the way home.

Like children, nature’s expert learners and explorers, we, as child life specialists, also believe in the power of learning from experience. Volunteering, shadowing as a practicum student, and practicing with supervision through a child life internship, our training processes are deeply rooted in the idea of education as a lived process, a dialectic relationship between observing, doing, evaluating, and repeating. Furthermore, our interventions offer the same opportunities for children to engage in the moment with their surroundings as they construct an understanding of what an illness means for them and their family. Fundamental tools like play, socialization, and therapeutic relationships help draw the child into a space where learning and experiencing become one and the same.

Whether examining curriculum design, the concept of experiential learning, or applications through a teddy bear clinic in China, this issue reminds us of the value of learning through experience and of the supports that we can provide for one another to further our knowledge and skills. In addition, learning through experience is a theme that carries through our two new features in this issue, “Specialized Resources” and “Global Perspectives.” Both of these columns highlight the experiential knowledge of authors who are well-versed in particular patient populations or international frontiers of child life. Finally, the reprinted article in Focus highlights evidence for directed medical play in decreasing children’s distress and pain perceptions in the context of a burn dressing change procedure. Now, not only can we anecdotally speak to the power of medical play, but this article offers published results that further validate the claims of our field.

Education is a priority in the field of child life, whether in the classroom, the clinical training program, or the clinic itself. We should all be supported in learning to love, well, learning. No matter the setting, the words of John Dewey remind us that education is “a process of living and not a preparation for future living” (Dewey, 1897, p. 79). Thank you for looking to Bulletin as a staple feature of your educational process, growth, and life!

As you know, the Child Life Council is an active and thriving organization, dedicated to supporting our members and advancing the field for the children who benefit from our services. This is an exhilarating time to be involved in CLC, as there are so many new and exciting things going on! I’d like to take this opportunity to tell you about a few of the behind-the-scenes activities that will immediately and positively impact your experience as a CLC member.

We’re rebranding the association! As you know from reading the President’s Perspective column in this issue, the board has just approved our strategic plan for 2015 – 2018. One of the three major initiatives in our plan is CREDIBILITY: increasing the credibility of child life with key stakeholder audiences like hospital administrators, corporate funders, and government grant makers to ensure that every child and family has access to the work of a child life professional as an integral part of their comprehensive health care. One way we’re going to increase our credibility is by rebranding the association. Child life may be well known and accepted in children’s hospitals, but it is less familiar to audiences outside of our main bastions. Our name will always be the Child Life Council, but for audiences not familiar with what we do, we are creating a new graphic image (logo), taglines, and other messaging that better inform people outside of mainstream health care about the vital services we provide as part of the health care team and the difference we make to those children and families undergoing treatment at our facilities. That is the goal of our rebranding effort.

I mentioned in my first Bulletin column that the association will be introducing a new website that will be easier to use and offer greater functionality to members. We also plan to use the new website to leverage the new brand we’re creating to increase our profession’s credibility with several important stakeholder groups. The website will have specific pages and “user paths” designed for hospital administrators, designed to provide additional information on the vital role child life plays in health care and encourage support for child life programs. The same goes for pages and “user paths” designed for potential funders of our profession as well as parents and caregivers; the graphics, messages, and taglines for all of these audiences will be developed during the rebranding project. We are fortunate that the expense of rebranding and rebuilding our website has come from grant funding, so that member dollars won’t need to be tapped for these important efforts.

The CLC office has moved! Our lease for the old office expired at the end of August, and our move to a new location means that we’re able to restructure our internal departments to provide better service to our members. We are combining the staff from three separate areas (membership, certification, and administration), into a single department called the Member Service Center, which will be dedicated to responding to members questions, calls for service, and processing transactions. This one consolidated area will now be responsible for responding to your inquiries around member renewal, certification eligibility, testing, PDUs, and much more! What’s more, we are reprogramming our phone system so that when you call the CLC office you’ll be speaking with one of our staff members rather than speaking with a voicemail system.

We’re addressing the predicament with PDUs! Creating new continuing education choices is another priority for the Child Life Council. Gaining the PDUs to recertify every five years and staying current with the latest innovations and interventions is much easier if you can squeeze a webinar, grand rounds, or class into your schedule every few months. Don’t wait,

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Global Perspectives: Furthering Paediatric Psychosocial Services in South Africa

Karen van Zijl, CCLS, MDiac, PhD (candidate), President, Organisation for Paediatric Support in South Africa (OPSSA), Pretoria, South Africa

What a privilege it was to attend the two-day International Summit on Pediatric Psychosocial Services hosted by the Child Life Council in May 2014! To meet with people from around the globe, sharing the same passion as well as similar obstacles in advocating for paediatric psychosocial support in their respective countries, was exhilarating to say the least. My colleague and I returned to South Africa with renewed fervour to promote the rendering of paediatric psychosocial services within our health care sector.

South Africa faces unique challenges as a developing country, including a population consisting of more than 18 million children under the age of 18, constituting 36% of the total population (Hall & Sambu, 2015). There is only one free-standing paediatric hospital in the Southern African region, The Red Cross War Memorial Children’s Hospital in Cape Town. It is rare for hospitals to render any form of psychosocial support; most hospitals do not even have a play room. Currently we only have two hospitals that officially provide paediatric psychosocial services. We do have non-profit organizations as well as individuals in various professions who render some of these services. Currently I am the only South African who is a Certified Child Life Specialist, and I work from a private practice. We have one American Certified Child Life Specialist on the Organisation for Paediatric Support in South Africa (OPSSA) team, and my South African colleague completed the course work towards becoming a child life specialist but has not been able to complete an internship.

The most challenging aspect of providing psychosocial care in South Africa is the lack of experience and lack of awareness among medical staff regarding the need and value for psychosocial care. In addition, the lack of specialised academic training, the lack of funding, overall hospital staff shortages, and ever increasing patient numbers limit the growth of psychosocial services.

Returning from the summit our immediate plans were to develop an academic course and to establish an internship program at an academic hospital. Unfortunately, due to budget constraints, possible funding for such a program was postponed. The plans have been placed on ice and we at OPSSA went back to the drawing board to see what we could do to further child life as a profession in South Africa. We realised that we would have to be creative and think on our feet in our march to advance psychosocial services in children’s health care in South Africa while remaining culturally appropriate and relevant.

Our strategic action plan included the following activities:

- We presented training courses, with accreditation from the Health Professions Council of South Africa, to the staff of non-profit organizations that render psychosocial support to children. The courses included the following:
  - Utilizing the “Tree of Life” (REPSSI, 2015) technique with children and families affected by cancer
  - The rights of children in health care
  - Why hospitalization is traumatizing for children and ways to prevent trauma
  - Creatively facilitating resilience in traumatised children by utilizing play

- We have co-authored a manuscript in collaboration with American colleagues which has been accepted for publication in the South African Journal of Radiology. The article’s focus is on the value of psychosocial support within a radiology unit.

- We presented a three-day course to the 4th-year information design students at the University of Pretoria on the use of developmentally appropriate play towards the development of a tool kit for children addressing health care issues. The aim of the project was for the students to design a creative intervention for the purpose of cultivating health awareness in young learners and their parents/teachers. The project illustrated that information design could act as a catalyst for positive social change, specifically with regard to children’s health care.

Our plans for the future include:

- A two-day interdisciplinary academic conference in September 2016 on the rights of children in health care and the need for psychosocial support.
- Research projects in conjunction with the Youth Research Unit of the University of South Africa (UNISA) in the fields of play and paediatric psychosocial support.
- Research projects in conjunction with the University of Pretoria to test the tool kits designed by the information design students with hospitalised children.
- To co-author, develop, and present coursework on children’s rights in medical care as part of the planned Children’s Rights Certificate Course, in collaboration with the College of Law at UNISA, which is planned to roll out in 2016.
- The development of a forum where all parties who render some form of paediatric psychosocial service in South Africa can connect and dialogue.

Guided by the saying, “There is strength in unity,” our aim is to support all the individuals and non-profit organizations that are rendering psychosocial services in South Africa, as well as to advocate for the furtherance of these services. We are most grateful to the Child Life Council for their support towards attaining this goal.

References


Inflammatory Bowel Disease (Crohn’s Disease and Ulcerative Colitis)

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

Inflammatory Bowel Disease (IBD) is a broad label for two important gastrointestinal diseases: Crohn’s disease and ulcerative colitis. Although usually diagnosed in adolescents, these chronic illnesses may appear in earlier childhood, and are often diagnosed with a combination of lab tests and endoscopy/colonoscopy. IBD is a chronic condition that is closely controlled by medication, diet, and surgery. It impacts many parts of the patient’s life including school, participation in outside-of-school activities, pain control, and diet regulation.

Explanations for Children

Preschool: The part of your tummy where your poop is made is swollen and hurt.
School age: It is an illness where part of your intestines gets swollen or may have holes in it. It causes stomachaches, a hurting tummy, or problems with pooping. Sometimes it goes away for a while and sometimes it comes back.
Teens: It is a disorder where your immune system attacks your GI tract and causes inflammation. There can be a wide range of symptoms pertaining to digestion and going to the bathroom.

Books

Trachter, A. B. (2001). Coping with Crohn’s disease: Manage your physical symptoms and overcome the emotional challenges. Oakland, CA: New Harbinger Publications. [Strategies for coping with the daily physical effects of the illness, including physical activities and traveling and how to successfully manage pain. Also explores the significant emotional and psychological challenges that accompany the disorder.]

For more books, click here.

Children’s Books


Apps

Poop Log (free for Android). Records bowel movements using Bristol Stool Scale, including volume, time, and photos.
Bathroom Scout ($1.36 for Android, $.99 for iOS). Over one million public bathrooms mapped and rated.
Carezone (free for Android and iOS). Family organization app for those caring for someone with a chronic illness. Tracks appointments and medicines.
GI Monitor (free on Android and iOS). Tracks GI symptoms and pain levels; logs meals, stress patterns, custom symptoms. Can also talk to other patients in real time.
MyIBD (free on Android and iOS). Tracker from Hospital for Sick Children that tracks all symptoms of IBD, appetitive notes, and bathroom visits. Visually attractive app.

For additional apps, click here.

Child Life Teaching Tools

Cloth teaching doll with stoma: www.shop.shadowbuddies.org/Ostomy-Buddy-1104.htm
Video for school-aged children about digestive system: www.youtube.com/watch?v=-VwrsL-iCZYo
Chart of digestive system: www.amazon.com/Digestive-System-Anatomical-Laminated-Chart/dp/B000VH2TC/ref=sr_1_2?ie=UTF8&qid=1428348011&sr=1-2&keywords=anatomical+gastrointestinal
Anatomy apron showing internal organs (preschool level): www.amazon.com/MotivationUSA-ANATOMY-APRON/dp/B0015411C4

For additional websites, click here.

Websites

Crohn’s and Colitis Information. Despite being sponsored by a pharmaceutical group, a very strong website. Information provided to encourage self-advocacy and taking charge of a chronic illness. Includes an advocate program for patients 18+. Outstanding “Expert Advice” section that helps families understand symptoms and advocate for their children. www.crohnsandcolitisinfo.com/
Chronic Illness Support Community. Support information for many chronic illnesses including Crohn’s disease and ulcerative colitis. Includes message boards, information, and support groups. www.healingwell.com/ibd/
Crohn’s And Me. Sponsored by UCB Pharmaceuticals, this site has supportive materials for patients with Crohn’s disease. Links to Crohn’s Advocate magazine, with information, diet and nutrition, and the Crohn’s experience. www.crohnsandme.com
Living with Ulcerative Colitis. Canadian-based website sponsored by Janssen Inc. with information, support, find-a-doctor. www.livingwithuc.ca/

For additional websites, click here.

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Next Steps: Getting a Journal Club off the Ground

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

In the last “Pathways to EBP” column, we discussed beginning a journal club as a great way to start incorporating evidence-based practice (EBP) into your department. In this issue, we provide an example of an article, as well as discussion questions and tips for leading an interactive journal club. We hope that these tools will help you navigate your first journal club experience.

Identifying an Article

When seeking articles to discuss in journal club, don’t limit yourself to child life-specific titles and publications. By searching for keywords and topics from everyday child life practice, you can find a host of articles that are relevant. For example, by searching for terms such as pain management, assessment, pain, pediatric, children, intervention, and non-pharmacological, we were able to locate an article of interest to our team. This article appeared in the Journal of Pediatrics, and although it is not a child life-specific article or journal, it is very relevant as it emphasizes the importance of involving child life when developing a pain management program.

Developing Discussion Questions

Tips for generating discussion questions:
• Identify key components of the article relevant to your clinical practice.
• Choose questions that are thoughtful, open-ended, yet simple to identify within the article.
• Provide opportunities for questions to have multiple answers, allowing participants to identify and discuss content that is most meaningful and interesting to them.

Sample questions for the example article:
• What are some common obstacles to implementing a pain-management program? How did these programs overcome them?
• Which strategies do you see as essential elements in developing a pediatric venous access pain-management program?
• Which nonpharmacologic interventions mentioned in the article feel most useful to you?
• What content from this article can you incorporate into your clinical practice?

Troubleshooting

Programs continue to report that time is a factor to consider when implementing a journal club or engaging in EBP. While interactive in-person journal clubs can be very helpful, similar opportunities can be provided if this is not feasible at your institution. One possible solution is to hold journal club via teleconferencing or videoconferencing, allowing for staff from multiple buildings to participate together. Another possible solution is to partner with your institution’s eLearning department to make the articles available online. Discussion questions can be posted at the end of the article. This is a great way to track participation.

Tips for Facilitators

Thoughtfully read the article and be prepared to provide a summary for participants who may not have had the opportunity to read the article ahead of time. However, make the article available in advance and encourage participants to read it if possible. If there is a lull in discussion, ask participants to discuss ideas from the article that they can implement into their practice.

Journal club is meant to be inviting and exciting, encouraging stimulating discussion of relevant topics. We hope this toolkit will contribute to the success of your first journal club.

If you have a specific question or challenge related to engaging in the EBP process, the Child Life Council Evidence-Based Practice Committee is available to help. Email ebp@childlife.org for assistance.
Interpreting Silent Cries: Providing Child Life Services to Children with Severe Cognitive Impairment and Altered States of Consciousness

Vanessa Andrews, MA, CCLS, ATR-BC, LCAT
Elizabeth Seton Pediatric Center, Yonkers, NY

Children with severe cognitive impairment and/or altered states of consciousness, either organic in nature, due to multiple, prolonged medical interventions, or arising from traumatic brain injury, often become lower priorities for child life specialists due to the subtleness of their stress response and their inability to verbally communicate and interact. When faced with balancing the needs of a child who can verbalize discomfort and a child with severe cognitive impairment, the ‘squeaky wheel’ is typically prioritized. However, quiet as they are, children with cognitive impairments feel both pain and apprehension not only during medical interventions, but often in response to stimuli that a typically developing child would not find uncomfortable (e.g., light, noise, brushing hair or teeth, bathing, transitioning) (Kranowitz, 2005). On an average day, children with severe cognitive impairment are bombarded with anxiety-producing stimuli that they lack the cognitive capacity to process. The result is a child who is frightened, isolated, unable to express themselves, and often without the support they need to effectively cope (Auer & Blumberg, 2006).

A well-intentioned caregiver once told me that a child she was working with (who had a trach and was non-verbal) did not react to blood draws or other painful stimuli. I watched as two tears slid silently down the child’s cheeks and though her facial expression never changed, her arm pulled back from the needle just enough to indicate her awareness. Despite her inability to communicate, she was indicating discomfort, but because pain was being assessed as “vocal crying,” the child’s cues, and an opportunity for support, were overlooked. When a child with severe cognitive impairment perceives stressors, subtle (but often visible) signs indicate distress (e.g., heart rate can increase, oxygen levels may decrease and/or a sudden bowel movement can occur). The child may instinctively draw back from the perceived stressor or exhibit decerebrate (extensor) posturing (the child will suddenly arch her head back, thrust out her tongue, and extend her legs and arms). Despite the absence of a typical verbal cry, a child with cognitive impairment often cries out physically for comfort. To assume a child is not feeling pain because she does not have the cognitive capacity to express it vocally would be inaccurate. Observing each subtle cue is imperative to assessing and providing supportive interventions. Including caregivers is equally important as they are often the best reporters of how their child is coping. Simply asking the family to tell you about their child is a great way to discover effective interventions (Rollins, Bolig, & Mahan, 2005).

Learning to interpret a child’s subtle cues is challenging, but finding ways to prepare, support, and increase coping can be even more difficult. A typically developing child learns about his world through his senses (hearing, seeing, smelling, touching, and tasting are external senses, while vestibular and proprioceptive are internal) (Kranowitz, 2005), but a child with severe developmental delay may only have one or two senses intact or may have over-functioning senses, making it difficult for him to process his environment. An assessment of the child’s sensory profile and how he interacts with and interprets his surroundings (e.g., fascination with a spinning light toy, auditorily ticklish, tactile seeking, enjoys deep pressure/womb like environment) can provide valuable information on how best to support the child through his functioning senses while avoiding senses that may be hyperactive.

External Senses

Once the child’s sensory profile has been evaluated, effective interventions can be implemented to meet her specialized needs. For example, during a tracheostomy change with a child whose vision is intact but who has limited or no ability to hear, using a mirror can give information visually which may not be able to be processed auditorily. Utilizing toys that light up, vibrate, or are visually stimulating, or simply allowing the child to feel your throat as you explain the procedure can give her something on which to refocus. Playing for a child with hearing deficit (or any child who is unable to play independently) can also be beneficial. Watching a specialist play out a tracheostomy change, blood draw, or other procedure can help her understand what is next, even if she is unable to manipulate the materials independently (Gaynard et al., 1998).

Conversely, a child who cannot see, but is able to hear, may find loud sounds, bright lights, or many voices speaking simultaneously confusing and frightening, especially when he already struggles to process his environment. Utilizing the ONE VOICE 4 Kids (n. d.) technique, rhythmic speech, or low shushing sounds close to the ear allows the child to refocus on the relaxing sounds. Additionally, relaxation music can change the environment of the procedure and often simultaneously helps staff relax. Lastly, a child who is visually impaired may have difficulty regulating pupil dilation and filtering out
bright light. Placing sunglasses or a soft dark cloth over the eyes can eliminate light as a source of discomfort. This is especially useful during dental visits where bright light is prominent.

A child with hearing and vision impairments can learn about her world through her tactile sense. Understanding the spectrum ranging from sensory-seeking to tactile-defensive can help tailor the intervention to the child. A child who is tactile-seeking enjoys textured distraction items such as a rough piece of fabric, a vibrating pillow, smooth plastic, or a bumpy squeeze ball. On the other hand, for a child who exhibits tactile defensiveness, giving them tactile input can cause further agitation and other sensory methods should be explored (Kranowitz, 2005).

Often, a child with severe cognitive delay seeks sensory input through his mouth. Repetitive chewing and sucking can be both relaxing and fulfill an oral sensory need. Similar to infants who derive comfort through sucking, a child with cognitive delay may enjoy utilizing specialized chew tubes that help her stay still and calm during procedures and other daily activities (Kranowitz, 2005). Conversely, some children can be orally defensive and may benefit from subtle cues (gentle cheek massage, resting hand near mouth, or gentle gum massage with the help of a speech therapist) that help “wake-up” their mouth, especially during invasive dental procedures.

**INTERNAL SENSES**

Proprioception (the perception of where your body is in space) is an important sense to evaluate when attempting to help a child with severe cognitive delay cope with medical procedures. Due to a highly disorganized neurological system, a child with severe cognitive impairments may have difficulty regulating her proprioceptive system. Often, she will flail her arms, wiggle, and have difficulty calming (Kranowitz, 2005). Staying still for a procedure is difficult for a typically developing child, but for a child with proprioceptive impairment, it can be impossible. Asking a child to stay still is unreasonable due to her inability to process the directive or control the movement. Helping her become ‘centered’ by modifying proprioceptive input allows her to refocus on coping rather than staying organized. Weighted blankets or vests, swaddling, therapeutic touch, infant massage, and Reiki all provide proprioceptive input, improving body awareness and attention while simultaneously calming the child. Additionally, utilizing positions for comfort or providing resting hands on shoulders, legs, or arms can help the child cope. The power of simply being present is often underutilized reminding them they are not alone.

Often, their inability to advocate for themselves, their sensory deficits, and their difficulty interpreting the world leave children with severe cognitive impairment extraordinarily vulnerable to stress, anxiety, and trauma. Child life specialists may feel helpless to intervene due to inexperience or lack of knowledge about this population. However, though their ability to communicate is minimal and their cries often silent, each of these children can benefit tremendously from assessment, preparation, therapeutic play, and support for medical procedures. Though children with severe cognitive impairment struggle to communicate, their relief at being understood radiates once their subtle language is interpreted. With attentive observation, accurate assessment, and appropriate implementation of specialized interventions, child life specialists can support each child to minimize stress and enhance quality of life.

**REFERENCES**


**UPCOMING CLC WEBINARS**

To meet member requests for more webinars on a variety of topics, CLC has scheduled frequent sessions for the remainder of this year, and several webinars are already on the calendar for next year.

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

For details of each session and to register for a webinar, see the webinar page on the CLC website. Check back often, as the schedule will be updated as new sessions are added!

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

October 7 — ***The First Year: Establishing a Child Life Program in a Maternal-Fetal Center

October 14 — Empowering Smaller Programs to Make Bigger Impacts

Thursday, October 22 — ***Spirituality of Children: A Multidisciplinary Approach to Supporting Children Through Change, Grief and Loss

October 28 — ***Moving Past Pinwheels and Prep Books: Preparation and Procedural Support for Adolescents and Young Adults

November 4 — ***Child Life Services in an Adult Setting: Transitioning Child Life Skills to Serve Children of Adult Patients

November 11 — Leading the Way for New Hires: Creating a Child Life Preceptor Program

November 18 — Helping Families with the Unique Challenges of Type 1 Diabetes Management

2016

January 13 — “But They Are Too Little to Understand!” Helping Very Young Children Cope with Parental Illness

January 20 — Ways to Plan and Prosper: Insights from a Financial Planner

January 27 — Everywhere You Look — Play is Possible

February 10 — A Comprehensive Approach to the Training, Management, and Retention of a Child Life Volunteer Program

March 2 — Legacy of Life: The Importance of Activities for Chronically Ill Patients

March 16 — Yellow Belt, Purple Belt, Black Belt - Introducing Operational Efficiency & Lean Six Sigma to the Field of Child Life

*** Best of Conference 2015
Applying Experiential Learning to the Child Life Classroom

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The things we must learn before doing them, we learn by doing them. – Aristotle

The journey from child life student to working professional requires a great amount of learning. University and college programs offer a range of courses covering theory and techniques fundamental to the profession. For most aspiring child life specialists, however, it is with their first experiences using classroom knowledge to “do” child life that the real learning begins.

As an instructor of child life, I often wonder how to give students more opportunity to learn by doing. Internships and practicums already exist in child life curricula to help students learn by working directly in health care settings with children, families, and health care professionals. Integrating classroom knowledge with authentic clinical practice engages students in an effective learning process known as experiential learning. The question I found myself repeatedly asking was whether experiential learning also had a place in the child life classroom.

Experiential learning, most attributed to educational theorist David A. Kolb, is the process involved in making sense of authentic experience. Kolb (1984) posited that this learning process extends beyond the experience itself. True learning, according to Kolb, required that the experience be “shared and interpreted through dialogue with one another” (p. 2). The Association for Experiential Education (n.d.) further described experiential learning to occur when “educators purposefully engage with learners in direct experience and focused reflection in order to increase knowledge, develop skills, clarify values, and develop people’s capacity to contribute to their communities” (para. 2).

To create an experiential learning opportunity for a child life class, I, as an educator, would need to provide a real-world situation with problems to solve and decisions to make. In turn, students would need to take initiative and face the possibility of learning from authentic consequences, either mistakes or successes. Finally, critical reflection and dialogue could allow students to transform their authentic consequences, either mistakes or successes. Finally, critical reflection and dialogue could allow students to transform their experience into a new, more sophisticated body of knowledge.

While preparing to teach Child Life Clinical Issues and Techniques, a classroom-based course, I became determined to incorporate this experiential learning process. I wanted the students in this class to learn more than just words and key phrases that represented techniques for the field; I wanted them to begin to understand how to use those techniques. To this end, I added an assignment to create an off-site teddy bear clinic to the course agenda. I was ready to challenge students to learn child life skills by actively using them in a real-life context.

As the educator, my role in the teddy bear clinic assignment included “setting a suitable experience, posing problems, setting boundaries, supporting [students], insuring physical and emotional safety, and facilitating the learning process” (Association for Experiential Education, n.d., para. 3). To set boundaries, I limited the focus of the teddy bear clinic to a wellness visit at a primary care pediatrician’s office. I acquired a group of participants for the event by contacting a community MOMS Club. Finally, I reserved a suitable venue in the community for the students to use. I then stepped back for the remainder of the semester and allowed students to take initiative in planning how best to accomplish their task.

Every student accepted the challenge and found a way to use their strengths to contribute to the planning of the event. Some recognized the need for organization and assigned class members to stations representing various steps in a pediatric check-up. Another took on the role of creating a budget proposal to present to our department chair. Enthusiastic discussions occurred every week surrounding topics such as age-appropriate language for the medical information, building rapport with the children in attendance, and setting up child-friendly displays and activities. The characteristics of experiential learning were evident as the students posed questions and creatively problem solved. I supported the process and resisted making recommendations unless needed to avoid physical or emotional risk to participants.

Following the teddy bear clinic, students engaged in two forms of critical reflection: class discussion and exam essay questions. Observations and connections made by students were insightful. One student, who was simultaneously completing her child life practicum, thoughtfully contrasted working with well children to working with children needing medical treatment. Another student, whose main experience with children was through her work at a daycare center, reflected on behavioral differences in children when accompanied by a caregiver and when lacking a well-established level of trust in her. Elements of program implementation were also discussed, including participant flow from station to station and the effectiveness of the chosen language, props, and games.

Over the course of this experiential learning assignment, I observed students effectively translating conceptual information into practice. For instance, the students all knew that children need concrete, simple explanations of medical information. To successfully prepare for the event, they questioned what those explanations should sound like, investigated language options, and made decisions regarding how best to describe the equipment or procedure showcased at their station. They then practiced using child-friendly language in a real-life context with authentic responses from children. Knowledge and practice were integrated, and the result was a deeper level of understanding.

From this teddy bear clinic assignment, I concluded that experiential learning could be successfully integrated into a classroom-based child life course. In an appropriately controlled, real-world setting, my students directly applied child life techniques while working with children and caregivers. As Aristotle suggested in the opening quote, they learned how to “do” child life by doing child life.

References


Play has an impact. The primary tool of child life specialists is play. Much time is spent advocating for play in the health care setting and educating others about the positive impacts of play on both development and the responses of children to the health care setting. Frequently, however, demonstrating positive impacts of play can be difficult, and sometimes not as impactful as we would hope. This study examines the effects of directed medical play on the pain and distress responses of young children undergoing burn wound care. Three gaps in the literature are addressed with the study participants and intervention: burn wound care, very young children, and the use of medical play.

As was mentioned in the editor's column, many of the articles in this issue have an underlying theme of learning through experience. While this study does not examine participants' experiential learning, per se, it's important to note that the process of designing, implementing, and publishing a study with a collaborative research team can be a valuable, time consuming, and eye-opening learning experience for anyone, but in this case, a child life specialist.

The "backstory" of this study involves perseverance in finding and maintaining a research team, sometimes over a few years. A collaborative team can share strengths and expertise as well as balance out gaps in knowledge. In particular, the literature review conducted as a part of this study can be valuable to child life specialists in noticing how few empirical studies are published on the use of directed medical play in health care settings. With the team including seasoned nursing researchers, there are also insightful perspectives shared about nurses' role in using play to support pediatric patients. Child life specialists can use this information to continue to advocate for play in health care settings.

— Katherine Bennett, MEd, CCLS

The Effect of Directed Medical Play on Young Children’s Pain and Distress During Burn Wound Care

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Abstract

Directed medical play is used to reduce children's pain and distress during medical treatment. In this pilot study, young children who attended the burn clinic received either directed medical play provided by a child life specialist or standard preparation from the burn clinic nurse to prepare for their first dressing change. Data were collected using validated instruments. Children who participated in medical play experienced less distress during their dressing change (M= 0.5, n=12) than did those receiving standard preparation (M=2.0, n=9). Children who received standard care reported a 2-point increase in pain during the procedure, whereas children who participated in medical play reported a 1-point increase. Change in parental anxiety was similar for both groups. Parent satisfaction was higher for caregivers who observed medical play than standard preparation. Although all findings were in the hypothesized direction, none were statically significant, most likely because of the small sample size. J Pediatr Health Care. (2015). 29, 265-273.

Key Words

Medical play, procedural distress, young children, pediatrics

Children with burn injuries are likely to face multiple painful procedures throughout the course of medical treatment. Children may display outward negative reactions to medical procedures (Burnstein & Meichenbaum, 1979; Lumley, Melamed, & Abeles, 1993). The discomfort and distress associated with painful medical procedures


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has demonstrated long-term negative effects for patients and their caregivers, including eating and sleeping disturbances, decreased cooperative behavior, increased fears, and post-traumatic stress (De Young, Hendrikz, Kenardy, Cobham, & Kimble, 2014; LaMontagne, Wells, Hepworth, Johnson, & Manes, 1999; Lynch, 1994; Roberts, Wurtele, Boone, Ginther, & Elkins, 1981; Tiedeman, 1997). Therefore, strategies designed to reduce the pain and distress associated with burn wound care procedures should be considered as a means of improving the overall experience for children and their caregivers.

When investigating a child’s distress during burn wound care procedures, the caregiver’s emotional state is important to consider. For example, parents/guardians of pediatric patients with burns have been shown to exhibit significantly higher levels of anxiety and depression than the general population (Phillips & Rumsey, 2008), with as many as 69% showing levels of anxiety outside of normal boundaries. A body of research provides evidence to support the idea that a caregiver can impact the distress and pain responses of a child (Blount et al., 1989; Bush, Melamed, Sheras, & Greenbaum, 1986; George & Hancock, 1993; Koller, 2008; Spagrud et al., 2008; Wolfer & Visintainer, 1975). Therefore, understanding the role of medical play as potentially mitigating parental distress is an important consideration. The positive impact of medical play on the pediatric patient could directly affect parental anxiety and satisfaction with the care received, as well as facilitate greater understanding of the specifics of the procedure. Information of this kind could foster greater parental self-confidence in support of their child during the wound care procedure, decrease anxiety, and promote a more positive experience. Based on the evidence, it is plausible that lowering parental anxiety could then lower child distress and anxiety (Chambers, Craig, & Bennett, 2002).

A large body of research on the construct of psychological preparation has shown that some form of information provided to children and teens prior to a medical experience can reduce the child or teen’s anxiety and distress. Three components of psychological preparation that have been identified as essential to effective interventions include: (a) providing developmentally appropriate information, (b) providing opportunities for emotional expression, and (c) establishing trust with the pediatric health care team (Felder-Puig et al., 2003; Hatava, Olson, & Lagerkranser, 2000; Thompson, 2009; Wolfer & Visintainer, 1975).

Directed medical play incorporates many of the basic elements of preparation and further provides the opportunity to examine and manipulate medical equipment, process procedural information, and gain mastery, all in a playful, non-threatening environment (Gaynard et al., 1998; Webb, 1995). To be clear, the construct of medical play is described utilizing terms such as therapeutic play, role play with medical equipment, health care play, and even a literal description of play with medical themes and/or equipment in the literature. For the purpose of this study, the term “directed medical play” refers to a play activity with children involving the use of actual or toy medical equipment in playful, pretend, exploratory, and educational ways with the presence of a supportive, knowledgeable adult.

Child life specialists use expertise in child development to assess the needs of children in health care settings and provide interventions to prevent and decrease the negative impact of the novel and/or stressful health care events on a child’s development (Koller, 2008). In fact, as child life practice is more thoroughly examined in the literature, the therapeutic presence of child life specialists has been demonstrated to be valuable (Smith, Murray, & McBride, 2011). Using play as a primary tool, child life specialists practice with the following three major goals:

1. To build therapeutic, supportive relationships with children and their families
2. To provide consistent play opportunities to normalize the environment
3. To provide education about the health care environment through the use of developmentally appropriate language and preparation tools

Thus, this study focused on directed medical play delivered by child life specialists.

**About the Views Expressed in Focus**

It is the expressed intention of *Focus* to provide a venue for professional sharing on clinical issues, programs, and interventions. The views presented in any article are those of the author. All submissions are reviewed for content, relevance, and accuracy prior to publication.

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medical play or therapeutic play to reduce anxiety, distress, or pain in children during medical procedures. Eight articles were removed because they were case studies, qualitative in nature, or literature reviews, and an additional seven were removed because they did not meet inclusion criteria. Four studies remained from the systematic search to include with the five studies that the research team and other content experts had identified. In total, nine studies were found to provide relevant empirical evidence about the use of therapeutic play in healthcare settings.

**STUDY DESIGNS AND SUBJECTS**

Of the nine studies identified, four were quasi-experimental in design (Bloch & Toker, 2008; Brewer, Gleditsch, Syblik, Tierjens, & Vacik, 2006; Hatava et al., 2000; Zahr, 1998) and five were randomized controlled trials (Burns-Nader, Hernandez-Reif, & Thoma, 2013; Li, Lopez, & Lee, 2007; Li & Lopez, 2008; Wee, Chan, Cheung Li, & Hong-Gu, 2014; Wölfer & Visintainer, 1975).

The children who participated in all of the studies were between the ages of 2 and 12 years, with only two of the studies including children as old as 12 years (Li et al., 2007; Li & Lopez, 2008). The studies were culturally diverse, with enrollment of children from North America (Brewer et al., 2006; Burns-Nader et al., 2013; Wölfer & Visintainer, 1975), Israel (Bloch & Toker, 2008), Lebanon (Zahr, 1998), Sweden (Hatava et al., 2000), Singapore (Wee et al., 2014) and Hong Kong (Li et al., 2007; Li & Lopez, 2008).

**MEDICAL PLAY PROCEDURES**

The specific intervention of directed medical play was implemented in several ways in the studies. Six studies utilized directed medical play provided by nurses, physicians and/or the researchers whose backgrounds were in medicine, as a tool for preparation for upcoming surgical procedures (Hatava et al., 2000; Li et al., 2007; Li & Lopez, 2008, Wee et al., 2014; Wölfer & Visintainer, 1975; Zahr, 1998). In three studies (Hatava et al., 2000; Li et al., 2007; Li & Lopez, 2008), directed play took place in a group setting of 5 to 6 children in the operating room several days before surgery. The equipment involved in anesthesia induction (such as a blood pressure cuff, pulse oximeter, intravenous tubing, electrocardiogram electrodes, and an anesthesia face mask) were demonstrated by a nurse, and children had the opportunity to role play the procedures with a doll. In the study by Wölfer & Visintainer (1975), children were given accurate information about surgery, including the sequence of events, sensory information, child role expectations, and appropriate responses, along with previews of procedures using play techniques. In the study by Zahr (1998), children were provided with therapeutic play in the form of an interactive puppet show pertaining to the surgery.

**The positive impact of medical play on the pediatric patient could directly affect parental anxiety and satisfaction with the care received, as well as facilitate greater understanding of the specifics of the procedure.**

Two of the studies used some form of medical play (directed and one nondirected) provided by child life specialists (Brewer et al., 2006; Burns-Nader et al., 2013). The study by Burns-Nader, Hernandez-Reif, and Thoma (2013) contained four activities occurring in a pediatrician’s office: nondirected medical play, a medical information video consisting of a taped play session, diversionary play using a board game, and a control safari video. Children (5½ to 12 years old) were randomly assigned to one of these activities.

The study by Bloch and Toker (2008) was different from the other studies reviewed in that it provided directed medical play in a “teddy bear hospital.” This half-day intervention was conducted in a play hospital setting with medical students as the “physicians.” The children selected a “diagnosis” for their self-identified toy (a doll or teddy bear). The medical students conducted a physical examination on their toy, and the children were encouraged to perform examination procedures. Although the children in this study were not currently hospitalized, all research-related observations took place at a medical center, in a central courtyard setting. The study specifically measured a child’s self-reported anxiety, on a visual analog scale, toward a potential hospital admission both before and after directed medical play.

**FINDINGS IN THE INCLUDED STUDIES**

State anxiety, or transitory unpleasant feelings of tension, worry, nervousness, or apprehension experienced in specific situations (Spilberger, Gorsuch, & Lushene, 1970), of children was the most common outcome measured. In fact, investigators who measured anxiety found that it decreased significantly in the groups provided with some form of therapeutic play with a medical theme (Bloch & Toker, 2008; Brewer et al., 2006; Li et al., 2007; Li & Lopez, 2008). Wölfer and Visintainer (1975) found that children and parents in the intervention group showed significantly less upset behavior, more cooperation, and fewer negative posthospital adjustment behaviors than those in the control group. Zahr (1998) and Wee, Chan, Cheung Li, & Hong-Gu (2014) also reported the findings of fewer negative posthospital upset behaviors.

Three of the studies examined children’s responses at time of anesthesia induction and found that those who received some form of directed medical play as a part of preoperative preparation were calmer and had fewer negative responses surrounding anesthetic events (Hatava et al., 2000; Li et al., 2007; Wee et al., 2014; Zahr, 1998). The study by Burns-Nader and colleagues (2013), however, had conflicting findings in that the children who received nondirected medical play had more difficult behaviors and lower moods at a pediatrician’s visit than did those who watched a video or engaged in activities unrelated to the medical setting.

Two studies found that physiological responses of children, including decreased blood pressure and pulse rates, shorter time to first void, and ease of fluid intake postoperatively, were all significantly better in children who received the intervention involving medical play (Wölfer & Visintainer, 1975; Zahr, 1998). Li, Lopez, and Lee (2007) and Wee and colleagues (2014) also measured postoperative pain and found that children in the experimental group had lower levels of postoperative pain, but these results were not statistically significant.
None of the other studies measured pain outcomes.

Also examined in two of the studies were parental anxiety and satisfaction with the information and care provided. Parents in the intervention groups reported significantly lower anxiety when either observing the preparation and medical play provided to their children or directly receiving information themselves (Li & Lopez, 2008; Wolfer & Visintainer, 1975).

Across these studies, findings on child behavior and physiology were consistently in favor of medical play, with the exception of one investigation. The study by Burns-Nader and colleagues (2013) was different in that it utilized a nondirected medical play group. Children in the medical play group exhibited more distress behaviors than did those in the other three groups during nurse triage procedures. Perhaps play needs to be directed, with procedures being performed on a doll in the same manner and sequence that they will be conducted on the child, to decrease the child’s distress. Unstructured play, where the child explores the equipment that interests them, may not be as effective in reducing anxiety preprocedurally or for this age group.

**Gaps in Current Research**

The selected articles were all relevant to the current study; however, this study attempts to begin filling some important gaps in the research literature. First, only two of the studies measured pain as an outcome. Pain is one of the primary outcomes measured in the current study. Also, the body of evidence, although mostly consistent in its findings, is still relatively small on the use of directed medical play and its impact on young children in health care settings. In addition, only one of the studies utilized child life specialists in providing directed medical play and preparation (Brewer et al., 2006). Although nurses are able to incorporate play and preparation into care, child life specialists have unique qualifications and training, allowing them to focus specifically on these elements of pediatric care. This study utilizes child life specialists to provide directed medical play. Finally, no studies were located that focused on the impact of directed medical play on the pain, distress, and anxiety experienced by the pediatric burn population and the caregivers of these children. The potential benefits of the current study include extending our knowledge of effective methods to prepare young children for painful medical
procedures to include therapeutic play as a tool to increase understanding and decrease anxiety, pain, and distress in children.

The objective of this study was to investigate whether children between the ages of 3 and 7 years with burn injuries who receive directed medical play delivered by a child life specialist just before their first burn wound dressing change would (a) self-report less pain and (b) show fewer pain/distress behaviors than children who have standard burn wound care preparation provided by a burn clinic nurse (standard care). Secondary outcomes were parent state anxiety and satisfaction with burn wound care.

**METHOD**

A quasi-experimental design was used for this pilot clinical intervention study. Participants were assigned to groups based upon the day of their clinic appointment. A child life specialist was available to conduct the study intervention three mornings a week. During the period of enrollment, young children and their caregivers who consented to participate in the study on these three days received directed medical play. Children who received care on the two days the child life specialist was not available received standard care provided by the burn clinic nurse.

**SETTING AND SAMPLE**

Data were collected from an outpatient facility located immediately outside of the Inpatient Burn Unit in a large academic medical center. The clinic serves children and adults from a wide geographical area in the southeastern United States. The staff includes a nurse manager, nurse practitioner, two burn wound specialists, and a medical receptionist.

Children and their parent/guardian were recruited from the Burn Clinic between November 2010 and June 2012. Eligibility criteria included children who were between the ages of 3 and 7 years, receiving their first burn wound care procedure in the Burn Clinic, and who provided assent. Inclusion criteria for the parent or guardian were being 18 years or older, being able to read and understand English, and being able to provide informed consent. If the child required intravenous sedation during the procedure, refused participation, or became otherwise unable to communicate during wound care, the child was withdrawn from the study. This study was approved by the Vanderbilt University Medical Center Institutional Review Board and included parental informed consent and child assent procedures.

**MEDICAL PLAY INTERVENTION**

Within the scope of this study, the effects of only guided, or directed, medical play were examined. The directed medical play session was introduced to each study participant using a standard script. The child life specialist assessed the interests and nonverbal cues of each child (e.g., withdrawal or engaging) to meet the ultimate goals of mastery, control, education, and familiarization.

To standardize each medical play session, the same group of medical equipment (blood pressure cuff, thermometer, scissors, tweezers, washcloths, play camera, ointment/cream, commonly used dressings, gauze, tape, Ace wraps (3M, Maplewood, MN), Acticoat (Smith & Nephew, Andover, MA), and a teaching puppet or doll) were offered to each child to manipulate and play with in the same sequence the child experiences during burn wound care, guided by the child life specialist. This process is typical of the current standard of care provided by the child life specialist in the burn center.

**STANDARD CARE**

Children were prepared for the burn wound care procedure by the burn clinic staff using verbal explanations of the procedure. The burn clinic staff prepared the patient and family member in the treatment room just prior to the procedure and had access to toys that may be used to distract the patient during the procedure.

**MEASURES**

All self-report instruments were administered verbally by a member of the research team in a room selected for privacy in the burn clinic. The parent/guardian completed a State-Trait Anxiety Inventory (STAI; Spielberger, et al., 1970) and a demographic information form prior to the burn wound care procedure. Child participants were oriented regarding how to rate their pain using the Faces Pain Scale (FPS; Belville & Seupaul, 2005; Hicks, Von Baeyer, Spafford, Van Korlaar, & Goodenough, 2001) (minimum = 0, maximum = 6) and asked to try using the FPS to complete a preprocedure pain measure. Children completed the single-item FPS twice after the wound care procedure. Immediately after the procedure, they were asked to remember how they felt while having the old dressing removed and to choose the face for how they felt during that time for the during-procedure measure. Then they were asked how they felt now that the dressing change was finished for the postprocedure measure. In addition, child pain and distress behaviors were observed by a trained member of the research team during the entire burn care procedure. The observed behaviors were recorded using the Face, Legs, Activity, Cry, Consolability scale (FLACC; Merkel, Voepel-Lewis, Shayevitz, & Malviya, 1997; Nilsson, Finnstrom, & Kokinsky, 2008) The FLACC is composed of five categories—Face, Legs, Activity, Cry, and Consolability—each of which is given a score of 0 to 2. Higher scores on the FLACC indicate higher levels of distress. Immediately after the procedure, the parents completed the STAI again, as well as a parent satisfaction questionnaire (How Did We Do?). The internal consistency of the STAI scores prior to the procedure was 0.92 (Cronbach’s α); after the procedure the respective reliability was 0.94.

**STATISTICAL ANALYSIS**

Data were entered into an IBM SPSS Statistics database (IBM, Armonk, NY) by a research assistant. To ensure accuracy of data entry, the principal investigator randomly selected 10% of the records for double entry checks. Frequency distributions of all raw data were evaluated for any outlying values and checked against the values recorded on the respective data collection sheet. Nominal and ordinal data were summarized using frequency distributions. Because of the small group sizes (N = 9 and 12), continuous data were summarized using median and minimum, maximum values. Demographic and clinical characteristics were compared using χ² tests of independence (nominal, ordinal variables) and Mann-Whitney tests (continuous variables). Mann-Whitney tests were also used to test for differences between the measures with a single pre-post score (e.g., length of time for preparation and the procedure, FLACC, and parent satisfaction). Linear mixed-effects analysis using a tweedle with log-link function was used to test for differences in the patterns of change in the FPS and STAI scores between the two study groups. All tests of statistical significance maintained a Type I error rate of 0.05 (i.e., p < .05).

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RESULTS

Twenty-one children participated in this pilot study, with 12 in the medical play group and 9 in the standard care group. The Figure depicts the participant flow through this quasi-experimental study. Both male and female children were enrolled. The majority of children attended preschool or kindergarten. Most of the caregivers were mothers with a high school or college education and a White racial background. No statistically significant between-group differences were observed in the demographic characteristics (see Table 1).

The majority of burns (n = 6) were caused by a hot water, coffee, or tea spill. All of the children (except three) had second-degree burns. Two children had more severe first-degree burns. One child in the medical play group had first-, second- and possibly third-degree burns. Typically, children with more superficial first-degree burns are treated by their family at home and do not require a dressing change in the burn clinic. Children with more severe third-degree burns are hospitalized and undergo multiple dressing changes before their first appointment in the Burn Clinic. Clinical characteristics of the children and the burn are summarized in Table 2. A statistically significantly higher percentage of children in the medical play group had burns to the arms and hands compared with the standard care group (8 of 12 [66.7%] vs. 0 of 9 [0.0%]). The standard care group was composed largely of children with burns to legs, feet, and multiple locations (6 of 9 [66.6%]; \( \chi^2(3) = 9.7, p = .021 \)).

Two children (one in each group) received stitches in the past year. This previous experience could have contributed to their pain perceptions and behavior during the burn wound dressing change. Three children had medical conditions (asthma, kidney surgery at 2 months of age, hernia repair at 6 months of age) that were less likely to contribute to their pain experience during the procedure. Two children (one in the medical play group and the other in the control group) had unspecified previous medical procedures.

Seven of 12 children in the medical play group received premedication for pain before their first burn wound dressing change. Four of these children received a premedication containing codeine, two...
Table 2. Child Clinical Characteristics

<table>
<thead>
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<th>Overall (N=21)</th>
<th>Medical Play (N=12)</th>
<th>Standard Care (N=9)</th>
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<td>Other medical conditions</td>
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<td>3 (25.0)</td>
<td>4 (44.4)</td>
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<td>Time since burn</td>
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<td>1 day</td>
<td>11 (52.4)</td>
<td>7 (58.3)</td>
<td>4 (44.4)</td>
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<td>5 (55.6)</td>
<td></td>
</tr>
<tr>
<td>Location of burn</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arms, hands</td>
<td>8 (38.1)</td>
<td>8 (66.7)</td>
<td>0 (0.0)</td>
<td>0.021</td>
</tr>
<tr>
<td>Chest, abdomen</td>
<td>4 (19.0)</td>
<td>1 (8.3)</td>
<td>3 (3.3)</td>
<td></td>
</tr>
<tr>
<td>Legs, feet</td>
<td>3 (14.3)</td>
<td>1 (8.3)</td>
<td>2 (22.2)</td>
<td></td>
</tr>
<tr>
<td>Multiple locations</td>
<td>6 (28.6)</td>
<td>2 (16.7)</td>
<td>4 (44.4)</td>
<td></td>
</tr>
<tr>
<td>Pre-medicated for pain</td>
<td></td>
<td></td>
<td></td>
<td>0.577</td>
</tr>
<tr>
<td>No</td>
<td>7 (33.3)</td>
<td>5 (41.7)</td>
<td>2 (22.2)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14 (66.7)</td>
<td>7 (58.3)</td>
<td>7 (77.8)</td>
<td></td>
</tr>
<tr>
<td>Length of time burn</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>wound care prep (minutes)</td>
<td>19, 5.0 (0.25)</td>
<td>10, 10.0 (5.14)</td>
<td>9, 1.0 (0.25)</td>
<td>0.004</td>
</tr>
<tr>
<td>Length of procedure</td>
<td>21, 25.0 (6.94)</td>
<td>12, 29.0 (6.94)</td>
<td>9, 20.0 (11.60)</td>
<td>0.476</td>
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Table 3. Summaries of Key Study Variables

<table>
<thead>
<tr>
<th></th>
<th>Overall (N=21)</th>
<th>Medical Play (N=12)</th>
<th>Standard Care (N=9)</th>
<th>p-value</th>
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<tr>
<td>Child pain (FPS) a</td>
<td></td>
<td></td>
<td></td>
<td>0.717</td>
</tr>
<tr>
<td>Baseline</td>
<td>20, 1.0 (1.7)</td>
<td>12, 1.0 (1.7)</td>
<td>8, 1.0 (1.2)</td>
<td></td>
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<tr>
<td>During dressing change</td>
<td>14, 3.0 (1.7)</td>
<td>7, 2.0 (1.7)</td>
<td>7, 3.0 (1.4)</td>
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<tr>
<td>Post dressing change</td>
<td>18, 1.0 (1.7)</td>
<td>11, 1.0 (1.7)</td>
<td>7, 1.0 (1.6)</td>
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</tr>
<tr>
<td>Distress behaviors</td>
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<td></td>
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<td>0.165</td>
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<tr>
<td>during dressing change</td>
<td>21, 1.0 (0.8)</td>
<td>12, 0.5 (0.8)</td>
<td>9, 2.0 (0.7)</td>
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<tr>
<td>Parent state anxiety (STAI) b</td>
<td></td>
<td></td>
<td></td>
<td>0.421</td>
</tr>
<tr>
<td>Baseline</td>
<td>20, 33.5 (20.61)</td>
<td>11, 29.0 (20.61)</td>
<td>9, 21.0 (20.63)</td>
<td></td>
</tr>
<tr>
<td>Post procedure</td>
<td>20, 26.0 (20.63)</td>
<td>11, 32.0 (25.57)</td>
<td>9, 32.0 (20.55)</td>
<td></td>
</tr>
<tr>
<td>Parent satisfaction (HDWD)</td>
<td></td>
<td></td>
<td></td>
<td>0.292</td>
</tr>
<tr>
<td></td>
<td>21, 38.0 (31.40)</td>
<td>12, 39.0 (32.40)</td>
<td>9, 37.0 (31.40)</td>
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</table>

a N=7 with all 3 times: Main effects: Group: p = 0.753, Time: p = 0.010; Interaction effect: p = 0.717
b Main effects: Group: p = 0.105, Time: p = 0.001; Interaction effect: p = 0.421

received hydrocodone, and one received ibuprofen (Advil). The premedications were given between 2 hours and 10 minutes and 4 hours and 15 minutes before the procedure.

Seven of nine children in the nurse preparation group received premedication for pain. One child received a medication containing codeine, four received hydrocodone, and two received ibuprofen. The time between premedication and the procedure ranged from 1 hour and 55 minutes to 8 hours and 30 minutes in the control group.

As would be expected, the median time for burn wound care preparation was considerably longer in the intervention than in the control group (10 minutes vs. 1 minute, Mann-Whitney test, z = 2.90, p = .004). The length of the medical play sessions in the intervention group ranged from 5 to 14 minutes. Medical play is a child-driven activity, and the length of sessions was influenced by the child’s anxiety level, understanding of the procedure, and the length of time the child wanted to play with the medical equipment. Length of sessions was also influenced by the number of questions asked by the child and his or her caregiver. Caregiver preparation included observation of the medical play sessions. Caregivers were also encouraged to ask the child life specialist any questions they had about the procedure. No statistically significant differences between the groups were observed in actual length of procedure (Mann-Whitney test, p > 0.05). The median time for the procedure was 25.0 minutes (interquartile range = 6-94 minutes), which was not statistically significantly different between groups.

As summarized in Table 3, no statistically significant findings were observed in this pilot study. Nevertheless, the descriptive summaries illustrate that the effects were in the hypothesized direction and were directionally consistent. Children who participated in directed medical play experienced lower median distress values during their dressing change than did those receiving standard preparation. All but 1 of the 11 children who participated in the medical play group, and had both pre- and postprocedure FPS pain scale scores, reported the same or lower scores after the procedure than they had prior to the procedure (seven with the same score, two decreased by one face, and one decreased by two faces). On the other hand, only one of the six children in the standard care group with pre- and postprocedure FPS scores demonstrated a decrease in pain. Three of the six had the same score, whereas one child had a three-face increase and another child had a four-face increase. Although median parental satisfaction with the care their children received was higher for those in the medical play group than in the standard care group, the difference was not statistically significant (see Table 3).

Discussion

Directed medical play as a part of preoperative preparation has been theorized, and has been demonstrated in surgical settings, to have the ability to decrease anxiety and/or distress during invasive procedures by providing information, affording rehearsal of coping skills, and allowing for control, mastery, and expression in children. (Barnett & Storm, 1981; Barnett, 1984; Li et al., 2007; Li & Lopez, 2008; Rollins, Bolig & Mahan, 2005; Wolfer & Visintainer, 1975). Li and colleagues (2007) and Li and Lopez (2008) concluded that the children in the medical play group perceived the surgery to be less threatening because the intervention enhanced their perception of control as they learned both problem-solving skills, and allowing for control, mastery, and expression in children.
and emotion-focused coping skills. Parents reported less preoperative anxiety and greater satisfaction with the care their child received. Results of this study support the conclusions from previous research.

The current study has several important strengths. A step-by-step protocol was developed for the medical play procedure so that child life specialists would be consistent in their implementation of the intervention. One research nurse was assigned primary responsibility for data collection. However, several other nurses served as backup when she was unavailable. To make sure that data collection with use of the FLACC scale was consistent between observers, all research personnel watched several videotaped burn wound dressing changes and scored them independently. Results were compared, and any discrepancies were discussed, and a consensus was reached on how to score the child observations.

A randomized controlled trial would have been the ideal design for this type of study. However, child life specialists were available in the burn clinic only 3 days a week. Although not strictly randomized, we feel confident that assigning group by day of the week did not produce unequal groups. In addition, if we had randomly assigned the subjects to groups, there is a good possibility that diffusion of the intervention would have occurred.

The primary weakness of this pilot study was the small sample size. Participant recruitment was slower than expected because of several issues. The number of children meeting eligibility criteria were fewer than anticipated. Turnover in the burn clinic among both nurses and child life specialists resulted in breaks in recruitment while training was completed for new study personnel. Time limits on funding prevented the recruitment of eligible subjects after June 2012.

Another weakness was the lack of cultural diversity of study subjects. Sixteen children were White and five were African American. Three Hispanic families were excluded from the study because they only spoke Spanish. When the study was first implemented, FPS scores were only collected at baseline and after the procedure and the FLACC was used to obtain a measure of child distress during the procedure itself. After gathering data on seven subjects, a decision was made to obtain an additional FPS score by asking the child to rate their pain during the procedure. The change in procedure resulted in postprocedure scores being collected for 18 children.

Although the provision of directed medical play is an intervention unique to the expertise and training of child life specialists, nurses can use play as a tool to build rapport and promote a therapeutic environment. Pediatric nurses have been using play (even directed medical play) in their practices to provide therapeutic care and emotional support to children and their families for a very long time. This fact is evident in the literature because a larger number of medical play studies used nurses rather than child life specialists to deliver the intervention.

Strategies such as the use of directed medical play as part of a package of psychological preparation that are designed to reduce pain and distress should be considered as a means of improving the overall experience for children and their caregivers.

In the early years of the development of pediatrics as a medical specialty, nurses were encouraged to use play as a part of the daily care of the pediatric patient. Parents were not allowed to be present at the bedside for most of the hospitalization period, and the role of the child life specialist had not yet been defined. Child life specialists, who provide supportive care in addition to the nursing role, are specifically qualified to address the needs of children in health care settings. As health care has modernized and family-centered care has become common practice, provision of a therapeutic or healing environment is the collaborative responsibility of all members of the multidisciplinary team (Chambers, 1993; Jessee, 1992).

Young children may have difficulty with behavioral control, particularly during painful and frightening procedures. If the child is unable to control his or her behavior (i.e., remain still during dressing removal and wound cleaning), sedation is required. Children typically receive ketamine or propofol for conscious sedation during a painful procedure. A more potential, be it intangible, benefit of the use of directed medical play is the reduction in anxiety for the parent. This outcome may result in high parent satisfaction with burn wound care, which may increase the likelihood that they would return for care and recommend that others seek care at our facility.

This study, with its definite limitations, does clearly demonstrate outcomes in the expected direction for directed medical play. Future research with a larger sample size or across multiple sites could increase the statistical significance of the findings. Also, it is possible that the FLACC instrument, which originally was developed for use in clinical practice and not research, was not sensitive enough to show differences between groups. Although the results are more clinically significant than statistically significant, persons working with children who are undergoing painful medical procedures should take notice of the implications of research such as this. Strategies such as the use of directed medical play as part of a package of psychological preparation that is designed to reduce pain and distress should be considered as a means of improving the overall experience for children and their caregivers.

SUPPLEMENTARY DATA
Supplementary data related to this article can be found online at http://dx.doi.org/10.1016/j.pedhc.2014.12.006.

REFERENCES


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- 25% discount on CLC Annual Conference registration, or
- Two free individual CLC webinar registrations.

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

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

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A Novel Procedural Preparation Approach: An Intern Perspective

Leah Nawrocki, CPST
Driscoll Children's Hospital, Corpus Christi, TX

A daptive Care Team,” “tell, show, do,” “preparation homework,” and “clustering care,” are all words with which I was unfamiliar until my child life internship at Cincinnati Children’s Hospital Medical Center. Some of these words construct notable phrases that can benefit the work of every child life specialist, but these also have an even deeper meaning when providing family-centered care for a very specific patient population.

During the second rotation of my child life internship, I was introduced to the Adaptive Care Team, (ACT). Comprised of child life and other medical staff, the ACT specializes in providing remarkable care for children diagnosed with developmental delays and behavioral disorders who may also have medical complications. Some of these diagnoses can include autism spectrum disorder, Angelman syndrome, and Down syndrome, and these children often have difficulty with health care encounters.

I started this rotation by observing several children having their vitals checked. I immediately noticed that some of these children experienced high anxiety, discomfort, and extreme emotions during what was just the beginning of their appointments. I heard crying, watched children hide, pull hair, hit, kick, and scream at their caregivers during their appointments. I learned that this was often due to their sensitivity to touch, difficulty with waiting, and other significant changes in their daily routines caused by adding a clinic visit.

The ACT was sensitive to these patients’ unique needs and adapted in several ways. One of these is known as “clustering care.” This is seen when preparational resources were introduced to the Adaptive Care Team, (ACT). Comprised of child life and other medical staff, the ACT specializes in providing remarkable care for children diagnosed with developmental delays and behavioral disorders who may also have medical complications. Some of these diagnoses can include autism spectrum disorder, Angelman syndrome, and Down syndrome, and these children often have difficulty with health care encounters.

I also witnessed how these difficult experiences were improved when preparational resources were provided prior to the appointments. These helped patients build up their coping skills over time, starting before they arrived. With practice ahead of time, the child does not have to accomplish learning to cope with every aspect of care all at once. The child will instead have opportunities to practice their skills through a “tell, show, do,” education approach. The preparation resources included “preparation homework,” preparation books, and video modeling DVDs. These tell and show each child what their specific medical experiences will include.

The preparation homework specifically instructs children and their caregivers about various ways to prepare for and cope during specific medical experiences. As an intern I created a homework page and preparation book to be used for these children when they are anticipating the influenza vaccine. The homework was modeled after an original template created by the child life team. Preparation homework educates the child and family about the medical experience. The preparation homework is commonly used with preparation books and modeling DVDs which provide more visual representations of what the child will experience.

It was evident to me as an intern that medical staff and patients were not the only ones to benefit from these resources. When preparation materials are provided to caregivers, the caregiver can gain more control over the medical experience because they have resources to answer questions and to share with the child what the experience will be like. I witnessed many conversations with caregivers and the child life staff who offered these resources prior to appointments, and I recognized that many of the caregivers demonstrated a deep appreciation for the medical staff because of their sensitivity to their child’s needs.

By advocating for clustering care and providing education to patients and families, the Adaptive Care Team demonstrated the true importance of enabling patients and families through family-centered care. I can now incorporate these efforts to create more positive healthcare experiences for patients into my work efforts as a child life specialist. This innovative approach to providing family-centered care helped me realize another crucial purpose for meeting every patient at their level: this can empower both the child and the caregiver. Providing preparational resources prior to appointments can offer familiarity that is essential to promoting long-term positive healthcare experiences for children.

Written for parents of young children, Everybody Stay Calm: How to Support your Young Child Through Medical Tests and Procedures is an introductory guidebook to emotionally supporting children through healthcare experiences, particularly children newly diagnosed with a chronic illness. The author, Dr. Angela Mackenzie, is a pediatrician in Australia with 25 years experience and a strong career focus on pain management. She has advocated for pain management policies, offers international workshops, and has a private practice specializing in mind-body medicine. Arranged in short readable chapters with titles like “Your Emotions” and “Getting on the Team,” the author uses patient anecdotes to illustrate key points about how family members can best support the emotional well-being of a child during procedures and tests. In essence, the book serves as a primer on what we know as child life practitioners, with focus on preparing children at their developmental level, encouraging coping and advocacy for the child, parental presence and support during procedures, emotional outlets, and distraction techniques. Mackenzie offers techniques and practices familiar to child life specialists, but written for a caregiver’s perspective.

Based on her work with families in a hematology clinic, Dr. Mackenzie’s guidelines and recommendations are clearly and simply written and based on child development and attachment theories. Although there is reference to a few theorists, the bibliography list in this book is quite light with Selma Fraiberg and Leora Kuttner referenced along with many parenting books. Sometimes the author makes important statements such as, “holding [the child] down forcefully while a procedure is carried out is potentially damaging to the developing brain” (p.40), yet makes no reference to the research or basis for this statement. Although Dr. Mackenzie may not have wanted to frighten away readers with a theory-heavy volume, a more solid theoretical base would have solidified her arguments and references would have allowed inquisitive parents to discover more.

A strength of the book is the encouragement of parents to be mindful of their own behavior, language, and emotional responses when supporting their children through any health care experience. Paired with the author’s strong encouragement of parents to advocate for the emotional needs of their children, this book empowers caregivers of children with a new diagnosis who are seeking advice on supporting their children before any medical intervention.

Some of the strongest resources Dr. Mackenzie offers are on the website associated with her book, www.everybodystaycalm.com. On the website, she includes the “Magic Glove” video from Leora Kuttner, as well as a downloadable resource for caregivers entitled “Comfort Action Plan.” These resources, and this website in general, are worthy of note for our professional practice and could easily be recommended to families during a pre-op visit, clinic visit, or in anticipation of future visits for procedures.

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

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Everybody Stay Calm is a parent-supportive introduction to much of what is offered by child life. New parents and those overwhelmed by supporting their child through procedures would benefit from her ideas, which are presented using gentle, encouraging language as well as interspersed cartoons. Although it provides little new information for child life specialists, this resource would be a practical addition to a resource library and a generous offering to families with children facing a chronic illness.

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Unaccompanied Children

continued from page 1

There has been much research done on the detrimental effects of separating hospitalized children and their families, and better health outcomes have been observed when FCC is the model (American Academy of Pediatrics Committee on Hospital Care & Institute for Patient- and Family-Centered Care, 2012). Hospitals strive to incorporate families’ values and beliefs when providing care for the patient and family. The philosophy of FCC views family as the constant source of strength and support in a child’s life and as an active participant in the child’s plan of care. What are the implications, then, when family is not able to be present during a child’s hospitalization, and how can we, as child life specialists, better support unaccompanied children in the hospital?

My clinical career has focused on these questions over the past five years, during which I have worked as a child life specialist in the Josh Cares Program at Cincinnati Children’s Hospital Medical Center. Our patient population consists exclusively of children whose families cannot be with them at bedside on a consistent basis. We serve patients and families on nearly every inpatient unit in the hospital. Our team has observed a multitude of reasons why a child might be alone in the hospital; most are socio-economic. There are single parents who need to care for other children at home or who must work to maintain their health insurance. There are limitations in transportation to the hospital, as some parents cannot afford a car or do not have money for gas. There are other seriously limiting social issues such as the incarceration of one or both caregivers, or mental health or substance abuse issues. In addition, many caregivers have difficulty coping with a child’s long-term hospitalization or a child’s chronic illness. There is also the increasing issue of multiple births where the caregiver needs to be home to care for a healthy twin, while the child with medical complications remains in the neonatal intensive care unit.

The Josh Cares team has also worked with numerous patients in complex social situations when they are removed from the biological family’s custody and are awaiting placement in foster care. These children can be particularly difficult to place because of their complex medical needs and the training required for foster caregivers. These children need significant psychosocial support as they cope with separation from their biological family, hospitalization without caregiver presence, and then preparation for and transition to a new family.

Cristine Roberts (2012), a nurse researcher, discusses nurses’ perceptions of children who are unaccompanied in the hospital and the negative implications of this situation, including the effects on children’s development and attachment. She states that caregiver absence is challenging on all fronts and that nurses observe more detrimental effects on children between mid-infancy and early school age. Roberts reports that nurses observed unaccompanied children to be more highly sedated than those with family present and pointed out health risks, such as “sustained crying in infants with hemodynamically unstable congenital heart defects. Crying necessitated that nurses comfort these fragile infants during their parents’ absence” (p. 135). Nurses were also concerned with “a lack of bonding between parent and child, resulting in potential developmental delays” (p. 135). Other concerns included older babies being swaddled and thus limited in exploring their environment in a developmentally appropriate way and infants lying in their cribs for as many as four hours between vital sign assessments. The toddler age group seemed to be especially challenging as their needs for exploration out of the crib are much greater and they are awake more often during the day than an infant. The child’s developmental needs as well as safety present a great challenge for nurses who are caring for more than one patient.

The developmental impact of an unaccompanied hospital stay for a child cannot be overstated. According to Rollins, Bolig, and Mahan (2005), from a developmental perspective, the first issue of concern due to hospitalization is separation (from caregivers) for infants through school-aged children. Troublesome responses include possible failure to bond, regression, and delayed skills development, among others. Child life specialists are well equipped to provide interventions, including opportunities for play, to address such developmental concerns (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014).

Bridging the Gap in Service

One solution to better serve the unaccompanied patient population is a dedicated child life specialist program such as the Josh Cares Program at Cincinnati Children’s Hospital Medical Center. Founded in 2005, Josh Cares was established to provide psychosocial support to unaccompanied children in the hospital and has grown and been transformed substantially over the years. Josh Cares started as a fellowship program, with two child life specialists who worked with several patients in the pediatric intensive care unit. Through the years, the program grew as the need for more child life support for unaccompanied patients throughout the hospital was recognized. The program now funds six full-time Certified Child Life Specialists, who are known as the Josh Cares team. Since the launch of the program, Josh Cares has experienced a consistent and steady population of patients with extended hospital stays who need additional psychosocial support. Families also need support as they are dealing with competing responsibilities or obstacles that keep them from being present at the hospital with their child. Based on our census, we have cared for nearly 400 patients and their families since our program began, and the number continues to grow.

It doesn’t seem possible that the issue of unaccompanied hospitalized children exists only in Cincinnati, Ohio. Josh Cares is a separate (501(c) (3)) non-profit organization that works in partnership with Cincinnati Children’s Hospital Medical Center. Josh Cares raises funds for the sole purpose of paying child life specialists’ salaries. The Josh Cares team also assists in presentations to donors to demonstrate the need for support. Individual donors as well as numerous foundations throughout the city support Josh Cares. Josh Cares is just one solution to this difficult issue, and is a strong model that could be replicated at other hospitals. However, establishing and maintaining a program like Josh Cares may not be feasible in smaller hospitals.

For hospitals that are not able to establish a program like Josh Cares, it would be ideal to allocate specific positions to support unaccompanied children. If this is not possible, there are ways for child life specialists to provide additional care for these patients and families in addition to other clinical responsibilities. Here are some ways that the Josh Cares role differs from the role of a traditional unit specialist and some interventions to consider:
• Unit specialists make referrals to us based on length of admission and lack of parental presence. We accept patients who have been hospitalized for more than 2 weeks and are expected to be inpatient for a month or more. Caregivers are either sporadically, rarely, or never present at bedside. Our census tends to consist of fewer patients than a unit-based position so that we can spend more devoted time with each patient.

• The Josh Cares team at our hospital makes it a priority to see each patient at least once a day, for an hour or more—primarily to get them out of bed for playtime or (as in the case of an infant), to provide developmentally appropriate stimulation, comfort, and developmental support.

• We conduct developmental, therapeutic, and medical play interventions including preparing dolls for surgery, building forts, building Legos, and having pretend and real picnics, either inside a room or outside of the hospital for a dose of fresh air, sunshine, and normalization.

• We keep families connected and involved by taking weekly photos and sending them home in the mail or by email. We include photos of everyday activities as well as children achieving milestones, working with therapies, celebrating birthdays, etc. We also send regular, creative “sibling hello” photo collages, whether from an infant or an older child, in order to help siblings stay in touch and maintain bonds that are affected due to physical separation.

• We collaborate closely with unit child life specialists to make these outings a reality. We regularly with psychologists, nursing staff, and social workers to coordinate our outings with other professionals to offer additional support to unaccompanied patients. The nurses alone cannot carry the extra responsibility of the increased psychosocial care needs of unaccompanied children. Wolfer and colleagues (Wolfer, Gaynard, Goldberger, Laidley, & Thompson, 1988) report that children cope better during procedures, adjust and radiology procedures, PICC line placements, and more.

We prepare, accompany, and support our patients during bedside and radiology procedures, PICC line placements, and more.

• As our patients can be in the hospital for months or years, we collect and arrange photos in a scrapbook called an “All About Me” book, which tells the story of a child’s life during hospitalization. One child lived in our hospital for eight years and his foster family was thrilled to have a large collection of books that we sent home with them. The books filled in many gaps and provided an amazing catalogue of the child’s growth, development, and experiences during those critical years.

• Frequently we are able to facilitate outings for patients experiencing a long-term hospitalization. Several of our patients have benefited immensely from the normalization, diversion, play experience, and social opportunity that the outings provide. I have participated in many outings over the years to the museum, zoo, library, park, shopping mall, and, most memorably, to a patient’s new foster home and school. We even planned and facilitated a combined outing with three patients to a Cincinnati Pops children’s symphony. These outings provided tremendous support to long-term hospitalized children who were facing immense psychosocial challenges and major life transitions. We collaborate regularly with psychologists, nursing staff, and social workers to make these outings a reality.

With our background and expertise in child development, child life specialists are the best-equipped and trained child development professionals to offer additional support to unaccompanied patients. The nurses alone cannot carry the extra responsibility of the increased psychosocial care needs of unaccompanied children. Wolfer and colleagues (Wolfer, Gaynard, Goldberger, Laidley, & Thompson, 1988) report that children cope better during procedures, adjust better to hospitalization, and experience less emotional distress when they receive support from child life specialists. If family is not able to be present at the bedside during hospitalization, the need for child life support is even more critical to help with a child’s coping and adjustment. Unaccompanied children are among our most vulnerable patients and need additional, devoted time and child life presence. More consistent and dedicated support would positively impact their coping and overall adjustment, as well as their long-term growth and development.

**References**

that all certification candidates hold a master’s degree in child life from an academic program accredited by the Child Life Council (Child Life Council, n.d.). CLC has previously developed both undergraduate and graduate program curriculum recommendations that outline recommended topics to be covered. Undergraduate programs will soon have a CLC endorsement process, and graduate programs will in the future have CLC accreditation requirements, both of which will be an extension of certification eligibility requirements developed by the Child Life Certifying Committee. Academic institutions will, however, have the freedom and flexibility to plan a program and design a curriculum compatible with their own philosophies and organizational structures within these new processes. This, therefore, enables creativity in curriculum development so that attention can be placed on developing an integrated child life core and focus on specialized skill building and defined areas of expertise to best serve children and families.

These new CLC requirements for a graduate degree enable a programmatic view of child life education. Instead of working within the silo of individual courses, curriculum designers have the opportunity to ensure learners have basic prior knowledge in content before new knowledge is being acquired. Tasks and concepts can then be built upon and become increasingly difficult and complex as learning progresses (Morgan et al., 2013), with careful attention placed on the sequencing of content in order to reduce cognitive load as well as “prevent overload and free up processing resources that can be devoted to genuine learning” (van Merrienboer & Sweller, 2010, p. 91).

Learners have been described as “active sense makers” who seek to build coherent and organized knowledge (Mayer, 2004). In a programmatic approach to curriculum design, not only is there opportunity to build on previous knowledge, but there is also opportunity to help learners understand the interactions and interrelationship of the parts learned across courses, as “learning how things are interconnected is often more useful than learning about the pieces” (Fraser & Greenhalgh, 2001, p. 800). While a focus on content and facts is important, “without this understanding of the interactions and relations between the pieces, it is difficult to apply the learning in a unique context” (Fraser & Greenhalgh, 2001, p. 800), like a new clinical environment.

Fraser and Greenhalgh (2001) beautifully articulate the intricate world of clinical practice for health care providers where textbook cases may not be common place, but present as “messy, fuzzy, unique, and context embedded problems” (p. 801). Academicians are challenged to then find opportunities to extend beyond knowledge and skills to include “the exercise of judgment and the ability to act wisely in complex, unique and uncertain situations” (Bordage & Harris, 2011, p. 90). In clinical practice, a child life specialist is challenged to assess situations as a whole; integrate and interpret many different pieces of information; prioritize issues; and proceed, often while multi-tasking an incoming donation and addressing his or her pager about the next patient in need of support and intervention. Education with a predominant focus on “planned, formal events,
with tightly defined, content oriented learning objectives” (Fraser & Greenhalgh, 2001, p. 801) can potentially pose a disconnect with this real clinical world of constantly changing contexts and circumstances.

Our challenge in curriculum design is, therefore, more than just what we as teachers will deliver, but how the second element of curriculum noted above—the teaching strategies we use—can enhance learning, clinical competence, and most importantly the quality of capability, which Fraser and Greenhalgh (2001) define as “the ability to adapt to change, generate new knowledge, and continuously improve performance” (p. 800). A process-based curriculum design, for example, places an emphasis on context and interactions of the teacher, learner, and knowledge. Case studies, for example, provide a different context, a relevance to the clinical setting which enhances motivation for learning, and build on prior knowledge integration while enabling reflection on learning (Neville, 2009). The ability to identify the issues present and idealize what interventions one would plan to carry out can be followed up with, “Do you want to know what really happened? Yes, it would have been ideal to prepare the six- and eight-year-old in that way before seeing their four-year-old brother in the ICU, but the father, in his distress, brings both boys in to see their brother (who will soon go to the OR for organ donation) just as you arrive. Now what will you do?” Every clinical situation, every health care environment, every health care team and family interaction, and every context and child is different. Our learning examples and teaching strategies can be equally varied, too. Role plays, individual and group presentations, portfolios, use of storytelling, examples, and analogies to clarify abstract principles, and even Jeopardy-type games engage learners with material and bring it life and meaning. The literature also describes the importance of role modeling, including deliberate practice opportunities and providing individual feedback about performance.

If we don’t know what we’re hoping our students will be able to do, it’s very difficult to measure if they are capable of doing it themselves. The third important element of curriculum is, therefore, assessment of learners. Often cited in the literature is Miller’s position that assessment drives learning (1990). Assessment influences study habits, but it can also influence learners’ views that what you assess is more important than what you don’t. As Cohen (2006) would say, “They don’t respect what you expect; they respect what you inspect” (p. 613). We must, therefore, clearly determine what we’re assessing, and why we’re assessing it. The conditions for learning and conditions for testing also need to be considered. If your only work performance evaluation, for example, came on a day when you had not slept the night before and had just received bad news, your results may be skewed and not accurately reflect your best performance. This doesn’t mean we should bell curve each student’s grade because you are disadvantaged to those who can articulate their thoughts well on paper, but assessing students’ knowledge and skills when interacting with children and families may warrant other assessment forms too.

Our profession and the children and families we serve deserve and expect us to only graduate those competent to practice.

The final piece of curriculum is the evaluation processes of the program and the curriculum itself. Beyond course and faculty evaluations, feedback into our programs can improve teaching, learning, and the student experience. Information collected through stakeholder surveys (e.g., graduate exit surveys, employer feedback), graduates’ reported certification exam pass rates, employment rates, and other sources can be used to enhance and improve programs.

Quality of the patient experience is paramount in our clinical work. Quality of education is just as paramount for those preparing to embark on a child life career. Our profession, children, families, health care colleagues, communities, and the outcomes of current and future research are counting on it. 🌟

**References**


Internship Accreditation: Promoting Credibility of the Child Life Profession

Michelle Townsend-Barksdale, MS, CCLS
Chair, Internship Accreditation Oversight Committee

The Child Life Council defines accreditation of clinical internships in child life as an assurance that a program meets the minimum standards and requirements set forth in the Standards for Academic and Clinical Preparation Programs in Child Life, as found in the most current Official Documents of the Child Life Council as well as the Essential Curriculum Topics for Child Life Clinical Internships. It is a voluntary process of self-study and external review intended to evaluate, enhance, and publicly recognize quality child life clinical internship programs. This two-step process is intended to:

• evaluate the extent to which a program meets the competencies defined by the essential internship curriculum topics and the practice analysis and
• promote the interests of students through continuous quality improvement of learning and professional practice.

As part of the Child Life Council’s Strategic Plan 2012-2014, internship accreditation is one objective to meet the goal of promoting credibility of the child life profession. To attain this goal, a task force was formed to create criteria and an accreditation timeline. The task force focused on establishing the minimum standards of internship programs and the clinical preparation of child life specialists through benchmarking and literature reviews.

The Internship Accreditation Oversight Committee (IAOC) was born out of the findings and work of the task force. Its purpose is to manage the clinical internship accreditation process in collaboration with the CLC office by determining policies and procedures. The committee manages processes regarding accreditation eligibility, application review and approvals, maintenance, renewals, and appeals.

There are several benefits in having an accredited clinical internship. The reasons for obtaining accreditation are similar to the reasons for obtaining child life certification:

Professional Identity – An accredited clinical internship will attract exceptional interns and produce excellent job candidates. Also, the internship accreditation process may help one’s team explore and highlight many parts of the internship: quality assurance, evidence-based practice used by the team, and program self-evaluation.

Recognition – Formally acknowledge one’s internship accomplishments.

Advancement – An accredited clinical internship may help one’s interns benefit from enhanced career opportunities.

Respect – Accreditation can improve program credibility by validating a program’s specialized knowledge and expertise to peers, management, and other interdisciplinary colleagues. An accredited internship also brings enhanced recognition of the overall professional outlook and importance of the Child Life profession.

Growth – An accredited internship program prepares interns for continued professional excellence through strong education and professional development. The accreditation process asks institutions to critically evaluate their vision, strategic priorities, leadership, programs, and resources. The process of earning and maintaining accreditation provides internships with clear and compelling direction for implementing changes to move towards excellence.

Passion – Accreditation demonstrates a program’s commitment to the child life profession.

Pride – Enjoy satisfaction in knowing one’s internship meets the criteria of accreditation and strives to improve quality and care.

Accreditation will be facilitated by qualified reviewers who will work in a shared governance model to reach a consensus regarding the status of accreditation. Internship accreditation review is a blind process between the reviewer and the applicant. An invitation was extended to all eligible CLC members to apply for the role of clinical internship accreditation reviewer. The application included letters of recommendation, documentation of internship supervision experience, and exemplars highlighting communication and leadership skills. Twelve Certified Child Life Specialists have been selected by the Internship Accreditation Oversight Committee.

A 5-year plan for the acceptance and review of applications was recommended during the initial rollout of the Clinical Internship Accreditation process. Ten clinical internships per quarter will have the opportunity to submit an application for accreditation. To allow an equal opportunity for all interested clinical internships, a lottery process has been put into place to determine the order of application acceptance during the 5-year period.

The lottery process, which will allow some clinical internships to receive “early” accreditation, in no way indicates that early accredited clinical internships are better than those who have not yet applied. Those clinical internships receiving accreditation during the initial 5-year period (“early”) may be asked to have a statement on their website or on their clinical internship’s listing on the CLC Directory of Programs indicating details about early accreditation.

Fifty-five clinical internship sites were entered into the initial lottery to determine application due dates. The results of this first lottery have filled slots from January 1, 2016 to April 1, 2017. For the second lottery, clinical internships interested in applying for accreditation will be asked to submit an Intent to Apply Form between January 1 and March 1, 2016. The lottery and subsequent communication with interested clinical internships, inclusive of the assigned application deadline, will occur by April 15, 2016. The earliest application deadline will be April 1, 2017. Since each lottery entry has an equal chance to be included in the initial deadline, all clinical internships entering the lottery will need to be prepared for this potential application deadline.

The Clinical Internship Accreditation webpage is located on the CLC website. This platform allows for communication with membership regarding the timeline, clinical internship accreditation applications, fees, lottery process, and reviewer applications. Plans are being laid for the application submission process to be fully online.

Please email InternshipAccreditation@childlife.org with questions for CLC staff and IAOC members regarding the internship accreditation process.
Professionals in the child life field are well aware of both the power and the universality of play for all children. While working in a hospital in China, I, along with five other fellow travelers, had the unique opportunity to see firsthand the truth of a concept so deeply rooted in child life practice: Play is a universal language.

Loma Linda University (LLU), located in Southern California, has a remarkable, long-standing relationship with a hospital in the Zhejiang Province of China. For decades, students from both LLU and The Children’s Hospital of Zhejiang University, School of Medicine (ZUCH) have travelled back and forth to study and gain clinical experience. It was so exciting to find that hospital administrators and nurses from China were eager to learn more about child life and to possibly incorporate some of its basic practices and services into their own hospital. ZUCH invited LLU’s Child Life MS Program director, Michelle Minyard-Widmann, clinical coordinator Alisha Saavedra, and four fortunate students, Courtney Camp, Alyssa Garcia, Alejandra Kim Arredondo, and Ariele Macaluso to their hospital to collaborate on ideas for the implementation of child life services for the patients and families with whom they work. Ariele sums up the experience by saying, “We were able to share our passion and knowledge of child life and the benefits of therapeutic play.”

The work we did at ZUCH consisted mainly of lecture presentations to the hospital staff on the use of therapeutic play within child life practice, and also the provision of teddy bear clinics to the patients and their families. Our initial focus for the teddy bear clinics was to educate about PICC lines and IVs, as the first clinic took place on the hematology/oncology unit of the hospital. We were grateful to the hospital for providing us with a few nurses who would help out as translators for us as we conducted the teddy bear clinics for the children. Many of the young patients knew a few simple words in English, such as “hello” and “thank you.”

We had hoped to both demonstrate and explain to the children the procedural steps and some basic information regarding PICC lines and IVs with the help of our translators. What resulted was that the nurses who were translating for us—naturally—began to converse with the patients and families with little reciprocal translation between nurse and child life team member. What also resulted was that the ratio of nurse/child life person to patient quickly became lower and lower. As more children arrived at the clinic tables and fewer expressions were being translated to patients and families due to the high number of attendees, patients simply gravitated to the materials on the tables and began to “perform” familiar procedures using the dolls and real medical items provided. Many presented with extensive knowledge regarding the various materials and performed lumbar punctures, bone marrow aspirations, and induction on the dolls. When patients appeared to question or wonder about a particular item and/or its purpose, a child life team member simply demonstrated as needed with one of the dolls.

At certain times during the clinics, child life team members were able to experience more one-on-one time with some patients and translators, and had the pleasure of hearing the patients’ stories regarding their experiences in the hospital. At other times when there were more children and families than translators, eye contact, smiles, and modeling became the primary modes of communication between child life team members and young patients. It was amazing to witness, however, that these simple acts of communication were really all that were needed to run a teddy bear clinic and to attain positive, beneficial, and successful outcomes.

While we initially predicted that language would be the most significant challenge we would face, it turned out to be much less of a barrier than the limited space and availability of materials. Countless moments of enjoyment and satisfaction from both the patients and their families were clearly recognized by the LLU and ZUCH team members. It was also exceedingly rewarding to know that the medical staff of ZUCH were able to directly see the wonders of therapeutic play which we had lectured about prior to these clinics. Courtney says that “it was so amazing to interact and experience the culture difference and language barriers, but yet still be effective in our teaching with the patients.”

The positive outcomes of these teddy bear clinics truly strengthened the idea for us that play really is a universal language. This
Is a Doctoral Program Right for Me?

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Child life specialists are in a unique position to advance the field by obtaining a doctoral education and contributing to cutting-edge research that influences the policies and procedures of child life programs and hospitals. Given the changes in academic requirements in order to obtain certification in 2022, there is a need for more child life specialists with doctoral degrees to teach child life courses. This is due in part to the fact that some universities require faculty who teach graduate-level courses to hold a doctoral degree for accreditation purposes.

As current doctoral students, we have fielded questions from child life specialists who are interested in advancing their educational and clinical skills. By sharing our responses to these commonly asked questions, we aim to support and guide child life professionals who are considering taking the leap into a doctoral program.

How many doctoral degrees are there?

A lot! But, child life specialists often pursue a PhD, PsyD, EdD, or DrPH.

So, what’s the difference between the various types of doctoral degrees?

Generally, a PhD is more research focused, whereas a PsyD, EdD, or DrPH tend to be more clinically focused. All require a dissertation that uses qualitative, quantitative, or mixed methods research. A more clinically focused dissertation, however, must also focus on a specific population served, psychotherapeutic intervention provided, or an in-depth analysis of a theoretical orientation.

Which one should I get?

Well, that depends on the type of research and/or clinical work that is of interest to you. It also depends on what type of career you want to pursue once you obtain your doctoral degree.

Do I need to obtain a master’s degree before starting a doctoral program?

Some universities require a master's degree prior to enrolling in the program, while other programs allow individuals to earn a master’s degree as they are pursuing their doctoral degree.

How is a doctoral degree different from a master’s degree?

Master degree programs range from 1 to 3 years and usually require a thesis or final project prior to graduation. A doctoral program, however, ranges from 4 to 8 years. Doctoral programs generally require 2 to 3 years of coursework, 1 to 3 years of completing an independent research project, and 1 to 2 years of clinical training or a clinical internship, if applicable.

I think I found a great program. What do I have to do to apply?

Each university has its own requirements. Go to the school’s website and make sure to follow all instructions. Generally, universities require 1) the GRE and/or other entrance exams, 2) an application that includes a writing sample, personal statement, and curriculum vitae, and 3) an interview, either in person or over the phone.

What should I consider when identifying a program that fits my needs?

Make sure you know the focus of the university: research, clinical work, and/or teaching. Ask questions to learn more about the university. For example, what research does the program do? Is the program focused solely on one discipline? How do your research interests fit the interests of current faculty? What types of careers do alumni obtain?

Find out the length of the program, whether you can enroll part time or full time, cost, location, and the type of financial support the program provides to its doctoral students. Some programs require students to be “in-residence” or attend classes on-campus for at least two consecutive semesters before relocating or finishing a degree remotely.

Also, consider asking yourself these questions:

• Why do I want a doctoral degree?
• What do I want to do with my doctoral degree?
• If I only want to do clinical child life work, will this degree make me overqualified for future clinical jobs?

If I am interested in research, what types of universities should I consider?

If research is important to you, consider a university with a Carnegie Classification of “RU/VH” or Research Universities (very high research activity). These research-intensive universities tend to have more funding opportunities; however, they tend to be less focused on cultivating doctoral students’ teaching skills. Students interested in teaching may have to seek out teaching fellowships on their own.

What will make me successful in a doctoral program?

These are a few things that will aid in your success:

• Love of learning
• Research experience
• Critical thinking
• Strong writing skills
• Time management

Statistics, research methods, and the child life doctoral student

During your doctoral program, make sure to enroll in courses that are challenging and push you beyond your level of comfort, such as advanced statistical courses, both quantitative and qualitative. You may feel like you do not have the time to take these courses; however, when you are in a tenure-track position or another full-time position, you will not have more time to do so.

Remember, you do not have to become an expert in all types of methodological approaches. However, you do need to be able to understand the methods and analyses used in research articles that you’re reading. Remember mixed methods. Mixed methods research uses a combination of qualitative and quantitative methodological approaches to answer complex questions.

As part of becoming a researcher, developing “thick skin” in academe is essential. Researchers are critical! Your work will be constantly challenged, criticized, and questioned. Make sure you leave your doctoral program having the skills to defend your work and methodological approaches.
• Passion for your research, clinical work, and/or teaching
• Supportive cohort, family, friends, and/or partner
• Positive faculty relationships
• Taking the journey and making it yours to enjoy
• Thick skin
• Ability to negotiate roles
• Ability to say "no" when it does not benefit your future success
• Maturity
• Professionalism
• Research and/or teaching experience
• Intellectual curiosity
• Commitment to learning and conquering intellectual rigor
• Excellent time management skills
• Self-motivation
• Flexibility

**Why should a Child Life specialist consider getting a doctoral degree?**

If you are interested in becoming a tenure-track professor at a university that has a child life program, you will need a doctoral degree. If you are interested in pursuing private practice, obtaining a doctoral degree is a great next step. Additionally, those who have doctoral degrees can lead child life research, which is an area of need in our field.

**What are some challenges of getting a doctoral degree?**

The financial burden is a challenge. Often, those going back to school have been working full-time and earning a livable salary. However, depending on your funding and current financial situation, you will need to consider whether you will be able to live solely on your assistantship (see below). Though some may consider getting a part-time job, for many this can be a challenge because it may take away from teaching, research, and/or clinical work. Other challenges might include work/life balance, adjusting to school after not being a student for several years, accountability, setting personal deadlines, and family planning.

**What do you mean by “depending on your funding?”**

Generally, doctoral students are provided with a quarter-time (10 hours a week) or half-time (20 hours a week) graduate assistantship; however, this is not always the case for clinical doctoral programs.

The assistantship may include being a teaching assistant, instructor, or research assistant. Generally, included in these assistantships are 9 tuition credits waived, health insurance, and a small stipend. Because the stipends are generally not enough to pay rent and monthly living expenses, universities may offer fellowships and scholarships to offset the costs of obtaining a doctoral degree. Some graduate students even apply for financial aid.

**Do I have to know my research topic before I start a doctoral program?**

Not at all! Some doctoral students enter their doctoral program without a specific research focus. If you enter your program with a specific focus, however, you can apply for research funding, begin research projects, and even start publishing early on in your graduate career, which is to your advantage.

All in all, you want to be passionate about your research topic. Consider asking yourself these questions:

- What type of research do I want to be involved in for the next five to ten years?
- What is the problem or injustice I want to work towards fixing?
- What are the gaps in my area of study?
- How is my topic innovative?
- What intellectual knowledge will I be contributing?
- Why should someone care about this topic?

**What do you wish you would have known before entering a doctoral program?**

Getting a doctoral degree is challenging! While obtaining a doctoral degree, many students feel a variety of emotions and feelings—excitement, fear, and even self-doubt. Some students even talk about how they can feel their brain changing!

Often the advice advanced doctoral students give new graduate students is to take one step at a time. This can be frustrating advice, but it’s the truth and quite meaningful! Despite the challenges, amount of work, and timelines you face each semester, with hard work it is possible to finish what needs to get done in order to be successful.

Make sure your program is rigorous. When you earn your doctoral degree, you are expected to be an expert, so make sure you leave your doctoral program knowing your area of study. And, most importantly, have fun with your dissertation! Pick a topic you are passionate about and run with it.

**President’s Perspective**

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inquire about important issues, as well as outreach to program leaders and academicians for input on issues/trends that are surfacing. The planning session, along with the additional information collected, led to the final plan that now exists.

The part of the strategic planning process that ties it together and will bring it full circle is integrating the plan’s goals into the work of CLC’s committees, work groups, task forces, and office staff so that they can help actualize those goals. This is what will help us achieve our outcomes in a systematic and measurable way. I applaud all of our committee leaders, members, and staff who serve CLC because they are the individuals who will help drive our success through the work they are doing. It’s always an exciting time when you can feel re-energized by a new but relevant direction. I feel that way now, and I hope you will too.

**China**

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greatly enriching cultural experience will continue to remind us of this very significant notion in child development theory and child life practice, and it will serve us well in our future interactions with children and families from diverse backgrounds. I am certain that Alejandra speaks for the entire travel team when she says that “this trip has deepened [our] passion for practicing child life globally.”
Balancing Clinical Duties and Research: Lessons Learned from the St. Jude Study

An Interview with Shawna Grissom, MS, CCLS, CEIM

Kathryn A. Cantrell, MA, CCLS
University of Massachusetts Boston, Boston, MA

In 2014, the Child Life Department at St. Jude Children’s Research Hospital was awarded a grant from the Child Life Council (CLC) entitled Effectiveness of the Modality of Play for Hospitalized Children: Clinical Child Life Services Play Interventions. The primary objective of our study, *The Impact of a Play-Based Procedural Preparation and Support Intervention for Children Undergoing Cranial Radiation for Treatment of a Central Nervous System Tumor*, was to examine the effect of preparation interventions provided by a Certified Child Life Specialist on the use of sedation in children with malignant central nervous system (CNS) tumors during radiation therapy. The secondary objective was to analyze the cost-effectiveness of the interventions in reducing costs associated with daily sedation. A team of child life specialists including Shawna Grissom, MS, CCLS, CEIM, Jessika Boles, MEd, CCLS, Katherine Bailey, MS, CCLS, Amy Kennedy, CCLS, and myself collaborated with a nursing researcher, Belinda Mandrell, PhD, RN, and a statistician, April Sykes, MPH, to push the study to completion.

The outcome of the study, presented at the 33rd Annual Conference on Professional Issues in Cincinnati, was to examine the effect of preparation interventions provided by a Certified Child Life Specialist on the use of sedation in children with malignant central nervous system (CNS) tumors during radiation therapy. The secondary objective was to analyze the cost-effectiveness of the interventions in reducing costs associated with daily sedation. A team of child life specialists including Shawna Grissom, MS, CCLS, CEIM, Jessika Boles, MEd, CCLS, Katherine Bailey, MS, CCLS, Amy Kennedy, CCLS, and myself collaborated with a nursing researcher, Belinda Mandrell, PhD, RN, and a statistician, April Sykes, MPH, to push the study to completion.

The timeline was my greatest concern as we had a lot of work to do in a very short period of time. We wanted to produce great results for the field of child life and we didn’t want to let the Child Life Council or our child life team down. What were your fears after being awarded this grant from CLC?

The timeline was my greatest concern as we had a lot of work to do in a very short period of time. We wanted to produce great results for the field of child life and we didn’t want to let the Child Life Council or our child life team down.

What helped make this possible?

We utilized our strengths in completing this research. Some of the team was much more versed in research, navigating the IRB, gathering data, creating measurement tools, writing, etc., so we depended on and utilized the team’s knowledge and strengths. We also worked out a systematic process with which we were all familiar. At any time, any one of us could pick up where the last one left off. This was key to our process and keeping the flow moving.

What advice do you have for other teams who might be nervous about applying for funding opportunities?

It is so much easier to put off doing research or stretch out a project when you are not under a specific timeline. A funding opportunity, such as the one provided by this grant, really pushed us to make this study a priority, forcing us to walk into uncomfortable territory at times. However, we are much stronger and have great results because of the opportunity.

In addition to our team’s perspective, many factors inherent to the study made it easier to balance clinical and research duties. Because the data was collected from a retrospective chart review, the process of data collection, coding, and analysis was not dependent on recruiting new patients. In other words, we could use the clinical tools already in place instead of re-inventing the wheel. Our electronic medical record (EMR) system made this possible. Had we extended our study’s window back to the era before EMR, the study would have had a less efficient timeline. Because of these aspects of the study, our timeline and workload could be managed more effectively. Even with the limitations of a retrospective chart review, we still gathered promising results from our study.

Although...
a methodologically stronger outcome might have resulted from a prospective study complete with new recruitment, the design of our study afforded feasibility and a fast turnaround.

A perceived barrier related to conducting research within the field of child life is the burden of balancing our many roles within health care. Although it can sometimes be difficult to do it all, research cannot be overlooked, especially research aimed at validating our economic presence within the health community. Thus, we encourage others to consider ways to include research into their program. It’s possible, especially when completed with tools already integrated into clinical routines. So get digging— you never know what you may find deep within your EMR or departmental statistics.

**References**


Moments from the past...

If you are a brand new graduate in child life, excitedly looking forward to taking the exam and getting a “real” job, or if you’re a student just beginning to think about an internship, there are so many decisions to make! Or perhaps you have discovered your dream job and are just beginning your professional career. No matter your station, think of the possibilities! You could become a legend in child life!

This photo, taken in 1975, shows Sheila Palm during her internship at Johns Hopkins Hospital in Baltimore, MD. After completing her degree at Colorado State University, she learned from a college friend about an article featuring the Johns Hopkins child life training program and it sounded intriguing. Sheila recalls thinking, “East Coast, large renowned medical center, working with children and families….here I come!! Let’s get this journey started.”

After her internship at Hopkins, Sheila began her professional career at Minneapolis Children’s Medical Center (now Children’s Hospitals and Clinics of Minnesota), where she has been an outstanding and innovative leader for 40 years! (For a closer look at Sheila’s career, see the Bulletin article about Sheila’s receipt of CLC’s Distinguished Service Award in 2011.)

Celebrating Sheila’s forty years of child life accomplishments is exciting and inspiring, and we congratulate her. But since this column also celebrates the CLC Archives, it’s a good time to reflect upon the fact that where we have been in the past helps define who we will become in the future. Our profession is young in terms of our history, but rich in the resources of gifted leaders and motivated young professionals. We love to document our history, acknowledge our present, and look to our future. So preserve your treasures through the years and perhaps in 20, 30, 40, or even 50 years, we will be publishing your photograph and celebrating you and all that you have accomplished! 🌟