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ACLCP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

FALL 2017 | VOL. 35 NO. 4

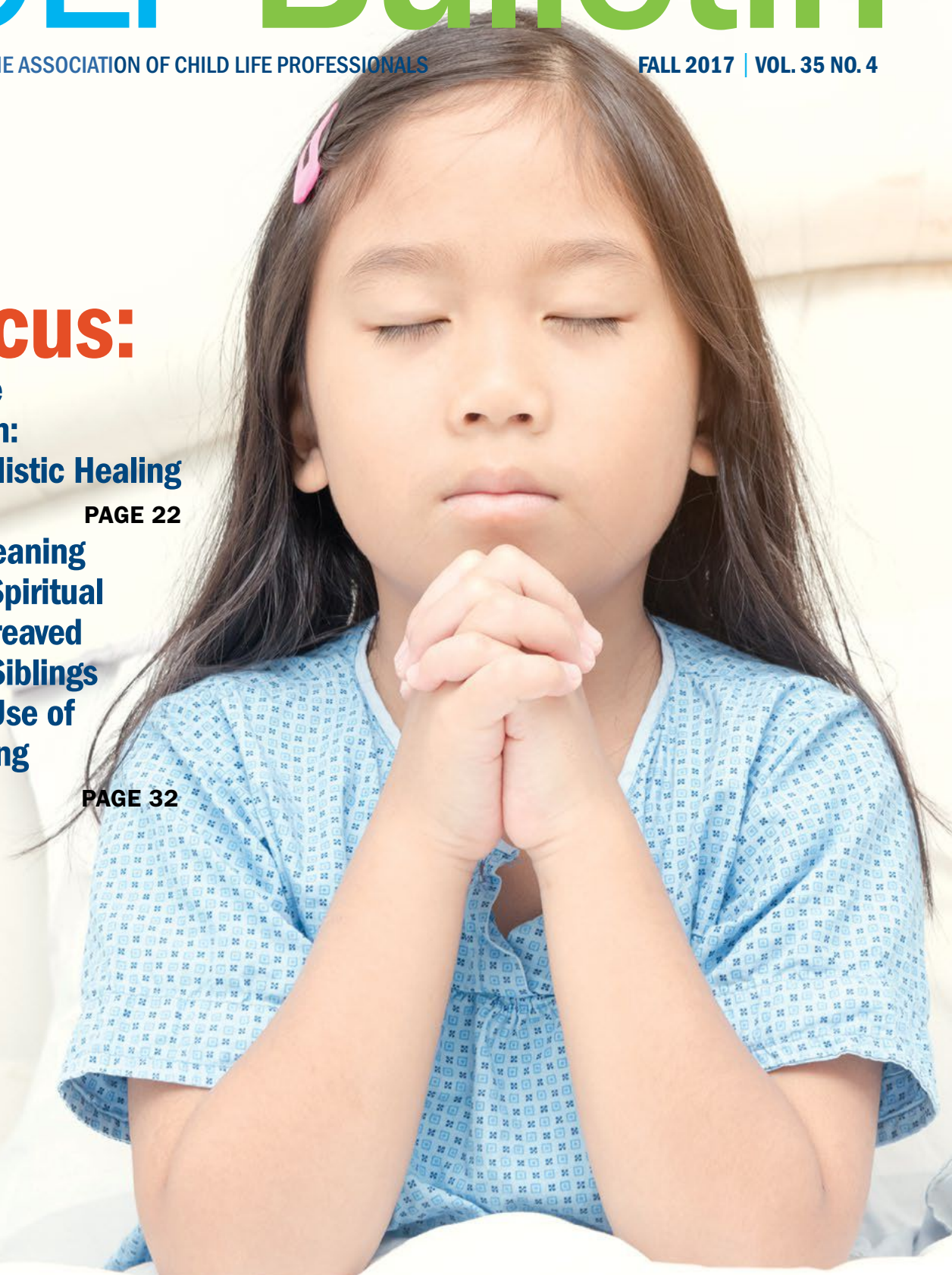
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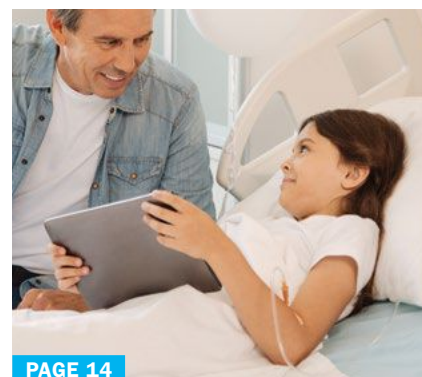
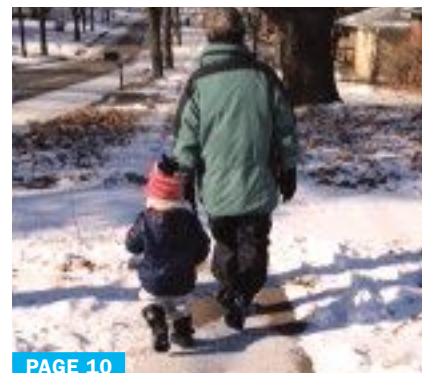
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from the **Executive Editor**
Katherine L. Bennett, MEd, CCLS

Back to School: Professional Edition

Much of my life's patterns have, in some form or fashion, been heavily influenced by a traditional school schedule. There are few things that the fall season conjures in my mind more looming than back-to-school.

My daddy was a school teacher, principal, and bus driver. The big yellow school bus was parked in a designated spot beside our home for nine months out of the year, sometimes making our tree-filled yard an easy target for toilet paper “decorating.” More frequently, though, that school bus represented responsibilities for me and my brother. We were tasked with sweeping the bus weekly (we got to keep anything we found, though 50 cents may be the most I ever got) and helping with annual goodie bags for each bus rider at Christmas time. Almost nightly, I helped pack my daddy's lunchbox, which was shaped like, you guessed it, a school bus. If you want a visual, just search eBay for “school bus lunch box.” I think I can still recall exactly where each lunch item was placed to allow for maximum capacity and minimal spillage. No one wants pickle juice to leak onto his Little Debbie cake!

My grandmother was a lifelong educator, and, even in retirement, taught the private kindergarten class at the child care center my mom owned for a time. Because of this, I learned how to read at an early age by rote memorization and repetition. Phonics had not yet taken hold as “the” way to teach reading. As my brother and I grew, my mother sold the child care center and began working in the school system in multiple roles, with her priority being a schedule that mirrored that of the rest of the family. School was, literally, everyone's job.

While this may seem a highly predictable and somewhat prosaic introduction to this Fall 2017 issue of *ACLP Bulletin*, the return to school, and the almost new year-like feelings that this time of

year brings with it, impacts me, and, I'm thinking, many others.



Two of my favorite things about school were getting a new schedule of classes each semester and new school supplies. The schedule of classes promised a variety of subjects (and different combinations of classmates) for each day. I liked knowing when my favorite classes would happen and when my least favorites would be over. To be completely honest, I've always loved the clarity and tidiness of a schedule. School supplies, or as adults call them, “office supplies,” are something that still cause a sense of giddiness and fresh, clean starts amidst the daily-ness of life. I think I love school supplies because of the way they add organization to complex—or sometimes just dry—information. As a student, I had to make sense of several different subjects, assignments, and timelines. Wait—this sounds a lot like my days now! To me, school supplies are almost like a coping tool, though I wasn't aware of it until now. Because I can choose them for myself (days

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This issue of ACLP Bulletin is a lot like a new school schedule, filled with diverse topics to increase your understanding of ways to empower yourself, children, and families, as well as support professional learning.

of the week pencils, anyone?), they remind me of restarting, refreshing, and resetting. I can reframe big jobs and large amounts of information into manageable, relatable pieces.

This issue of *ACLP Bulletin* is a lot like a new school schedule, filled with diverse topics to increase your understanding of ways to empower yourself, children, and families, as well as support professional learning. In fact, this issue's Alphabet 2.0 column is titled "K is for Knowledge." You

will find some history in the Moments from the Past and Beyond the Classroom columns. The Global Perspectives piece, "The Journey of Child Life in Hong Kong," will educate you about pediatric healthcare in a country outside North America. The article "Viewing the Internship Application Process Through Both Sides of the Window," could even be viewed as a sort of orientation for students and professionals involved in internship selection. In addition, this issue's *Focus* section features two complimentary articles examining the concept of spirituality. Consider these articles as a "special topics" seminar on supporting spiritual development and needs of children, youth, and their families in healthcare settings.

So, pull out your Trapper Keeper, highlighter, and freshly sharpened pencil and make time in your schedule to read, learn, and grow. If it helps, pack yourself a delicious snack or lunch in a new (or vintage) lunchbox, to get the full back-to-school effect. ✨

Milestones

The child life community recently lost a steadfast advocate as **Rosemary Bolig, PhD**, passed away on July 28, 2017. Throughout the course of her long career, Rosemary worked in many settings, including child life, but the thread running through all of them was a constant focus on improving the lives of children. Her contributions to child life were recognized when she was honored in 1988 with the Distinguished Service Award, ACLP's highest honor. After a child life career at Johns Hopkins Hospital in Baltimore, MD, and the Hospital for Sick Children in London, England, Rosemary continued her education and began working in academia, where her research reflected her continued interest in the foundations of child life, including children's responses to illnesses and hospitalization and play. Most recently, she served as a professor of early childhood education at the University of the District of Columbia, retiring last year. Among child life professionals, she is widely known, along with coauthors Judy Rollins and Carmel Mahan, for her contribution to a seminal text in our field, *Meeting Children's Psychosocial Needs Across the Healthcare Continuum*, published in 2005. Before her death, she was able to complete a revision of this book, which is to be published in 2018. Her other writings, including peer-reviewed publications on issues relating to children, may be explored through a database search.

Recognizing Rosemary's devotion to children and animals, her family has requested that donations in her memory be made to the Association of Child Life Professionals, 1820 Fort Myer Drive, Suite 520, Arlington, VA 22209, or the Humane Rescue Alliance, 71 Oglethorpe Street NW, Washington, DC 20011. If you prefer, you may make donations on the ACLP website through your member profile.



President's Perspective

Eileen M. Clark, MSM, CCLS

Leadership in Action

I often describe myself as an *eternal optimist*. As I embark upon my role as president of ACLP, my optimism is centered on the collective wisdom of the child life community. I admire the tremendous commitment of members and the many opportunities ACLP has available to share experiences, resources, and knowledge. This community of professionals demonstrates a compassionate skill set that sparks creativity, rejuvenates inspiration, and ignites resilience that leaves children with the strength to conquer the unknown of illness, disease, and treatment.

This community of professionals demonstrates a compassionate skill set that sparks creativity, rejuvenates inspiration, and ignites resilience that leaves children with the strength to conquer the unknown of illness, disease, and treatment.

The focus of my efforts in the first months of my tenure has been on building a strong foundation and decisively moving the association forward. Along with our talented and dedicated board members, I have been working to put a strong leadership structure in place, launch the Graduate Program Review Committee, and support the work of ACLP's various committees as they began a new year of work after May's conference. Our efforts over the next few months will include aligning our financial and volunteer efforts around identified priorities, as we do our best to position our profession for success in the changing healthcare arena.

As I transitioned into this role, an early task involved conferring with the board, volunteer leadership, and an advisory council of public stakeholders as we deliberated the best structure for our staff leadership. As you know, we

extended an offer to Jennifer Lipsey, MA, and she has accepted the permanent position of chief executive officer. We have been incredibly fortunate to have Jennifer leading ACLP through the transitional period, and we are confident that she is a good fit for our organization. In August, Bailey Kasten joined the executive team as chief operating officer. Bailey completed her bachelor's degree in political science at American University, has worked in the association industry for 13 years, and is currently working towards her Certified Association Executive designation (CAE). The structure of two leaders is not new to the association; however this division of roles and responsibilities offers an additional layer of accountability with an infrastructure to fully support transparency and collaboration.

Also this summer, the Graduate Program Review Committee was formed, with the intention that this group will recruit and train reviewers to evaluate graduate-level child life programs, mirroring the structure and process of the Undergraduate Program Review Committee. As a part of the larger Students and Emerging Professionals Committee, this group will collaborate with other subcommittees to ensure that the education and training of future child life specialists is appropriate and consistent. Also under the umbrella of the Students and Emerging Professionals Committee, the newly-struck Practicum Task Force is working toward understanding the impact of practicum programs on students, universities, and clinical training programs. This task force was struck in response to discussions about the role of practicum programs in child life education and training during the Academic Summit held last summer.

We are fortunate to have a very involved membership, which translated to very active committees. One group that I would like to highlight is the Patient and Family Experience Committee, recently elevated from a task force. This group will propose and recommend partnership opportunities and identify possible pilot projects that

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Leadership in Action

will allow us to explore the impact of child life specialists on the patient experience, evaluate ways to support the work of child life specialists in relationship to the patient and family experience, and recommend ways to increase our involvement and recognition in this work.

Looking ahead, ACLP has plans for exploration, growth, and connection. As part of her onboarding as CEO, Jennifer identified three priorities that provide a vision for the future, allowing us to align our financial and volunteer efforts around these priorities. Highlights include research and data collection, outreach and marketing, and partnerships, which are already reflected in work that is being done by staff, leadership, and the many ACLP members who volunteer on our highly active committees. I'll highlight a bit of that work as it relates to these priorities here.

ACLP has begun collecting data about child life programs in order to begin translating the impact of child life services into numbers that will make sense to hospital administrators and decision makers.

We often think of research taking place at the program level, but our professional organization itself is also involved in research on members' behalf. ACLP has begun collecting data about child life programs in order to begin translating the impact of child life services into numbers that will make sense to hospital administrators

and decision makers. The article on page 42 details the purpose, history, and capabilities of the Child Life Professional Data Center. I encourage you to learn more about this undertaking, and most of all, to participate by entering your data. The success of this important project is dependent upon participation of all child life programs, from the smallest to the largest.

Outreach and marketing projects are already underway as well. Jennifer's column on page 5 highlights some of the collaborations, along with the goals and projected benefits of these projects. We are confident that capitalizing on opportunities to demonstrate the value of child life to those interested in pediatric healthcare and psychosocial care will lead to future inroads for the field.

As for the third priority, partnerships, we have recently charged a Partnership Development Committee with defining and developing policies and processes to help define our capacity in relationships with potential donors, supporters, advertisers, and other individuals, organizations, and agencies that have an interest in collaborating with ACLP in service of short or long-term goals. This committee is part of our new CEO's plan to create strong partnerships that will allow ACLP to manage current programs and initiatives for members and to develop a structure that will help enhance the membership experience while attending to the organization's financial health.

I could not be more proud or excited to be working for and representing you, child life professionals doing the work we are all passionate about. ✨



CEO Shares

Jennifer Lipsey, MA

Outreach and Opportunities

Fall 2017 marks an incredibly exciting time for ACLP partnerships. As we prioritize outreach and public engagement, we have found a number of organizations eager to join our efforts in exposing the value of child life specialists as vital members of the interdisciplinary healthcare team. As hospital funding becomes increasingly tied to patient satisfaction, we have made efforts to emphasize the need to demonstrate excellence in patient and family care, and we have found organizations that agree that child life specialists are an essential component in creating the best patient-family experience.

This November, I will have the honor of attending a convening hosted by Hope for Henry, an organization dedicated to improving the hospital experience for children. This meeting will focus on the theme “Reimagining Care for Hospitalized Kids: A Convening of Experts,” and I will be joined by medical professionals, child life specialists, parents, and community supporters to discuss our mutual focus on improving the pediatric experience. All attendees will continue working together to identify key concepts and seek development and implementation support, with the ultimate goal of minimizing anxiety and maximizing support for hospitalized children so that they can focus fully on recovering quickly and with minimal long-lasting trauma. ACLP looks forward to continued efforts with Hope for Henry as we join voices and share ideas and resources to raise the credibility of the child life profession.

In addition to collaborating with Hope for Henry, ACLP has engaged other organizations that share an understanding and respect for the work of our members. In September, ACLP president Eileen Clark represented child life on panel presentations at the Global Genes Rare Disease Summit in Irvine, CA, and at the Association for Vascular Access (AVA) Annual Conference in Phoenix, AZ. ACLP also had a presence in the AVA exhibit hall, and used this opportunity to educate nurses and other health professionals on the ways that child life can make vascular access procedures

successful for medical staff and less traumatic for pediatric patients and families. ACLP and AVA continue to work together, with ACLP consulting on the development of a pediatric PICC placement course for nurses by providing content expertise on child development, effective procedural education, coping methods, and more. These partnership activities align with our strategic goal of enhancing the professional credibility of the child life profession, and we look forward to future opportunities to collaborate with other professional organizations on our shared goal of improving the healthcare experience for patients and families.

Related to partnerships, ACLP received grant funding to support the development of a sustainable internship program abroad. The Children’s Cancer Foundation (CCF) child life program in Hong Kong was selected for the initial location, based on the number of certified and highly experienced child life staff members, their previous involvement with ACLP, and their established program development towards solidifying an internship experience. In August, three representatives from CCF visited the U.S. for two weeks to learn from the child life internship programs at Huntsville Women’s and Children’s Hospital in Alabama, St. Louis Children’s Hospital in Missouri, and Cook Children’s Medical Center in Texas. The CCF team will take what they learned and begin to develop materials for their own internship program. In January, they will share a rotation of an intern with a U.S. program, and will be ready to host a full internship for the first time next summer. We are thrilled to support CCF in this endeavor and look forward to continuing to support their internship efforts over the next few months.

As these relationships begin to take shape and new opportunities to engage the public in who you are and the significant work you do, we don’t want to lose sight of your needs as members of this organization. We recently sent the ACLP Member Survey to your inbox and appreciate the

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Have you heard about the ACLP Mentor Program?

Jennifer Fieten, MA, CCLS

ON BEHALF OF THE LEADERSHIP DEVELOPMENT MENTOR PROGRAM SUBCOMMITTEE

“Colleagues are a wonderful thing—but mentors, that’s where the real work gets done.”

~ Junot Diaz

The purpose of the ACLP Mentor Program is to help child life professionals achieve their aims, whether that be to perform well in a current role or to identify career goals and developmental actions to move toward these goals. The developmental focus of these goals can be related to clinical skills, leadership skills, or personal effectiveness skills. Mentorship opportunities are also available for academic child life professionals seeking opportunities to develop and enhance skills related to the academic setting, as well as for experienced professionals.

The Mentor Program consists of several specific key elements: a selection and matching process, monthly meetings (in-person or virtual) of mentor/mentee pairs, a mentor guidebook, live webinars for both mentors and mentees, a mid-point check in, and a final evaluation of the impact of the program from the perspectives of both mentors and mentees.

Individuals interested in applying to participate in the Mentor Program must meet the following eligibility requirements:

- Must be a professional member of ACLP and maintain membership for the duration of the mentoring program
- Must be a Certified Child Life Specialist and main-

tain certification for duration of program

- Must be willing to adhere to the guidelines of the mentoring program, including participation in orientation webinars

Individuals applying to be a mentee must have a learning or development need for either their current or future role as expressed in the application. Those applying as a mentor must have a specialized skillset or talent that they are willing to share. Additionally, mentors are provided with a mentor-specific training webinar. Mentors are also eligible for 1 PDU for participating in the ACLP Mentor Program.

“Mentoring is a powerful way to help people develop enhanced skills, increase their confidence and resilience, and define career direction” (Nourse Leadership Strategies, 2014, p. 3). Previous participants in the ACLP Mentor Program identified the following benefits:

“My mentor encouraged me to keep asking, and to keep finding new ways to ask.”

“The program... helped me to settle into what I feel are my priorities and what things can wait. With that, learning that things will sometimes take longer than I planned and that it is okay and not a reflection on my abilities and practice.”

There is still time to apply to become a mentor or a mentee in the 2018 Mentor Program! Help us to spread the word! Applications are being accepted now through Friday, October 6, at 5:00 p.m. Eastern time. For additional information about the Mentor Program, or to fill out an application, go to the [Mentor Program page](#) on the ACLP website today! ✨

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[continued from page 5](#)

Outreach and Opportunities

feedback from all those who participated. For those who missed it, we anticipate the ongoing practice of an annual member survey to ensure a consistent platform for members to share with us and confirm or correct the current direction.

Reflecting back upon the year, an underlying theme of much of the work that ACLP leadership, volunteers, and staff have been engaged in has been outreach and collaboration. We intend to keep up the momentum so that every child and family can request and receive the care of a child life specialist. ✨



ALPHABET 2.0



K is for Knowledge

Jessica M. Hotchkiss, MS, CCLS

ST. JUDE CHILDREN'S RESEARCH HOSPITAL, MEMPHIS, TN

Knowledge is power. This is a phrase utilized by many individuals, in a variety of contexts. It offers insight into the potential of one's ability, but overlooks an important aspect of learning—that the true power of knowledge lies not in the quantity of information possessed, but in the ways in which it is applied as we continue to obtain it. Merriam-Webster (2017) defines knowledge as “the fact or condition of knowing something with familiarity gained through experience or association...the range of one's information or understanding” (para.1). As child life specialists, that range of knowledge includes a culmination of both professional responsibility and clinical practice. It is apparent that simply obtaining knowledge in child and adolescent development is not a stand-alone process, as our expertise is not found in our ability to recite Piaget's stages. It is the ability to *integrate* and *build upon* knowledge in our work with children and families. Therefore, the foundation, application, and advancement of knowledge becomes crucial to the development of each child life specialist.

The Mission, Values, Vision statements of the Association of Child Life Professionals (ACLP; formerly known as the Child Life Council) make up the cornerstone of our clinical practice. These statements highlight the importance of knowledge grounded in theory, collaboration among disciplines, and the progression of standards (Child Life Council, 2011). The competencies set forth by the ACLP identify the minimum standards needed for professional practice and comprise a foundation of knowledge that sets the bar for our profession (Child Life Council, 2016). These standards establish a minimum level of competency, vital to the foundational knowledge of child life professionals. Yet, professional responsibility is often looked at as a self-regulated task regarding awareness of the standards of clinical practice, code of professional

conduct, and core competencies. Often overlooked is the importance of these standards as they are integrated throughout one's day-to-day practice and duration of one's career.

Integration of knowledge is enhanced through the culmination of education, experience, and practice. The ability to identify developmental considerations and stressors of the healthcare environment decreases trauma for children and families (Child Life Council, 2016), allowing child life specialists to bring different perspectives to the interdisciplinary team. Although experience, connection, and play are often discussed within our roles, the overarching framework of our practice comes from that knowledge—our ability to understand, disseminate, and apply information regarding the families' response to stressors and potential trauma due to hospitalization. This becomes especially important when differentiating our role from other disciplines within the hospital setting; without the ability to articulate our core competencies and knowledge, we are unable to advocate for services and grow as a profession.

To this point, what was once viewed as simply “play” has now become a therapeutic tool to facilitate coping and reduce emotional distress during healthcare encounters (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014). The implementation of therapeutic play in situations such as intravenous medication administration allows children to have a sense of control, reduces stress, and creates an environment of both learning and emotional expression (Dantas, Nóbrega, Pimenta, & Collet, 2016). This concept has evolved throughout our discipline to form the basis of our competency in therapeutic play. Yet one must be able to understand and speak to the significance of that therapeutic intervention for it to truly have an impact within the healthcare environment.

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K is for Knowledge

Additionally, ethical principles highlight the importance of maintaining competence to improve the application of knowledge. This occurs through a commitment to enhance one's practice by updating skills and knowledge relevant to the population that they serve (Child Life Certifying Committee, 2017). The ACLP's value statement on professional standards of practice reiterates these principles: "The commitment to excellence and integrity in our professional practices involves lifelong learning, adherence to our code of ethics, and the development and support of educational and training programs based upon defined clinical competencies" (Child Life Council, 2011, p. 2). Maintaining this stance allows us not only to showcase our ability to connect with families, but to identify the evidence-based practices behind those interventions. Through the understanding of our competencies and ethics, child life specialists are better able to identify ways to integrate that knowledge into practice.

Utilizing models centered on theories of social learning and intrinsic motivation may enhance adult learning outcomes, creating opportunities for deeper exploration in areas often underexplored in child life, such as grief models, neurobiological responses to healthcare encounters, and relational theory.

Knowledge can be obtained through a variety of modalities. According to Steffens (2015), in formal education and training programs, learning is often guided by a professional with specific goals in mind. Alternatively, opportunities for informal learning are self-regulated, indicating a need for intrinsic motivation. This gives each child life specialist the responsibility for learning in order to address the minimum competencies required by the ACLP. Opportunities can be guided by experience, motivation for change, and one's passion regarding specific areas of practice. Alternative learning strategies and informal edu-

cational opportunities can then become effective modalities toward the expansion of knowledge.

One social learning theory, generativism, suggests that creating new meaning from concepts which have already been discovered assists in the production of new knowledge (Steffens, 2015). This strategy focuses on the importance for adult-based learning outcomes, noting the significance of knowledge-generating opportunities to form new meaning structures (Ross-Gordon, Rose, & Kasworm, 2016). These opportunities center on social learning, allowing the specialist to utilize past experiences to enhance knowledge. This can enrich collaboration with professionals from across the discipline and beyond. Continuing to build on already established knowledge allows child life specialists the opportunity to become advanced practitioners in their own right. Utilizing models centered on theories of social learning and intrinsic motivation may enhance adult learning outcomes (Steffens, 2015), creating opportunities for deeper exploration in areas often underexplored in child life, such as grief models, neurobiological responses to healthcare encounters, and relational theory.

The application of knowledge is at the core of child life. It is not only showcased through one's clinical ability, but through professional responsibility as well. The ability to complete assessments speaks to the integration and enhancement of knowledge in all areas of professional practice. Identifying whether a child is able to process abstract concepts or requires concrete information is one such example of the crucial assessment needed to successfully fulfill our duties (Hollon & Skinner, 2009). Without the basic understanding of these principles of cognitive development, we would not be able to apply them when providing diagnostic teaching, distraction, or bereavement support. Although assessment is a critical task in one's clinical work, it proves to also be an essential tool for professionals to identify self-awareness regarding professional responsibility. Consequently, without the desire to build upon knowledge, information may be missed and adversely affect a child's coping and the significance of a therapeutic intervention.

Through the mastery of these competencies and the addition of knowledge from professionals in differing specialty areas, achievements in the field of child life are ever-growing. There must exist a sense of intrinsic motivation within that continued learning to maintain accountability for one's own competencies. The adaptation of new learning theories, such as that of generativism, may also increase awareness of metacognition and inspire collaboration to build upon already existing knowledge (Steffens, 2015), assisting in the application of that knowledge to the field of child life. The saying "knowledge is power" is a great concept, but the true power of our knowledge is not measured by quantity. It is measured by the strength of one's continued enhancement and application of learning. The desire to both obtain and integrate knowledge may look different for each professional, but the premise behind the pursuit of knowledge remains the same—a commitment to personal and professional growth.

Therefore, make a commitment to your own professional development. Opportunities for

The power to become a great child life specialist is not about a certification, advanced degree, or award.

self-discovery and professional growth are not always found, they need to be created. Build upon already existing knowledge and explore a new theory, or research article. Call professionals from another hospital and have a dialogue on best practice for bereavement support. Look for challenges in your day-to-day routine, deconstruct your therapeutic interventions, and practice explaining them to the team. Identify how your work correlates with each competency area, and which areas you will choose to expand upon in the coming year. The power to become a great child life specialist is not about a certification, advanced degree, or award. It is through the continuous exploration of one's knowledge through practice, leadership, and the willingness to take risks to grow the profession. Knowledge is power. So go get it. ✨

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LESSONS IN PERSONAL AND PROFESSIONAL HUMILITY, HOPE AND RESILIENCE:

Experiential Knowledge from a Child Life Specialist in the Sandwich Generation

Kristen Johnson, CCLS

CHILDREN'S HOSPITAL AT DARTMOUTH, LEBANON, NH

In December, 2015, my mother was diagnosed with pancreatic cancer. My mother, the athlete, who took better care of herself than anyone I have ever met. She was witty, quiet, an excellent planner, a caring listener, driven, and calm unless she needed to be fierce to advocate for herself or her kids. She was far from perfect but she was my mom and she was figuring out life just as each of us does every single day.



Lukas going for a walk with Grandma during a visit to the Midwest.

After learning of her diagnosis, my husband and I planned a two week trip to the Midwest with our son, Lukas, who celebrated his second birthday at my parents' home, a home they have owned for over 43 years. As an east coast-living child life specialist, I took time off, flew with our son, and was determined to make the most of time. My mother was hospitalized for part of our time there. In the following months, I had return trips alone in moments of crisis and one period of time when I was just able to be with my parents and help move the patio furniture and do tasks around the house to help as we spent time together, went out to eat, went for walks, and talked. My parents and two of my siblings met my husband, Lukas, and me in Cape Cod for a week vacation in the summer where they played hanger guitar at Lukas' request and taught him the Rolling Stones song, "You Can't Always Get what You Want."

In November 2016, I received a call from my father that my mom had collapsed at home and was taken by ambulance to the ICU. Some time after that, I received another call from my parents as conversations with the providers had shifted into talking about her wishes for resuscitation as they prepared for an unanticipated surgery. Before the call ended, she told me, "Whatever happens, it's going to be okay." I flew home when she was intubated post-surgery in the ICU. After a few days of continued conversations and difficult news, as a family we advocated to have her taken home on hospice for compassionate extubation. She lived at home for a few more days, surrounded by family and friends. I held her hand as she took her last breath the day before Thanksgiving.

I write this as there are aspects of this lived experience that now inform my professional practice and deepen my awareness of the patient and family experience. I share this writing with you as I hope it might offer some additional perspective for your own clinical practice and care of patients and families.

“Resilience is accepting your new reality, even if it’s less good than the one you had before.”

— Elizabeth Edwards, *Resilience: Reflections on the Burden's and Gifts of Facing Life's Adversities*

As a person...

I have felt anticipatory grief sitting in the ICU with my mother fighting for her life. I know what it feels like to sit next to a loved one and to try to will them to speak and hope that they show you some kind of sign without avail. I know how it feels to long to hear the voice of your loved one, one last time. What is it in reality? With the limitations in thinking while in the heart of stress, I can read the same page of a book at the bedside for hours and still learn something new, while also being distracted in the midst of reading it. I can vacillate from tears to calm to tears, to peace in the period of minutes. I can feel bone tired yet sleep will not suffice.

This has taught me to further appreciate individual experiences of patients and families for what they are—to meet them in the moment and to take time to learn about the person we are caring for and those who love the person we are caring for.

As a parent...

We included Lukas in our experience (he is now 3½). I spoke honestly about my feelings in the moment, saying, for example, “Grandma is sick. I’m crying because I’m sad (or worried) about Grandma.” It was important to me for Lukas to be a part of this shared life experience—to feel caring, compassion, and empathy.

When we traveled by plane (his first flight) to visit her shortly after diagnosis, I took photographs throughout our visit and made it into a storybook for him when we returned.

“What makes up resilience? If you look at the current research, here are five of the most common factors of resilient people: They are resourceful and have good problem-solving skills. They are more likely to seek help. They hold the belief that they can do something that will help them to manage their feelings and to cope. They have social support available to them. They are connected with others, such as family or friends.”

— Brene Brown, *The Gifts of Imperfection: Let Go of Who You Think You're Supposed to Be and Embrace Who You Are*

My mother inscribed in a book I brought with us, *The Invisible String* by Patrice Karst, with a message that when he is thinking about her, all he will need to do is “tug on that invisible string” and she will be with him. She recorded her voice into a recordable book, and it is so meaningful for him (and for me) to hear her voice. With the distance, we FaceTimed as often as we could, and continued to talk on the phone. Each pretend phone call Lukas made in play also happened to be to Grandma, followed by me making a real call to let her know and giving Lukas a chance to hear her voice as he got a little older and began to be able to carry on a conversation. Lukas played about our experience, and as I traveled a few times without him, there were a number of occasions he rolled my carry on suitcase through the house, into the garage, put it in the car (with assistance) and told me “we’re going to Nebraska to check on Grandma” and that he was going to drive us there. I went with it and played along in the passenger seat as he “drove.” Lukas

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Experiential Knowledge from a Child Life Specialist in the Sandwich Generation

even asked Santa Claus for “a rolling bag” (and was excited to find his very own on Christmas morning).

We chose to tell Lukas that Grandma died and she is in heaven. Our son, on his own, said, “Like the dinosaur daddy [in *The Good Dinosaur*]?” “Yes, buddy. Like the dinosaur daddy.” I used to think there was so much death in Disney movies—in almost every one there is a parent or family member who dies. Now I wonder if this has been done with intention to give children context and reference to life experiences nearly every child will have at some point. We also told our son that she lives on in our memory and our hearts (“Right here?” pointing to his side. “A little higher but, yes buddy, right there”). We talk to Grandma as we see the night stars in the sky. When he makes pretend phone calls now it is almost always to her: “Hi Grandma, sorry you died. I love you. I miss you. Bye.”

The continued conversations I have had with him reinforce what we have learned about developmental understanding of grief and loss: “Can we take an airplane to heaven to see Grandma?” “Will she come back?” “She lives in our hearts?” A recent one took my breath away in its inquiry: “Are there windows in heaven?” And another statement just made me gulp in it’s out-of-the-blue admission as we were sweeping out the garage: “Mommy, I’m going to miss you a lot when I die.” This was followed by me talking about how I hope he is going to live for a very long time with his response of, “Yeah, but when I’m really old and die, I’m going to miss you.” (That his 3½-year-old mind thinks that I am going to live beyond his really oldness makes the child life specialist in me smile and know that I will save that mortality lesson for another conversation).

As a parent, I think about all of the things I had hoped for and will miss—Lukas growing to have vacations at Grandma and Grandpa’s house, more time together when she was feeling well, Lukas getting to know her wit and talent for history and trivia, holidays, Mother’s Day, conversations during walks, and her having the chance to know him as he grows and becomes the person he is intended to be. In time, the memories he has of her will fade; however, I believe he will continue to know her from the pictures and stories I share.

This has reminded me that each family we interact with has layers beyond themselves in practicing care—caring for parents, for children, friends, and other loved ones.

“Having courage does not mean that we are unafraid. Having courage and showing courage means we face our fears. We are able to say, I have fallen, but I will get up.”

— Maya Angelou

As a family member and caregiver...

I learned first-hand that each person comes to an experience with their own perspectives and own pace—a pace in coping with a diagnosis, a change in prognosis, or the anticipated loss of a loved one. Each member of the family does this in their own way, in their own time, and there is significance in knowing there is not one right way to do this.

As an adult daughter, I can still be proud of my parents; they can still surprise me in the best of ways. I have been witness to their vulnerability and moments of selfless love—from my mother who wrote out plans for her own funeral and letters to each of us and kept them in an easy place to be found, to my father who stepped up by providing care in the hardest “labor of love” imaginable, and did so without complaint. I believe that love at its finest can be selfless in action.

We meet families every day who are living a life they likely did not plan for but are doing it because it is the life they were given. This has shown me the importance of acknowledging this, in giving people the benefit of the doubt, and to working together to identify support when it might be needed.

“Resilience is based on compassion for ourselves as well as compassion for others.”

— Sharon Salzberg

As a healthcare consumer and professional in the healthcare setting...

I was reminded that healthcare professionals are people—people with education and training, people with feelings, and people with opinions. While the medical system offered hope, in the long run continued interventions lessened my mother’s quality of life. There is no crystal ball to determine what the outcome will be for *any* decision—as healthcare

consumers, we hope that those offering options are doing so with compassion, objectivity, and insight into what is most important to those receiving care. We hope for the best and as my mother would say, you “give it the old college try.”

In this shared experience, I have learned simple lessons that further inform and guide my daily practice. In being present, it is important to accept that each patient is a person—a person with a past, a wished-for future, hopes and dreams, and people in their lives who care deeply about their well-being. In a healthcare environment, it’s important to let hope exist and to let courage happen. Saying goodbye to families at the end of your shift demonstrates an acknowledged awareness that the patient and family are staying but that you consider that presence worthy of a transition in care. I wish this would have happened for us, as we shared our hearts with those who provided care. It is important to call patients and families by the names they would like to be called—they are sharing their vulnerability with you, and knowing their name is a small practice of kindness. We wanted the people taking care of our mom to know her name instead of using a term of endearment.

As a healthcare consumer, know that when someone tells you what you “should be doing to take care of yourself,” even if it feels grinding, it is coming from a good place. In general, people have really good intentions; however, sometimes what they say is far from helpful. Sometimes advice offered is just that—take it for what it is.

As a healthcare professional, know that some people just don’t want to leave their loved one’s side, and that this is okay too. If you continue to tell people what they need to do to practice self-care, take a gentle hint that they may not agree with you.

As a consumer, give yourself permission to hold onto hope and belief even when the expressions of those around you say otherwise. Talk about the hard stuff, and remember the really good stuff. I learned first-hand the value of difficult conversations. There is importance in knowing the wishes of a loved one even if it’s hard to hear. Take notes and write messages to yourself; it is amazing how little one truly processes in the midst of stress. Even if your loved one isn’t talking to you, talk with them. Tell them about what is happening and what will happen.

I believe that when informed decisions are made out of love, they are the right decisions for your loved one. There are also really good people in the world to support you and to help

advocate for your loved one’s wishes—sometimes it takes a little extra effort to find them. For us, these were nurses in the ICU, the hospice team, and the ambulance team.

The lessons I learned from my amazingly organized mother: Appoint a durable power of attorney. Talk with that person; tell them your wishes for medical care. Complete the paperwork required legally, make copies of it and make sure that your loved ones know where that paperwork is. Write out what you would like your funeral to look like—if you’d like, choose the music, passages you would like read, and where you would like it to be. Determine what you would like done with your body. Share what you would like your headstone to look like. Planning ahead makes it so much easier for your loved ones and it is comforting knowing that your wishes will be followed. Consider writing a letter to your loved ones; finding it will bring a light to an otherwise darkened day. It has been beautiful for us to find all of the messages she wanted us to receive.

I learned first-hand that love and loss can hurt, even when you know your loved one will no longer be suffering. Although I am quite private in the professional setting, I needed to share my experience with my clinical team at work, as I knew that I was different, that they would see that I was different, that I am different from the experience I have lived. Not better or worse, just different. I have lived the transformation of grief. One of the biggest lessons I learned was about resilience: Sometimes it is about keeping one foot in front of the other until you can feel the ground beneath you again. ✨

“The most beautiful people we have known are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity, and an understanding of life that fills them with compassion, gentleness, and a deep loving concern. Beautiful people do not just happen.”

— Elizabeth Kubler Ross, *Death: The Final Stage of Growth*



RISKS AND BENEFITS OF TABLET USE:

Are Child Life Specialists Being Replaced by Technology?

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There is no debating that technology has taken a leading role in most people's personal and professional lives, and child life professionals are no exception. Child life specialists have always adopted technology into their approach, most recently incorporating tablets and other hand-held devices into their toolkits to interact with patients and families. There are obvious benefits to doing this: Children are familiar with tablets and many prefer

tablet play to any other activity; it is possible to carry both diversional and educational materials on the tablet; and tablets are extremely portable. But what are the potential risks of inviting tablet technology into child life practice? It turns out that many child life professionals have significant concerns about the impact of technology, specifically tablet use, on the child life profession.

Although the use of tablets as a child life intervention has been steadily increasing in recent years, a review of the literature found little inquiry into the impact of this practice on both patient care and the role of the child life specialist. In general, the often-anecdotal literature that does exist reflects a positive response to tablet

use. Tablets have been described as an effective tool for educating patients about procedures. One article reported that "the technology became a way to really grab children's attention...It is used by child life specialists to educate children and teens about procedures" (Case Management Advisor, 2011, para. 7). Also identified as a benefit of tablet use was communication of information to children with autism spectrum disorder. A study with interdisciplinary authors, including a child life specialist, reported "literature indicates that iPads are increasingly used for the delivery of social scripts and stories for children with ASD" (Johnson et al., 2014, p. 652). Tablets were noted to be highly effective at providing distraction during procedures

or in stressful situations, but also were demonstrated to be an effective tool for providing procedural preparation and thereby increasing a child's sense of mastery in the healthcare environment. Borges, Huber, and Lugo (2011) state, "child life specialists repeatedly say the devices are highly effective in helping children cope with procedures by not only distracting them, but by also giving patients a sense of mastery and control in an environment where these are relinquished" (p. 88).

While the literature that exists paints a glowing report of the many positive outcomes tablets can help to attain, it is also important to note that only one of the above noted scenarios was a randomized study and included child life participation. This begs the question: What do child life specialists think about the use of tablets in their professional practice? While there are broad effects of tablet use on children's learning and development, this paper presents a closer look at child life specialists' perceptions of tablet use in their professional practice, risks and benefits associated with tablet use, and implications for the continuing use of technology by the child life profession.

In order to answer the question of child life specialists' opinions of tablet use, child life professionals were asked to respond to a survey designed to elicit their opinions and attitudes about tablet use during child life interventions. The survey consisted of 22 questions presented in free text, Likert-type scale, and multiple choice formats. The survey included the following content areas: demographics, frequency of tablet use, age range of patients with whom a tablet was used, and types of interactions in which a tablet was used. Opinions about the influence of tablet use on family, staff, and child life specialist satisfaction were also gathered.

While the literature that exists paints a glowing report of the many positive outcomes tablets can help to attain, it is also important to note that only one of the above noted scenarios was a randomized study and included child life participation.

Participants known to the authors were recruited as a convenience sample via email and asked to have 3 to 5 child life staff in their departments respond to a Survey Monkey questionnaire, with a two week response time. A follow up email was sent prior to the deadline to encourage participation. Potential participants were selected from healthcare settings of varying sizes and locations. The final group of participants (n=47) represented three countries and seventeen states across the United States, and the participating programs varied in size from 1 to greater than 25 employees. Specialists ranged in experience from 0 to greater than 20 years, and 66% of respondents indicated that they had been using a tablet in their practice for 3 to 5 years. Two percent of respondents indicated that they never used a tablet, some citing the patient population they worked with (i.e., neonates), and others citing personal preference. Following the close of the survey window, authors examined responses to identify trends. The responses revealed what child life specialists see as benefits, risks, and concerns about educating students about tablet use.

Benefits of Tablet Use

The benefits of tablet use reported by child life professionals focused on ways technology enhanced child life services. Child life professionals reported tablets as multi-functional because, as one participant said, they are "easily accessible and cover a wide range of needs [varying] from education to alternative

focus to legacy projects." By their very nature, tablets are innovative and familiar to children. One respondent said, "In the age of technology where children no longer know a life without cell phones, internet, or wifi, the tablet is a great resource for building rapport and giving children a choice of distraction that is fun and comfortable for them to manipulate." Other respondents spoke to more inventive uses for tablets. "Tablets can be used in unexpected situations and are easy to utilize in challenging positions and spaces. A translator app can be utilized to communicate with families for non-medical needs in quick situations." In addition, one participant noted "tablets can aid in changing the environment quickly with the use of a music app, colored screen, and quick dim of the lights." Multiple child life professionals reported the ability to engage children of varying developmental ages and with a wide spectrum of abilities due to the "plethora of resources in various domains: educational, entertainment, communication, and sensory." Tablets provided adaptability to child life professionals because of the "multitude of apps [that] work with any population." One participant spoke to the usefulness of tablets with both "developmentally delayed and autistic patients."

Risks of Tablet Use

As noted above, tablets have the ability to greatly enhance child life practice; however, child life professionals also reported multiple concerns and risks

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Are Child Life Specialists Being Replaced by Technology?



related to tablet use. Given that tablets are so versatile, a child life specialist runs the risk of developing dependence on a single tool. One respondent stated, “When our field becomes dependent on them is when it is a problem. They should be used in moderation.” Some child life professionals also related concerns that other hospital staff perceive a tablet as equivalent to a Certified Child Life Specialist, expressing thoughts such as, “The CCLS may become known as the ‘iPad lady’ and thus consulted only for the use of the tablet rather than the service that the child life specialist can offer.” As in the past when child life specialists were perceived as “the play lady,” child life teams will need to be mindful when educating staff to emphasize the importance of trusting relationships built with patients, procedural preparation, and the plethora of coping strategies engaged with patients, in addition to the role of distraction in interventions.

Sometimes, as in the case when a child life specialist is called only to bring the tablet and in turn lacks time to build critical rapport with patients, tablets

can further inhibit rapport building because the patient is engaged with the tablet and not the child life specialist. A survey respondent wrote “it is hard to build rapport with the patient once they start playing the tablet.” With a growing awareness to include play in child life professional practice, tablets can potentially inhibit creativity and imaginative play. As one participant pointed out, “There is nothing better than open-ended, child directed/led therapeutic play. No ‘app’ can replace it.” These concerns voiced by child life professionals potentially have far-reaching implications on the future of the profession.

Implications for Tablet Use

Student education was noted to be an area for closer examination to determine how technology may impact skills learned during internship and other student training opportunities. Several survey respondents related experiences with new graduates who had only learned how to interact with children using electronics and thus had a limited toolkit for patient care.

During student training, students typically gain a variety of experiences, skills, and tools to use in practice. If students are solely relying on technology, their lack of experience using play, social connection, and active engagement may greatly affect their ability to adapt to any situation and provide a full scope of services. One respondent suggested guidelines for tablet use such as assessing when and with whom to use a tablet, not using the tablet as a ‘go-to’ tool every day, and modeling ‘old school’ coping and distraction techniques in addition to new technology. Leaders of child life departments, as well as individual practitioners, will need to closely assess how technology is being incorporated into the practice of their teams, and work diligently with their practicum and internship coordinators to assure that students are able to meet the needs of children and families without the presence of technology. To take this a step further, it will be essential that the Association of Child Life Professionals (ACLP) develop well-informed guidelines to actively shape the practice of child life professionals so that ever-advancing technology can augment rather than displace established techniques such as imagery, medical and therapeutic play, and child-led play.

While tablets certainly bear some risk of limiting a student’s or specialist’s ability to connect with patients or to engage families across a scope of services, they also bring innovation and growth. Child life specialists are looking outside the box to use tablets in new ways. One survey respondent described using her tablet frequently for legacy projects that included video diaries, songs, and slide shows. This type of use not only engages the child and family in a meaningful way, but leaves the family with incredible memories that are easily saved, stored, and accessed. These same

types of projects could also be used with a child who is expected to recover from a serious illness or injury as a method to record that child's journey to wellness. These examples showcase an innovative use of tablets in the child life field. Tablets are almost certainly being used in many new and interesting ways in child life work, and this is an area where the profession could be impacted by the collection of data and dissemination of these innovations with the greater membership.

Technology will continue to become more prevalent in everyday life, and as that happens, it will become of the utmost importance to retain a sense of what is at the heart of the child life profession — play. It will be up to all

child life professionals to be mindful of how we are using the tools at our disposal, to have a continual evaluation process to assess our profession's dependence on this particular tool, and to be aware of how this impacts our relationships with patients and families. At this time there are not many valid and reliable research studies that delve into the topic of using tablets with pediatric patients and fewer still authored by a child life specialist. This is certainly a topic that requires further research to assess the impact of tablet use on a child life specialist's skills, patient/family satisfaction, effectiveness of education and diversion, and undoubtedly many other topics. Research describing both the benefits and risks of tablet

use in the child life profession will be important as the ACLP moves forward in creating standards of professional practice and developing guidelines for the training of students. ✨

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BITS AND BYTES

System Updates from the Technology Integration Committee

BEYOND THE PHOTO PREP BOOK:

Augmenting Preparations with Digital Learning

Camilla Sutter, MA, CCLS

NEWTON-WELLESLEY HOSPITAL, NEWTON, MA

Child life specialists are often asked to teach and prepare children for upcoming events and procedures. Over the decades, there have been changes in the types of procedures children may experience, as well as advancements in many of the materials used for medical care. In the same manner, the ways that child life specialists demonstrate and educate has changed and will continue to change rapidly. For example:

- 30-40 years ago: “Prep albums” were common. These were often a homemade collection of Polaroid pictures assembled to show the machines, the rooms, and the people involved in tests and procedures.
- 20 years ago: Digital cameras allowed increased ease in updating albums.
- 10 years ago: Online photo albums become a part of the culture of many hospitals.
- 5 years ago: Development of digitally based apps provided for a more interactive style of teaching.

Technology is inescapable in our culture. A recent study shows that in an urban, low-income minority community, almost all children (96.6%) have used mobile devices, and most started using before age one (Kabali, 2015). With this pervasiveness of technology in all income levels, digital learning is being quickly incorporated into many settings. Even the National Association for Education of Young Children has stated that when used intentionally and appropriately, technology and interactive media are effective tools to support learning and development (National Association for Education of Young Children, 2012).

When considering how we, as child life professionals, prepare patients and their families, the core factors have remained the same over the years, with a focus on sensory/sequential preparation, rehearsal of coping, and

clarification of misconceptions. Supplementing our preparations with technology offers clear benefits:

- Availability of rich and informative resources
- Ability to personalize teaching methods and materials for the needs of each child
- Ability to offer materials for a variety of learning styles (particularly auditory and visual)
- Familiarity with digital media allows children to fully engage quickly
- Interactivity that provides the child life specialist a feedback mechanism to demonstrate patient understanding

It is possible that your hospital has already created a photo album, video, or slideshow for patients scheduled for surgery, admission or other procedures. There are hundreds of hospital-specific preparation sites, but these tend to focus on the overall hospital experience and admissions for a planned hospitalization or surgery and are less useful for specific preparations. Examples include the following:

- From Children’s Hospital Colorado: <https://www.childrenscolorado.org/your-visit/prepare-for-your-visit/kid-friendly-tour/>
- From Arnold Palmer Hospital for Children: <https://www.youtube.com/watch?v=Bh4PZCOyApk>

There are also programs and apps that allow you to create your own digital photo album or preparation slides. ACLP has been coordinating with iGetGoing to the Hospital and Child Life Services <http://igetitapps.com/app/i-get-going-to-the-hospital/>, which has been specifically designed for educational use by child life specialists. If this type of format is helpful in your practice, there is also a child life blog that provides tips on how to relatively quickly make your own: <http://community.childlife.org/p/bl/et/blogaid=526>

If you don't have time to create a digital prep book and want something more specific than a hospital tour, what resources are out there? What can you simply assimilate into your play, rehearsal, and preparation discussion to make your preparation more digitally lively? Below are some helpful resources, along with examples of how they could be used.

SHORT VIDEOS:

- **Kids Health.** Pre-made 2-3-minute animated videos on a wide range of topics: <http://kidshealth.org/en/kids/health-problems/>
- **Be Positive (B+).** Short 3-4-minute videos showing real children undergoing a variety of exams. Example: Patient could watch the four-minute video showing nuclear medicine scan of kidneys prior to going to radiology. <http://www.rch.org.au/be-positive/>

FULL APPS FOR SPECIFIC PREPARATIONS:

- **My First Surgery** (Free): Preschool-focused app preparing children for meeting staff, getting their bodies ready, and going to the OR. This app can be directed by the child. Smiles on animated characters are enthusiastic. Example: Basic preparation that could be introduced at a preop visit or preop clinic. <https://itunes.apple.com/us/app/my-first-surgery/id699122113?mt=8>
- **MyMRI at Kings** (Free): Use this app with or without virtual reality goggles to prepare child for both the visual and auditory components of MRI. Example: Could use simple VR goggles to rehearse lying still for 20 minutes in a bed prior to actual MRI. <https://itunes.apple.com/nz/app/my-mri-journey-kch/id1188242230?mt=8>
- **Riley Child Life Tour** (Free): This child life-designed app provides children with visual photographs of equipment that they may see in various treatment and procedure rooms, as well as preparation videos for ultrasound, waking up in the recovery room, and cold spray for IV placement. Example: Could use information about the interventional radiology room to prepare a patient for an upcoming procedure, even if your room looks a little different than the one on the app. <https://itunes.apple.com/us/app/riley-child-life-tour/id478875230?mt=8>
- **Curiscope** (App is free, but t-shirt must be purchased): This augmented reality anatomy app works together with a purchased t-shirt to allow patients to digitally "see" inside the chest cavity for education sessions about heart, lungs, and GI system. Involves use of phone or iPod touch. <https://itunes.apple.com/us/app/curiscope-virtual-tee/id1135840956?ls=1&mt=8>

APPS TO SUPPLEMENT YOUR PREPARATION:

- **The Human Body by Tinybop** (\$3.99): Child friendly

animations and diagrams presented with no narration. Could supplement a preparation by showing the body system in a child-friendly way. Example: Child puts food in the mouth and can follow it down the digestive path, allowing better understanding of the need for bowel preps for colonoscopy. <https://itunes.apple.com/us/app/the-human-body-by-tinybop/id682046579?mt=8>

- **Simply Sayin'** (Free): This child life-designed app for medical jargon is outstanding and often allows for simple interactions. Example: Prior to tonsillectomy preparation, use the diagram of the inside of the mouth and have the patient circle the parts that they think are the tonsils. <https://itunes.apple.com/us/app/simply-sayin-medical-jargon-for-kids/id645810680?mt=8>
- **Okee in Medical Imaging** (Free): Animated purple octopus with a child's voice takes young children to various radiologic procedures. Example: Your patient guides Okee through breath holding techniques to allow for better x-rays and CT scans. <https://itunes.apple.com/us/app/okee-in-medical-imaging/id964693081?mt=8>
- **MeditoonsHD** (Free): Adolescent-focused app highlights anatomical explanations of many GI disorders. Example: Show pre-teen who has a gastric ulcer what is going on inside his stomach to increase medication compliance. <https://itunes.apple.com/us/app/meditoons-hd/id512672910?mt=8>

Within our child life community, there are two committees exploring and promoting technology. Please check out the articles and blogs by the [Web and Online Networking Advisory Committee \(WONAC\)](#) and the [Technology Integration Committee](#) to discover more and help contribute to our growing use of technology with our patients.

Should digital teaching be the only way? No! Clearly, there is a need for a healthy and balanced media diet, combining media with other teaching methods, such as traditional psychological preparation. In addition, it is important to carefully consider the appropriateness of technology for each patient. There need to be limits on exposure of children to technology, especially very young children under the age of two. Adult supervision should be available to facilitate the process and clarify questions and misconceptions. It can and has become a helpful and fun way to augment our preparations and sustain the attention of a tech-seeking young audience. ✨

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Kathryn Cantrell, Katherine Bailey, Jessika Boles, Shawna Grissom, and Amy Kennedy after receiving the 2017 Professional Research Recognition Award.

2017 RESEARCH RECOGNITION AWARD:

Play-Based Procedural Preparation and Support Intervention for Cranial Radiation

Emily Jones, MS, MEd, CCLS

CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER, CINCINNATI, OH

The 2017 Professional Research Recognition Award was presented to authors Shawna Grissom, CCLS, CEIM, Jessika Boles, PhD, CCLS, Katherine Bailey, MS, CCLS, Kathryn Cantrell, MA, CCLS, and Amy Kennedy, CCLS, for their article entitled "Play-Based Procedural Preparation and Support Intervention for Cranial Radiation." This article was published in *Supportive Care in Cancer* in 2016 and explores the effects of child life interventions on sedation use in children receiving radiation treatment for central nervous system tumors. This seminal study was the first to examine the financial impact of preparation interventions provided by a Certified Child Life Specialist. Child life interventions, including developmen-

tally-appropriate and individualized play, preparation, education, and distraction, were provided with the goal of promoting patients' comfort with radiation treatment to decrease the need for sedation. Results explored the relationship between child life interventions and the subsequent use of sedation. After making adjustments for participants' tumor location, age, and receipt of craniospinal radiation, it was found that child life interventions sessions were "associated with a 23% increase in the odds of receiving cranial radiation with partial sedation over full sedation" (Grissom et al., 2016, p. 2424). Upon further examination of the financial data, the authors concluded that "child life intervention could significantly reduce the healthcare cost by reducing the need for sedation from full to partial, with a potential mean cost difference of \$77,814" (Grissom et al.,

2016, p. 2426). The findings of this article have significant implications for the child life community, concretely demonstrating that child life specialists' provision of play-based supportive interventions can decrease healthcare costs by reducing the sedation needed by children during radiation treatment.

The authors reported that they undertook this research as a way to demonstrate to the interdisciplinary team and hospital administration the impact that child life interventions were having in radiation oncology, as well as to contribute valuable information to the greater child life profession. This research was supported through a CLC grant and thus had tight deadlines for research completion. According to Shawna Grissom, speaking for the group, the authors relied heavily on "tried and true processes of chart reviews, daily stats entry, and

detailed documentation” to obtain study data to help meet these deadlines. When asked to share highlights of their research journey, Shawna was very open and honest, stating “At times the journey can seem daunting, and some of us even doubted our understanding of the analysis or our writing abilities. We just had to trust our previous experiences or lean on other team members to utilize their strengths. Each project provides you with a bit more knowledge about the research process... In the end, we all walked away feeling accomplished and more equipped to be a part of another research journey.” Shawna and the group also shared the following tip for other ACLP members undertaking research: “Don’t try to do it alone. Use your peers, your hospital resources, and the community.” The authors pointed to the group aspect of the project as a highlight for all involved. They also advised, “Be diligent in your documentation and daily data collection of your work as a child life specialist. The information is invaluable!”

This research was selected for the 2017 Professional Research Recognition Award for a number of reasons, including the quality of the research methods, particularly with the elegant statistical analyses demonstrating the benefits of each minute spent with a child life specialist; the impact on patients, as decreasing the use of sedation protects the patient from potential cognitive and psychological deficits

This study supports the value of the child life professional as a play-based developmental specialist and a crucial component of cost-effective care (Grissom et al, 2016, p. 2421).

and supports long-term well-being; and the impact this research has on the profession of child life as a whole. In the current healthcare climate with need to establish concrete outcomes of interventions and to demonstrate cost-effectiveness, this type of research is vital to supporting the longevity of the child life profession. In their manuscript, the authors summarized the importance of this study per-

fectly, stating “This study supports the value of the child life professional as a play-based developmental specialist and a crucial component of cost-effective care” (Grissom et al, 2016, p. 2421). ✨

REFERENCE:

Grissom, S., Boles, J., Bailey, K., Cantrell, K., Kennedy, A., Sykes, A., & Mandrell, B. N. (2016). Play-based procedural preparation and support intervention for cranial radiation. *Supportive Care in Cancer*, 24(6), 2421-2427.

The ACLP EBP/QI Awareness and Networking Subcommittee of the Scientific Advancement of Professional Practice Committee is honored to present the *Child Life Research Recognition Awards* each year. This year's award was presented at ACLP's Annual Conference in Las Vegas in May. The Professional Research Recognition Award honors significant work by a child life specialist and the Student Research Recognition Award acknowledges significant work conducted by a student. Both awards celebrate research initiatives that contribute to theory and practice within the field of child life.

To be eligible for consideration for the awards, research had to have been IRB-approved and published in APA style in a peer-reviewed journal within the past two years. Research teams had to include at least one ACLP member or child life student, and research had to address a facet of child life. Applications were evaluated on how well the research demonstrated the value and effectiveness of child life, increased knowledge, improved techniques, or advanced the field of child life. In addition, the research design, implementation, and analysis were carefully evaluated.

The Professional Research Recognition Award went to a team of child life specialists and multidisciplinary colleagues, who are profiled in the article below. Although we did not present a Student Research Award this year, we encourage ACLP members to spread the news about both awards to individuals who may be interested in applying for next year's awards. Applications for the 2018 awards will be available in early fall.

Child Life Focus



This issue of *Focus* includes two articles centering on the theme of meeting spiritual development needs of children and families in healthcare settings, specifically in child life practice. Spirituality is a topic that often goes undiscussed in professional settings for several reasons, including lack of knowledge, fear of offending, uncertainty of the role of child life specialists, and the perceived difficulty of seeing the spiritual aspects of human development manifested in everyday life.

The first article, by Kathleen Harris, PhD, takes a broad perspective in examining the provision of spiritual care to children in healthcare settings by the entire team, but with a distinct focus on what child life specialists can (and already) do to support effective care in this area. The second article, by Korie Leigh, PhD, CCLS, centers on legacy building activities

that tap into the spiritual needs of children and families at any point in a treatment plan, whether that be at diagnosis or end-of-life.

While these two articles will open readers' eyes about aspects of spiritual development and care as they relate to child life practice,

they should serve as a jumping off point for continued education and exploration about the role of child life specialists within the multidisciplinary team in supporting this impactful, and often deeply meaningful, aspect of being human.

Spiritual Care for Ill Children: A Facet of Holistic Healing

Kathleen I. Harris, PhD

SETON HILL UNIVERSITY, GREENSBURG, PA

ABSTRACT

Spirituality plays an important part in a child's holistic development and daily life activities. Holistic development addresses all of the needs of a child's life: emotional, physical, relational, intellectual, creative, and spiritual. The role of and need for spiritual expression can be intensified during stressful events such as illnesses or other health crises. Nash, Darby, and Nash (2015) identified 12 qualities that should characterize the practice of spiritual care for children who are experiencing illness or a healthcare experience. Focusing on two themes gleaned from these qualities, the consideration of spiritually supportive environments for providing spiritual care and the importance of rituals for children who are experiencing illness or a healthcare experience, this article defines spirituality and discusses the value of spiritual care in supporting holistic healing for children who are experiencing illness. While the medical aspects of healing are the concerns of the medical staff, child life specialists, pastoral care providers, parents/caregivers, and other members of the multidisciplinary team can work together with children and families to cope with many facets of being ill; in other words: whole-person healing. The article also discusses activities that child life specialists can use effectively to support a child's spiritual development when caring for young patients and their families in the hospital setting.

When a child is ill, everyday life takes on new stresses as a young child feels more vulnerable physically and the feeling of a normal life vanishes (Garipey & Howe, 2003). A medical condition or a prolonged stay at a hospital can increase stress and place a young child at risk of developmental delays (Eiser, 1998). Children must often leave familiar settings and submit to various medical procedures performed by unfamiliar hospital personnel. The hospitalization of a young child can

create stress for the entire family (Rollins, Bolig, & Mahan, 2005). For example, the needs and care of siblings while a child is in the hospital may often be given lower priority along with home responsibilities, work responsibilities, and the individual needs of the hospitalized child. Daily home routines and community activities important to a child's holistic development are often modified or put on hold. Professionals' understanding of the needs of the hospitalized child has resulted in a change of expectations for family members (Rollins et al., 2005).

In this context, the need for spiritual support can become more intense and spiritual care can be deeply impacted. This article will define spirituality and describe the role of spiritual care in supporting healing for children who are experiencing illness. Specifically, spiritual care activities addressing two themes from Nash, Darby, and Nash's (2015) principles of spiritual care will be discussed, the consideration of spiritually supportive environments for providing spiritual care and the importance of rituals for children who are experiencing illness or a healthcare experience, as effective practices that child life specialists and members of a multidisciplinary team can support when serving patients and families in hospital settings.

The National Institute of Healthcare Research has defined spirituality as "the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred" (Bourdreaux, O'Hea, & Chasuk, 2002, p. 439). Spirituality is considered a fundamental characteristic of humanness important in human health and well-being (Rollins et al., 2005). Spirituality is interwoven with every aspect of life and provides purpose, meaning, strength, and guidance during life (Young & Koopsen, 2011). Ebmeier, Lough, Huth, and Autio (1991) suggest that spirituality may play an important part in a child's daily life

and can particularly intensify during events such as health crises.

Defining Spirituality Related to Healthcare

Multiple attempts have been made in the last decade to establish a concrete functional definition of spirituality (Allen, 2008). Spirituality is revealed in day-to-day life experiences as well as in such disciplines as philosophy, health psychology, medicine, sociology, and science (Tuck, Wallace, & Pullen, 2001). Contemporary interest in spirituality, however, is often more pronounced among educators and healthcare professionals than among religious thinkers (King, 2008). People in the helping and health professions have been increasingly interested in notions of spirituality in recent years (Coholic, 2010), perhaps because health and education are two assets that individuals value very highly throughout their lives (King, 2008).

Since it is generally recognized that total health encompasses physical, mental, and spiritual components, spirituality has become more visible in healthcare due to the increasing evidence that spiritual factors are critical components of health and well-being (Dossey, 2001). Spiritual issues are significant for many reasons (Rollins et al., 2005). First, people of all developmental stages throughout the lifespan have a spiritual dimension (Carpenito, 1997). Second, spirituality affects people's interpretation of meaning in life, including young children (Houskamp, Fisher, & Stuber, 2004). This can be especially important when children are hospitalized and given medical treatment. Highfield (2000) indicated that those individuals with a chronic illness who demonstrated increased levels of spiritual health had higher levels of psychosocial well-being, more hope, less loneliness, and improved coping and

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quality of life. Research indicates that both children and adults experience themselves as spiritual beings, and want spiritual care when hospitalized (Winseman, 2004). Thus, those working in the health professions, including child life specialists, chaplains, music therapists, art therapists, and the entire multidisciplinary team, may have many opportunities to explore the importance of spirituality for children and families.

For the purposes of this article, spirituality is defined by the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists as “experiencing a sense of meaning and purpose in life together with a sense of belonging” (Dein, Cook, Powell, & Egger, 2010). It is a deeply personal experience highlighted through multiple expressions (Mueller, 2010). Spirituality (sense of meaning) as opposed to religion (a particular system of beliefs and worship) has been a subject of increasing study (Thomas, 2005). For example, experiences of spirituality include inner peace, heightened awareness, and a reaching out beyond the self (Allen, 2008). Spirituality involves the nonphysical, non-material traits of an individual (Weil, 1997), the essence of being (Miller, 1995), and is shaped by cultural experiences (Coholic, 2010). Spirituality involves faith, hope, love, and trust; it provides structure

and meaning to everyday activities (Hicks, 1999). Spirituality is considered a universal phenomenon, a means of deeper cultural awareness, and a source of connectedness with all people and cultures, including young children (Coholic, 2010; Reed, 1992).

Spirituality and Children

Spirituality is at the core of human development and is connected to a wide range of human experiences (Roehlkepartain, 2012). Spirituality can be considered a basic human quality that transcends gender, race, color, and national origin (Young & Koopsen, 2011). Human spiritual development occurs at all developmental stages of life, including childhood and adolescence. Each child has a spiritual domain; specifically, an area of development (analogous to the physical, motor, and social-emotional domains), that stimulates, energizes, inspires, and encourages every aspect of his or her life, but the manifestation and influence of the spiritual domain varies by individual (Young & Koopsen, 2011). Some researchers contend that children may be born with spiritual competence; that is, an inner quality for possible faith development (Mueller, 2010).

The spirituality of young children involves a feeling of belonging through relationships

that are interconnected within a child's culture and community (Harris, 2007). A young child's spiritual development includes innate qualities, temperament traits, dispositions and abilities, relationships developed through childhood, life experiences, and the culture and living spaces in which the child develops (Coholic, 2010). For the most part, children display their individual spirituality primarily through overt behaviors (Cartwright, 2001). For instance, children imitate and participate in rituals with family members; use symbols and storytelling in fantasy play; express values and make judgments with peers; and use art, dance, and music to express joy, wonder, or fear and to cope with pain and stress. As an infant reaches toddlerhood, autonomy develops—an independence suggesting the development of free will (Yust, 2003). During early childhood, young children are fascinated with mystery and wonder (Erikson, 1963; Piaget, 1959). For example, fantasy and imagination, combined with dramatic play, storytelling, and songs, increase opportunities for young children to participate actively in a community with family and peers. Young children take joy in living in the here and now (Morgenthaler, Keiser, & Larson, 2014). Spirituality is deeply connected with the imagination, creativity, and relationships (King, 2008).

Spirituality, by providing a sense of meaning and purpose, connectedness, hope, and faith, can produce tangible health benefits for people of all ages, including children, by helping them either to heal or cope with their illness (Young & Koopsen, 2011). Spirituality has been shown to give comfort to children in therapeutic settings and hospitals where children are given care (Coholic, 2010), as well as in children who have experienced significant threats to well-being and development such as in cases of abuse or homelessness (Kidd, 2003; Walker, 2005), or terminal illness (Attig, 1996).

Spiritual Care for Ill Children

Spiritual care involves such concepts as purpose, identity, and destiny (Nash, 2011). The Royal College of Nursing (2011) suggests that spiritual care acknowledges the needs of the human spirit when encountering trauma, ill health, or sadness, and can include the need for meaning and self-worth. Spiritual care is a critical part of an ill child's well-being, much like physical and psychological



Spiritual care is about being present in the moment with the child.

support (Carson, 2015). Spiritual care in the medical setting can enable children to (a) be connected to a community, (b) be respected as individuals, (c) interact socially with peers, and (d) have a happy, safe, and positive space where they can feel empowerment, enhanced privacy, and independence. Spiritual care also includes assisting a child's engagement with the existential questions of life (Nash et al., 2015). Spiritual care is quite different from religious care, which offers patients a variety of cumulative traditions, symbols, beliefs, and practices.

Spiritual care includes modeling respect when encouraging human contact in compassionate, respectful relationships, and moves in a direction that supports relationships that build on trust, shared experiences, and reciprocity. For example, listening to the life experiences and story of the ill child and family is essential to being able to provide the best possible spiritual care (Carson, 2015). Facilitating thoughtful conversations to help children and families discuss the difficult and complex aspects of their medical experience may uncover some positive meanings and connections along the way (Nash et al., 2015). In many ways, delivering spiritual care looks much like the work of a child life specialist. In fact, many child life specialists are already engaging in spiritual care without even knowing so.

Spiritual care is not about checking off a to-do list during the day; rather, it is intentional and purposeful, driven by the goal of supporting and uplifting the child who is under the care of multiple healthcare professionals. It relates to the spiritual aspect of our being by reminding the child in our care, "While you are under my care, I'm here for you to care and support you." Expressions of spiritual care for ill children that child life specialists and members of the multidisciplinary team often participate with can take place individually or with families in a hospital environment through supportive active listening, meditation and guided imagery, visualization, observing and engaging in art, picture therapy, journaling, and storytelling. One of the important components of spiritual care of young children is the inclusion of joy and fun (Thayer, 2001). Having fun by engaging in playful activities can be energetically effective for both the child and healthcare professional (Rollins et al., 2005).

Assessing and Providing Spiritual Care to Families

Spiritual care can be described as an approach that is purposeful and involves activities and interventions that have the potential to support the child's spiritual development. Spiritual care can be provided by anyone (Young & Koopsen, 2011). An example would be a trained chaplain, or an individual with specialized training in theological beliefs; however, other disciplines are capable of supporting and providing some aspects of spiritual care (Anandarajah & Hight, 2001). It is important to recognize that spiritual care occurs within a community as well as one-on-one (Nash et al., 2015). One way to initiate spiritual care for children is to examine and understand the child's home environment and family system, something child life specialists are already accustomed to assessing, so as to find the best ways to compensate for the changes in environment and routine that the hospitalized child experiences. The purpose of a spiritual care assessment is to collect baseline, background information about the child and family, make reflective observations, listen carefully, and inquire about strengths and note any cues that are spiritual in nature (Clutter, 2005). A spiritual care assessment conducted by a child life specialist or healthcare professional can include a family interview and/or questionnaire regarding routine activities and the child's interests and strengths. Asking open-ended questions to encourage reflective communications lets children clarify spiritual values, resources, and experiences (Sellers & Haag, 1998). These discussions may also lead to an understanding of specific activities for expressing the child's spiritual experiences during developmental stages (Grossoehme, 1999), parental spiritual inputs (Feudtner, Haney, & Dimmers, 2003), the impact of dreams and hope (Erickson, 2008), and the use of play in connecting with ill children (Garipey & Howe, 2003). Another effective assessment tool can be simply observing the child and family (Rollins et al., 2005), observing the child's behaviors and spiritual practices, noticing those family members who provide spiritual support while the child is hospitalized, and exploring the child's hospital room for spiritual symbols and materials. Research by Highfield (2000) suggests the significance of focusing the assessment on strengths such as an extended family

network, a sense of humor, resiliency, strong attachment, and good communication skills. By highlighting strengths, the child and family may depend on them through illness and stressful times.

Spiritual needs can also be met by appreciating families and recognizing that all members of a family possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for particular health services (Shelton & Stepanek, 1994). As healthcare professionals assist families in organizing their resources by recognizing key elements of their family-centered care (i.e., family strengths, needs, concerns, and coping strategies), the hospitalization stay for a young child can create a safe space for asking difficult questions, laughing, crying, and being reminded that others care. This can be accomplished through actively observing and listening, supporting family strengths, and noticing both the spoken and unspoken messages of children and families.

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ABOUT THE VIEWS EXPRESSED IN CHILD LIFE FOCUS

It is the expressed intention of Child Life 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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Spiritual care is also a reciprocal activity that can be strengthened by partnerships involving the child, family, health professionals, and other community resources. When a healthcare professional offers effective spiritual support, a child may respond by raising sensitive issues, such as their values, their culture's way of experiencing death and loss, or the nature of human beings and life events in general (Coholic, 2010). Valuing and respecting the child and family, whatever their culture, background, or gender, is a part of providing spiritual care (Carson, 2015). Most frequent spiritual and developmental needs include assistance in dealing with fears and anxieties, coping with pain or other physical symptoms, keeping hope alive, and maintaining strong relationships with family members (Mueller, 2010).

Twelve Principles of Spiritual Care for Ill Children

Nash et al. (2015) identified 12 principles (see Table 1) that should characterize the practice of spiritual care for ill children. These principles are evidence-based and acquired

from the analysis of data, ongoing reflections, and discussions from multidisciplinary spiritual care teams (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). The principles are child-focused and family-based and offer opportunities for interdisciplinary team members to participate in the development, implementation, and evaluation of spiritual activities. They offer healthcare professionals opportunities to increase a greater awareness and understanding of the potential spiritual topics and needs encountered by children and to feel more self-assured in engaging in spiritual care in an intentional manner (Nash et al., 2015).

This author has chosen two themes intertwined within these twelve principles to present descriptions of activities and interventions that child life specialists can use effectively when caring for ill children: the consideration of spiritually supportive environments for providing spiritual care and the importance of rituals for children who are experiencing illness or a healthcare experience.

To capture key components of holistic spiritual care for children, this author uses an acrostic in which the themes of spiritual care are arranged to spell the word *spiritual*:

- S: strengths-based spiritual care for all children, offering safe spaces to explore feelings and questions
- P: personalized care for the child and family emphasizing family's needs and strengths
- I: identity of the child as the center of all spiritual care, supporting independence, empowerment, and participation for every child
- R: rituals facilitated by child life specialists during a hospital stay that are important to the child and family
- I: involvement in meeting spiritual needs in a way that includes the child, family, and healthcare professionals working together and advocating for the child's needs
- T: timeline of aspects of spiritual care that are most important to the child and family during a hospital stay
- U: universal—the need for spirituality is universal, in that every person has a spiritual dimension that inspires and influences every aspect of his or her life, but individual understandings of spirituality will vary greatly
- A: attitude and authenticity; that is, caregivers must maintain a positive attitude and genuine interest, considering the family's culture while offering spiritual care that facilitates the child's healthy well-being. Valuing and respecting the child and family, whatever their culture, background, or gender, is a part of spiritual care (Carson, 2015)
- L: listening to the child's hopes, dreams, and thoughts by using active listening skills (e.g., I-we messages), maintaining eye contact, paraphrasing conversations, asking open-ended questions, using appropriate body language, and attentively listening to family members; listening to the stories of the child and family

Supportive Environments for Spiritual Care

An important aspect of young children's lives is their physical engagement with the environment. One of the key components regarding the principles of spiritual care is creating a comfortable environment, or physical space, for supporting the spiritual needs of ill children. Preparation of the physical space involves taking time to consider each child's unique needs and strengths and offering opportunities for positive growth (Nash et al., 2015). Meeting spaces and defined "landmarks" are important for children because they invite community, relationships, and participation (Clark, 2005). Generating physical space to support spiritual care entails conveying a warm welcome and acceptance, treating children and families with respect, listening attentively, and creating a comfortable, familiar environment (Nash et al., 2015). Most often, spiritual places for ill children may include hospital rooms, clinic exam rooms, clinics, chapels, community rooms, family waiting rooms, and activity play rooms. What makes these places have a spiritual element is that they are sites where both bodies and spirits are cared for, involving connectedness and support. In addition, providing a private area is a valuable intervention for pastoral visits and meditations (Rollins et al., 2005).

Healthcare providers can create spiritually supportive environments (Rollins et al., 2005); in fact, child life specialists often create this type of environment for children during hospital care. For example, a spiritually supportive space could be a play space that celebrates a variety of cultures, representing children of all ethnic groups, ages, and abilities in meaningful ways. When child life specialists meet and visit with children in this space, they actively engage each child's individual spiritual needs by using visual and tactile props, sharing stories, picture books, toys, and art materials and finding ways to listen and communicate. In this way, they can establish a relationship of trust in which the child is open, comfortable, transparent, and eager to share thoughts and feelings (Nash et al., 2015). Research has indicated that children who demonstrate the capacity to explore freely, engage in new situations, and adapt to changing environments in healthy ways do so because of warm caregivers (Masterson, 2005).

TABLE 1

Principles of Spiritual Care for Children in Healthcare Settings

- Participation, empowerment, and independence are the foundation and supporting values of spiritual care
- Spiritual care occurs in a secure space that is open, respectful, and accepting for all young patients
- Spiritual care takes place within the framework of relationships
- Spiritual care is optimized when families are present and participating
- Healthcare professionals need to connect and enhance existing spirituality and, if appropriate, faith
- Developmental and learning context including multiple intelligences and different learning styles is critical to understand in selecting activities, resources, and language
- Metaphor can be a significant emotional tool for spiritual care promoting a shift in perception revealing values, beliefs, and personal growth
- Spiritual care occurs within and by a community and offers opportunities of normalization
- Meaning making helps young patients to articulate, identify, and understand their spiritual needs
- Identity may have a sensitive importance in sickness
- Concrete and visible expressions and reminders of spiritual care are important
- Offering “episodes of spiritual care” reflects the often incorporated nature of assessment and intervention and the element of mutual cooperation

Adapted from Nash, Darby, & Nash (2015).

Child life specialists and other healthcare professionals should include certain considerations when creating a play space to meet spiritual needs for children. First, the aesthetics of the space are important. According to research, children will be happier, concentrate better, and have more positive attitudes when they are in a visually appealing, beautiful environment (Friedman, 2005). Second,

balance and harmony should be provided in the spiritually supportive space. If possible, nature may also be made accessible to ill children by providing a window view of natural surroundings, displaying an aquarium of fish, providing opportunities for therapy animals to visit children, and displaying pictures or photographs of natural settings throughout the space. When possible, the space should

encourage family members to relax and stay a while, interacting with their child and with one another. Finally, the attitude inside the spiritually supportive space should model wholeness and diversity. For example, child life specialists can be sensitive to this need by offering books that reflect the cultures, backgrounds, and uniqueness of all young patients. Modeling wholeness and diversity can also be practiced by sharing stories, allowing for individual expression with art materials, and creating areas for quiet reflection. The space should be playful with authentic learning experiences that can emerge from the children’s interests.

Table 2 summarizes a variety of spiritual care activities that child life specialists can consider for use in addressing children’s multiple interests when introduced in spiritually supportive environments. The activities described have the potential to promote the child life specialist’s relationship and connectedness with the child, which support spiritual needs through activities such as talking and listening.

Rituals for Spiritual Care

One intervention that can enable families to embrace values from home with one another and increase stronger relationships with the hospital staff is through rituals. Rituals help all of us to navigate emotionally important events in our lives and deepen our relationships with others (Howell & Reinhard, 2015). Rituals are a part of historical, religious, spiritual, and cultural traditions (Young & Koopsen, 2011). During difficult times, rituals can provide a caring, connected, and safe haven for children and families. Additionally, rituals can support children when change threatens their environment or daily routine (Bailey, 2000). They can help to awaken, foster growth in, and uplift ill children’s spiritual dimension by offering a personalized sense of familiarity with careful consideration of the child’s needs (Burkhardt & Nagai-Jacobson, 2005), and they can enable children to feel psychologically safe and comfortable in certain situations. Spiritual growth is supported through comfort, companionship, conversation, and consolation measures (Rollins et al., 2005). For a child encountering illness in a hospital setting, rituals can provide care for basic comfort needs and compassion.



Spiritual care offers a comfortable, supportive environment for children to converse with patients, be connected to the hospital community, and feel empowered with hope and peace.

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TABLE 2

Spiritual Care Activities Supporting Children's Multiple Interests

- Auditory: Books with sounds to add while reading the story; sing-along books; guessing games that encourage blending alphabet sounds; tape recorder/tapes; musical toys; creating homemade instruments, such as a rain stick, shakers, and tambourines
- Kinesthetic: Yoga movements; creative movement games; scarf and streamer dancing; movement games with bean bags
- Tactile: Modeling clay; play dough; felt board (sensory story time); finger paints; shaving cream; sponge painting; books with textures; bristle blocks; Wikki Stix; touch-and-feel bags with items related to an interest of the child; sand play, including writing alphabet letters in the sand; chalk with small chalkboard; creating a "magic bag" with objects of interest for children to select and play with peers; letter collages with different textures; creating a texture bulletin board with cotton balls, bubble wrap, aluminum foil, macaroni, yarn, sandpaper, and confetti; squishy bags with bubble solution, shaving cream, and food coloring
- Visual: Picture books; blocks with textures, colors, and sizes; puzzles with pieces that have oversized knobs; cars and trucks; dolls and dramatic play props; dress-up clothes in the dramatic play center that can be easily put on and removed; taking digital photos of the toys and objects used by children (e.g., block structures) and then posting the pictures near art materials so that children can be inspired to make pictures to represent their artwork; estimating games with small objects (crayons, marbles, candy) in a jar and having children guess how many objects are in the jar; creating "Look at Me!" self-portraits with a variety of open-ended art materials
- Use engagement strategies in the playroom that will initiate new projects offering play activities in centers. For example, with a variety of art materials, children can draw with scissors by making a colorful collage, cutting, arranging, and gluing different shapes in creative ways. Make "Me Blocks" using juice cartons and have children decorate the sides with their favorite sports, toys, hobbies, and friends. Other possibilities include dramatic play props, magnetic alphabet letters in a variety of sizes to play with and create words, contemplative writing using journals and technology such as the "My Story-Maker" software program (<http://www.carnegielibrary.org/kids/storymaker/storymaker.swf>)

For example, rituals may create or enhance bonding among family members, offering community and renewed hope.

Rituals contain five basic components: actions, meaningful patterns, intention, awareness, and purpose (Young & Koopsen, 2011). When planning rituals for ill children, it is important to have a purpose for the ritual. In addition, healthcare professionals should be sensitive to using two types of rituals: traditional and self-generated rituals (Young & Koopsen, 2011). Traditional rituals are passed from one generation to another, while self-generated rituals are initiated by an individual, such as the child, a hospital chaplain, or child life specialist, and have no cultural history or tradition. For example, a self-generated ritual, such as a special song or a blessing before the child receives medication or before an x-ray may ease stress and lower anxiety (Achterberg, Dossey, & Kolkmeier, 1994; Bell, 2007). When a ritual is practiced with a child life specialist or healthcare provider, a young patient in the hospital has the opportunity to feel recognized as their needs are being met and may experience less stress (Burkhardt & Nagai-Ja-

cobson, 2005). During rituals with a child life specialist or multidisciplinary team member, the child has the opportunity to relax and communicate interpersonally in a safe setting, incorporating healing and gaining a deeper sense of renewed energy. When a child life specialist, caregiver, or other healthcare professional is authentically present with a child, alertness and sensitivity to the spiritual needs of the child can be enhanced (Sterling-Fisher, 1998). Even the touch or smile of a simple greeting to each patient with a special handshake, hug, or high-five causes the child to feel acknowledged. Those near a child during these important times can share warmth, care, and compassion (Rollins et al., 2005). While it is important for child life specialists to consider rituals with young patients, it is also imperative to prioritize supporting family rituals. The patient/family relationship is primal to the patient/child life specialist relationship. Family relationships have the opportunity to increase partnerships that can be supportive in sharing the stresses and challenges experienced in the daily care of their child (Rollins et al., 2005).

Self-generated rituals that child life spe-

cialists can consider with children who are experiencing illness or a healthcare experience include art, meditation, breathing exercises, visualization, and storytelling. These types of rituals can support spiritual growth, presence, active listening, humor, and self-awareness for the child. For example, art can be a powerful tool in promoting healing and an important element of holistic and spiritual care (Rollins & Riccio, 2002; Young & Koopsen, 2011). Art in various forms, such as drawing, painting, and clay, can support the spiritual development of children who are ill (Burkhardt & Nagai-Jacobson, 2005). Notably, each activity for relaxation and stress can be individualized to the child's spiritual needs, strengths, and abilities. The child life specialist, art therapist, music therapist, or other creative arts therapist should take time to present activities at the children's level of understanding and guide children in regulating their own stress levels.

Another ritual that can empower young patients to advance their own resources for calming and decreasing stress levels is visualization meditation. Visualization as a form of meditation can be introduced using wordless picture books, digital pictures of nature, or storytelling that ends with time for reflection. Imagery is used to reframe experiences and perceptions, support problem solving, and build awareness of a child's sense of control (Rollins et al., 2005). Because children's minds are flexible, absorbing with all their senses what is around them, they can respond to meditation in a natural way (Garth, 1992). Visualization meditation and guided imagery initiated by child life specialists and other healthcare professionals have diverse applications in healthcare and can offer spiritual and physical benefits (Young & Koopsen, 2011).

New medical treatments, changes in medication, and new procedures can create stress for children in the hospital. Providing an area to conduct self-generated ritual practices for relaxation and comfort can be a simple strategy to support children and families in these situations. Such areas can be easily included in an activity playroom, and children can be encouraged to go to this space when they feel the need for extra comfort. Activities available in that area could include listening to music, nature sounds, or audio books on headphones; sitting in a rocking chair

while reading or meditating; or watching a lava lamp for a calming effect. Since there may not always be the opportunity to go to a specific space with a child, treatment and exam rooms may be alternative spaces for a child to regroup and utilize a ritual for coping, reassurance, or comfort.

Conclusion

Spirituality remains a highly subjective and individualistic concept (Coyle, 2002). Spirituality is defined as experiencing a sense of meaning and purpose in life, together with a sense of belonging (Dein et al., 2010). Spirituality is about hope, strength, relationships, trust, and self-expression. Spiritual care emanates from inspiring spaces and yields opportunities for building trust (Nash et al., 2015). Healthcare professionals are learning that spiritual empowerment can lead patients in hospitals, including young children, to a sense of control over their health, recovery from illness, and coping with chronic illness (Hammermeister & Peterson, 2001). All healthcare professionals, including child life specialists, should be aware of a child's spirituality because it provides a glimpse into the child's experiences (Young & Koopsen, 2011). The consideration of children's spirituality is an important part of children's healthcare (Ratner, Johnson, & Jeffery, 1998).

For a young child, going to the hospital is a unique experience. Every child entering a healthcare setting is first and foremost a human being with unique interests, hopes, dreams, and strengths. As an integral part of many interdisciplinary teams, child life specialists are trained to assess the devel-



Activities such as open-ended art materials focusing on the child's interests allows opportunities to express feelings, creativity, and conversations with child life specialists.

opmental needs of children and to develop interventions within the framework of a child's abilities, needs, family systems and medical conditions (Rollins et al., 2005). On a daily basis, child life specialists may provide spiritual care to young patients by offering hope, comfort, encouragement, respect, and unconditional caring. Spiritual care for young children is much more than doing; it is about being. The spiritual needs of young children addressed by child life specialists and other healthcare professionals may include being an active listener to the child, or saying little or nothing, as a situation demands. It could be supporting a family and allowing them to make their own decisions, or being the caregiver who gives spiritual support and

encouragement in the form of touch, storytelling, play, music, visual arts, poetry, or other expressive arts that can be used to address and support spiritual needs. Healthcare providers, chaplains, pastoral caregivers, counselors, and child life specialists are given opportunities each day to celebrate the holistic development of young children by providing spiritual care opportunities that have the potential to nurture the hearts and souls of each child and family they serve. If young children who are experiencing illness in health care settings are to be supported with opportunities to develop to their full potential, nurturing spiritual growth should be considered an important part of the process for caring for them (Smith & McSherry, 2004). ✨

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Promoting Meaning Making and Spiritual Growth in Bereaved Parents and Siblings Through the use of Legacy Building Interventions

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Our life is a spiritual life. It is not that some of us are spiritual and some are not; our entire existence is a spiritual event . . . a process of identity, of finding out more about who we really are. . . . It is also recognized as integration and wholeness; the more of ourself and the world we can integrate into our being, the greater our development.

— Toben Hart, *The Secret Spiritual World of Children*

By the nature of their profession, child life specialists employ a unique set of skills to assist patients, siblings, and caregivers to create meaning out of some of the most tragic and painful events families can experience. These attempts can be more effective when they are aligned with the patient's and family's spiritual belief systems, and are delivered with respect and understanding for their spiritual practices at the end of life. Through individually tailored legacy building interventions, bereaved siblings and caregivers are offered the opportunity to cultivate meaning throughout their bereavement process, not only with tangible items, but also through the process of creating a meaningful narrative from the patient's life, illness, and context, within a therapeutic relationship that can unfold.

Meaning Making

Following the death of a child, parents and siblings alike seek to make meaning of their grief (Lichtenthal, Neimeyer, Currier, Roberts, & Jordan, 2013). As the death of a loved one often challenges the personal beliefs, narratives, and meaning structures of the bereaved (Janoff-Bulman, 1989), researchers have

come to understand the grief process through meaning making. Neimeyer, Baldwin, and Gillies (2006) proposed that meaning making is a way that the bereaved can begin to address the impact of death by finding a new or renewed sense of purpose. In order to reconfigure this sense of meaning, the bereaved must engage in processes of sense-making and benefit-finding to aid in the reconstruction of the beliefs and narrative that was shattered due to the death experienced (Meert et al., 2015; Neimeyer et al., 2006.). Along these lines, sense making refers to the ability to understand the circumstances of the death and come to an understanding of the how and why a death occurred, such as within the context of spiritual or religious beliefs and practices. In contrast, benefit finding is the process whereby the bereaved are able to find the "silver lining," or ascertain a new purpose in life (Holland, Currier, & Neimeyer, 2006). By identifying positive aspects to the pain experienced in grief, such as deepened connection to spirituality, community, and personal values, benefit finding has also been linked to the concept of post-traumatic growth (Lichtenthal, Currier, Neimeyer, & Keese, 2010).

Some findings suggest that meaning making is associated with positive adaptation after bereavement (Holland et al., 2006; Lichtenthal et al., 2010; Davis, Nolen-Hoeksema, & Larson, 1998). For example, Batten and Oltjenbruns (1999) found some cases of adolescents grieving the death of a sibling in which the death was the catalyst in changing perceptions about their life's meaning, and



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furthermore sparked incidences of spiritual growth. The authors found that the death of a sibling propelled adolescents to redefine their role within the context of their family structure, as well as to reconstitute their personal identity. Considering their emerging developmental ability to think abstractly, adolescents can come to consider the presence of God, a higher power, or sense of spiritual connection after the death of a loved one through feelings of compassion, understanding, and support during such times of crisis.

Some literature has devoted attention to how meaning making may aid parents after the death of their child, as this has been observed to correspond with the cessation of negative grief responses. Keesee et al. (2008) examined the connection between mothers' and fathers' processes of finding meaning, and compared this with self-reported grief outcomes after an average of six years. The authors found that parents who were not able to make sense of their child's death had a more prolonged and intense grief process compared to parents who were able to make sense of the death.

Spirituality

Spirituality can be understood as a developmental process inherent to all humans that occurs in varied contexts throughout the lifespan. The cultivation of spirituality has also been suggested to entail symbolic representations of an individual's relationship with life forces greater than one's self, including questions about what happens beyond this lifetime (Moberg, 2008). In a spiritual sense, the ways that individuals cultivate and maintain a sense of meaning regarding the challenging existential questions in life is often a part of one's personality, and may reflect in how we all think, feel, and act (Krok, 2008). However, considering the elusiveness in attempting to describe such a highly personal experience, there is no definitive consensus regarding the meaning of the term spirituality. As psychologist and scholar Tobin Hart (2003) put it,

Defining [spirituality] is a bit like trying to hold water in our hands. We can hold some for a while and we may even bring some to our mouth and swallow, but a

great deal just passes through unconfined, ungrasped. (p. 7)

Still, it is important to understand the context of spiritual beliefs in relation to child life practice, as these mechanisms have consistently been found to help facilitate the bereavement process (Lichtenthal et al., 2010; Neimeyer et al., 2006; Batten et al., 1999). The capacity to derive spiritual meaning from the death of a loved one, gaining the ability to articulate a newfound sense of spirituality, and integrating the experience into a reconfigured spiritual framework have all been found to aid in the bereavement process (Andrews & Marotta, 2005). This process may actually be easier for children, as spirituality has been described as an innate capacity that may even be inherent from birth (Forliti & Benson, 1986; Miller, 2009). After a crisis like the death of a sibling, school-aged children have been found to call upon their spiritual belief systems and use their innate spirituality to make sense of the tragedy (Jerome, 2011). Developmentally, this has been attributed to the emerging verbal capacity of children, in that having cognitive schemas regarding spiritual concepts that are less concrete compared to adults assists in children's facility to understand and apply spiritual concepts such as after-death communication and an afterlife (Jerome, 2011). However, this can also make children vulnerable to confusion, and it is important to provide simple, concrete language to help children understand the physiology, permanence, and irreversibility of death.

Bereavement literature suggests that overwhelming and potentially traumatic events, like the death of a child, often compel parents to search for spiritual meaning (Janoff-Bulman & McPherson Frantz, 1997; Neimeyer, 2000; Park & Folkman, 1997). Such events can shatter core assumptions individuals have about themselves, the world, and their spiritual beliefs (Janoff-Bulman, 1989). The search for meaning and spiritual connection following traumatic losses may arise as an attempt to restore a sense of order and predictability out of individuals' shattered core assumptions. In adults, this typically entails a cognitive process of seeking solace through means including the

use of religious texts and symbols, contacting ordained spiritual leaders within their community, or joining groups of parents who have suffered similar losses. However, children who have yet to develop core assumptions of their world may experience spiritual meaning differently than adults, not as a means of restoring order or predictability, but as a way of expressing their internal affective states in a manner that may lead to the development of a concrete sense of identity.

Accordingly, Bellous and Csinos (2009) found that children express their spirituality using four different styles: (a) words, (b) emotions, (c) symbols, and (d) actions. Additionally, acknowledging the variance by which children may be capable of expressing their spirituality can promote trust, and thereby aid in the strengthening of the therapeutic relationship and provide opportunities for the enhancement of family-centered care. Helping children feel empowered and their voices be heard are at the core of the child life profession, and can thus be facilitated by supporting the child's individual spirituality as emerging through their intrinsic or preferred means of expression.

Spirituality and Meaning Making

Spirituality has been found to provide a framework for interpreting stressors through the uniquely human capacity to create a sense of meaning and purpose in suffering (McIntosh, 1995; Park, 2005). Thus, as viewed from a coping and stress model, spirituality can be viewed as a natural means of coping and adjustment (Vis & Boynton, 2008). According to Lazarus and Folkman (1984), stress and coping theory identifies the mechanisms in which people respond to stress, first by appraising the stressful situation, and then using either problem-focused or emotion-focused approaches to cope with the stress. Using the stress and coping theory (Lazarus & Folkman, 1984), Gall and colleagues propose that spiritual coping may "function at the level of person factors (e.g., beliefs), primary and secondary appraisals (e.g., God or high power attributions), coping behavior (e.g., prayer), coping resources (e.g., connection to nature), and meaning making (e.g., spiritual reappraisal)" (Gall et al., 2005, pg. 90).



Making sense of a loss based on one's spiritual beliefs, and identifying positive consequences or benefits associated with the loss experience, have been found to correlate with better adjustment outcomes for bereaved children, parents, spouses, and siblings (Blood & Cacciatore, 2014; Castle & Phillips, 2003; Dokken, 2013; Forward & Garlie, 2003). Therefore, the specific actions of spiritual practice, including prayer or social support from a religious or spiritual community, may help to develop meaning and positively influence the grief process (Aldwin, Sutton, & Lachman, 1996; Pargament, Desai, & McConnell, 2006).

The death of a child has the capacity to alter an individual's relationship with religion and spirituality, and in turn shape their experience of bereavement. In contrast to other losses, the death of children is frequently seen as more senseless and can represent a loss of innocence, potential, and even the future (Smith, 2006). Aldwin (1994) found that religious and spiritual beliefs may help people to reappraise stressful life events as less threatening or challenging, thus allowing them to recognize that positive changes can result from suffering. For example, Barrera et al. (2009) observed parents whose child died of cancer, and found that the most common way in which parents found meaning after their child's death was through discovering a renewed purpose in life. Integrating the dynamic spiritual practices or belief system of bereaved parents and siblings into the legacy of their deceased child may therefore aid in the overall process of bereavement.

However, the means of death can also positively or negatively influence the bereavement process, and is an important variable to consider when working with grieving parents. Matthews and Marwit (2003) found that bereaved parents whose child died due to an illness as opposed to a sudden or traumatic death had the most difficulty in finding meaning or making sense of the world. The authors found that death as a result of an illness resulted in parents still seeing the world as good and decent, yet they found it hardest to make sense of their loss. However, sudden deaths due to homicide, suicide, or accident were found to shatter the assumptive world view of parents, who thus saw the world as malevolent and unjust.

One of the most fundamental spiritual questions we can ask ourselves as humans is, "Who am I?" Whether in a traditional or nontraditional context, becoming a parent is one of the most important developmental shifts an individual can go through, in that their sense of themselves frequently becomes inclusive of their child and the inherent bonds embedded within the parent-child relationship (Klobučar, 2016). After experiencing the death of a child, however, a parent's core sense of identity, the very fact of having that child, is shattered. In a similar way, this can occur with siblings, as familial bonds are some of the most prominent means by which individuals locate their sense of self in the world (Hawthorne, Youngblut, & Brooten, 2016). Once a child or sibling dies, parents and siblings alike must seek to reform their identity, asking questions such as, "Am I still

a parent?" or "Am I still a big sister?" In this way, the magnitude of such experiences can shake the very foundation upon which spirituality had been formed. For the child life professional, providing opportunities to express and process these challenges to identity cohesion can be one of the most powerful therapeutic opportunities that we provide. Such opportunities can be found in the creation of legacy building interventions. When legacy building occurs within a therapeutic relationship grounded in individual-centered care, it can assist the process, becoming a means by which the exploration of meaning making can unfold.

Legacy Building

Legacy and legacy building are terms that have not been operationally defined in child life practice (Leigh, 2016). In one definition that stems from the gerontology literature, the creation of a legacy is understood as a complex and multi-layered experience that is "enmeshed in an individual's culture," and "offers the potential for a highly personal contribution to the future" (Hunter & Rowles, 2005, p. 328). Child life clinical practice has focused on legacy building as an intervention whereby a product is created (e. g., handprints, locks of hair, digital photo albums, etc.). Another approach to legacy proposes that producing tangible items has been found to provide enhanced meaning, purpose, and life satisfaction for children with terminal illness (Castle & Phillips, 2003; Clutter, 2005). Still others have defined legacy

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building as “doing or saying something that is remembered, including both intentional and serendipitous legacies” (Foster, Dietrick, Friedman, Gordon, & Gilmer, 2012, p. 573). Leigh (2016) offers a wide-ranging definition specific to the practice of child life, stating:

Legacy building encompasses various opportunities that promote emotional expression and validate life experiences for pediatric patients, their siblings, and families, oftentimes resulting in a tangible item or product... Considering the meaning and symbolism inherent in the act of creation, it is paramount that families are provided with the agency necessary to choose how, when, and if they participate in such opportunities... Legacy building is not a prescribed intervention, but rather it can be seen as an integrated method of assisting to create a narrative of a child's life that will continue the bond with their family in years and decades following their death. (pg.154)

Moreover, it has been suggested that leaving a legacy is a spiritual concern of children with terminal illness (Gibbons, 2001).

As an intervention, legacy building can be a group of activities designed to create tangible items, such as hand and foot prints, locks of hair, or scrapbooks, to promote meaning making for dying individuals, while also providing support to family and friends (Allen, Hilgeman, Ege, Shuster, & Burgio, 2008). Other legacy building activities include constructing a string of beads that document a patient's journey through their illness (Sisk, Walker, Gardner, Mandrell, & Grissom, 2012) and the creation of a digital storybook (Akard et al., 2015). However, according to Foster et al. (2012), the most common legacy building interventions utilized in child life programs for children at the end of life include memorializing the dying child's body through such things as hand and foot prints and memorializing the child's mind and spirit through memory books or journals.

Child life specialists are in a uniquely distinct position to provide patients and families with the opportunity to help represent a meaningful, evolving narrative for children with terminal illnesses and their families through offering legacy building interventions. As this has become a standard practice, child life specialists who work with hospitalized children have been found to provide legacy

building opportunities to patients nearly 94% of the time at various stages of illness from diagnosis to end of life (Foster et al., 2012). Frequently, these interventions offer the opportunity to include family members, such as siblings, parents, and grandparents, in the process of creation.

As previously mentioned, common legacy building interventions include the creation of hand and foot prints, scrapbooks, and photographs. However, interventions that integrate patients' and families' spiritual belief systems into the legacy building creation may be a further avenue for supporting culturally and spiritually sensitive care at the end of life. Legacy building that integrates culturally and individually appropriate spirituality into the process of creation can enhance meaning making, and aids coping during bereavement. Being that each culture and world spiritual tradition therein has different rituals and meanings derived from the death of family and community members, collaboratively and respectfully allowing for spirituality to be included in the legacy building process can greatly enhance the meaning that the legacy items and the process of creating them can contain. Examples of spirituality-infused legacy building interventions vary, as each patient and family has their own spiritual beliefs and practices that will dictate the specific meaning created within the interventions.

Facilitating Meaning Making Through Legacy Building

Below are some ways that child life professionals may foster the meaning making process while incorporating the spiritual beliefs of patients and families with whom they are working.



Narrative Approaches

Narrative approaches are means by which patients and families can tell their stories, and typically include activities such as writing

poems, letters, songs, or messages to loved ones. This aids in the expression of difficult feelings, and can also employ various technologies, including audio and video media. Narrative approaches allow psychosocial teams to “stand alongside children who have life-threatening illnesses, and their families at critical times and to create stories of agency” (Hedtke, 2014, p. 1). Narrative practice is built on the assumption that people live their lives through stories, and that there are many stories co-occurring within the same individual (Combs, 1996; White, 2007). Furthermore, Hedtke (2014) found that narrative approaches help the oncology psychosocial team engender hope, particularly through emphasis on making meaning out of the various frames in which individuals build their identity. For parents and children to have the opportunity to create a narrative, and thus begin the meaning making process early in the disease trajectory, legacy building may also become a vehicle that can represent the meaning contained within these narratives.

Case example 1:

Jenna* was a 14-year-old female newly diagnosed with an aggressive form of bone cancer. Before her diagnosis, she was an avid gymnast and dancer. Upon meeting the child life specialist, Jenna introduced herself as a gymnast, thereby voicing her formed identity. During the months that Jenna and her child life specialist worked together, they wrote a series of “I am” poems, a simple writing exercise that allows patients to create a personal narrative embedded in their identity. As the months shifted, so did Jenna's “I am” poems. Starting with imagery of an active, social, and outgoing adolescent with words such as “strong,” “flexible,” and “adventurous,” her words transitioned to a softer and more euphemistic version of herself over time, with the assertive, extroverted words gradually being replaced with terms such as “fluid,” “ever changing,” and “connected.”

Rituals

Rituals are practices that may derive from many world traditions, though can be independent of any particular cultural or spiritual practice. However, rituals are inherently infused with meaning, can validate even the most isolating experiences, and may even help to assist with the transition of identify within the grief process (Castle & Phillips,



2003). Thus, a simple shift in perspective can turn everyday events including how one wakes up, enters a room, or engages in an activity, into a ritual. This can be facilitated through discussions regarding patients' and families' cultural rituals, by inquiring into what might be important for them to prioritize in the time they have left with their children, or by simply trying to highlight moments in their routine that they may find to be a resource or a bright spot in an otherwise challenging and stressful time.

Case example 2

Monica's* one-month-old daughter, Sophia*, was dying due to a rare congenital condition. During their work together, the child life specialist assisted Monica in creating meaningful daily rituals that she could share with Sophia. During a conversation with the child life specialist, Monica reported that she wanted to allow Sophia to experience as many "firsts" as she could: her first bath, her first sunrise and sunset, her first experience petting a dog, and many others. The child life specialist worked with Monica to create a "ritual of firsts." Monica chose a time of the day to set an intention of providing Sophia with a "first" experience each day.

Legacy Items

Legacy items are sometimes tangible items, which, in a sense, are a record of the physical existence of a child and are connected to the bio-psycho-social context in the wake of that child's impending death as understood by the parent. Thus, the creation of these items can help embed fleeting memories, thoughts, and feelings into a narrative structure, which can further facilitate the healing process (Cacciatore & Flint, 2012). However, it is highly important to practice effective listening and clinically competent communication during these activities. When performed without respect for child and family autonomy, spirituality, and culture, legacy building can unfortunately become infused with negative

and painful memories (Leigh, 2016). Legacy building should be considered as a co-constructed process that extends naturally out of the therapeutic relationship that child life specialists build with patients and families. These are items not provided to the family, but made with the family.

Case example 3:

Adam* was a previously healthy and active 17-year-old male. After suffering an accidental trauma, he lost nearly all brain function and, as his parents stated, he "was in a vegetative state." During their time together, the child life specialist worked with Adam's parents and siblings to identify hopes they had for him. His parents firmly believed that Adam was "still in there" and hoped for him to regain all functioning. His siblings, aged 11 and 13, hoped to be able to talk with him again and "do things with him." During their conversations with the child life specialist, Adam's parents mentioned wanting to do something "with" Adam. The suggestion was made for the family to engage in creating a plaster mold of their family holding Adam's hand. The parents and siblings worked together to come up with how they wanted to hold hands, who would be on top, and how the fingers would be placed; and together with the child life specialist, they created the hand mold. Afterwards, the child life specialist asked the family members to write a short story about the process of creating something "with Adam." When the plaster molds were ready, the stories were framed and presented alongside them to create a whole narrative of the experience.



Dreams and Communication

Dreams of deceased loved ones are highly prevalent among the bereaved (Klugman, 2006). Being that dreams take place outside of a literal context, they provide means by which to make meaning that can be challeng-

ing through intentional cognitive processes alone (Gillies & Neimeyer, 2006). Moreover, dreams involving the deceased can provide the bereaved with experiences that may help them overcome complex feelings and help with adjustment post death (Ryan, 2006). Additionally, healing functions may occur through chances to communicate with the deceased, and some have reported receiving messages that are encouraging reminders of their connections with the deceased that can help survivors cope in stressful times (Leigh, 2016). Thus, dreams may function as a means of symbolism, as well as a way for the bereaved to feel connected to the deceased. While this may occur in many forms, Sormanti and August (1997) found that grieving parents experiencing spiritual connections with their deceased children wanted healthcare professionals:

...to be open, respectful, and nonjudgmental of their bereavement experiences and to allow and encourage them to talk openly about their experiences and beliefs. Parents want staff to know that these connections do exist, are reassuring to them, and help them in their grieving process. (Sormanti & August, 1997, p. 467)

Case example 4:

Ten-year-old Eric's* older brother died three years ago, and since the death, Eric has dreamed of his brother on many occasions. Talking with the child life specialist, Eric reported that dreaming of his brother "feels good" and he sometimes "feels like he's here with me." However, whenever Eric mentions his dreams or his sense of presence to others they tell him "That's weird." Thus, Eric has stopped talking with other children about his experiences. Together with the child life specialist, Eric created a "dream" journal. In it, the child life specialist provided prompts and open-ended questions such as "Who was in the dream?," "What was said during the dream?," "What was the color of the dream?," and "How did you feel when you woke up from the dream?" By keeping a dream journal, Eric was able to share with the child life specialist dreams that he otherwise might have forgotten. The discussions that these dreams initiated helped Eric to feel a greater sense of connection to his brother, and to

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something larger than himself, where he felt that his brother “went home to.” Making meaning out of his dreams thus aided Eric’s bereavement process.

Conclusion

Being attentive to and offering opportunities for the expression of spirituality can be a powerful tool that child life specialists can use to aid in the coping and bereavement process for patients, parents, and siblings. The child life professional is in a distinct position to provide such interventions. Barriers to care may frequently arise, as certain hospital settings may not feel like accommodating places to talk about spirituality, especially when there are individuals, including chaplains, who traditionally fill these roles.

Cultures that fall outside of the dominant religious and spiritual paradigms may face some stigma for practices that most Americans are not familiar with. The cultivation of cultural humility and approaching spiritual matters without assumptions and biases from our own experiences are crucial in cultivating a respectful, inclusive atmosphere.

It should be noted that when dealing with issues of grief, death, and spirituality, it is of upmost importance for child life professionals to use reflective practice in understanding their own relationships to such issues. If not, there is risk of individual assumptions and biases adversely impacting the experiences of patients and families in our care. Reflective practice will help maximize child life specialists’ ability to provide ethical and supportive

interventions to the benefit of the diverse spectrum of patients and families served, bringing greater levels of self-awareness and cultural humility into professional practice.

It is paramount to the profession that child life specialists engages in ongoing inquiry regarding the practice of legacy building. By examining closely how hand prints and foot prints are offered, asking how and why an intervention is helpful for families, and considering whether it allows for agency and expression on behalf of the patient and family will lead to better understanding of the complexity and spiritual implications of offering legacy building interventions. ✨

* Names have been changed to protect patient and family members’ privacy.

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PATHWAYS TO EBP

EBP, One Step at a Time

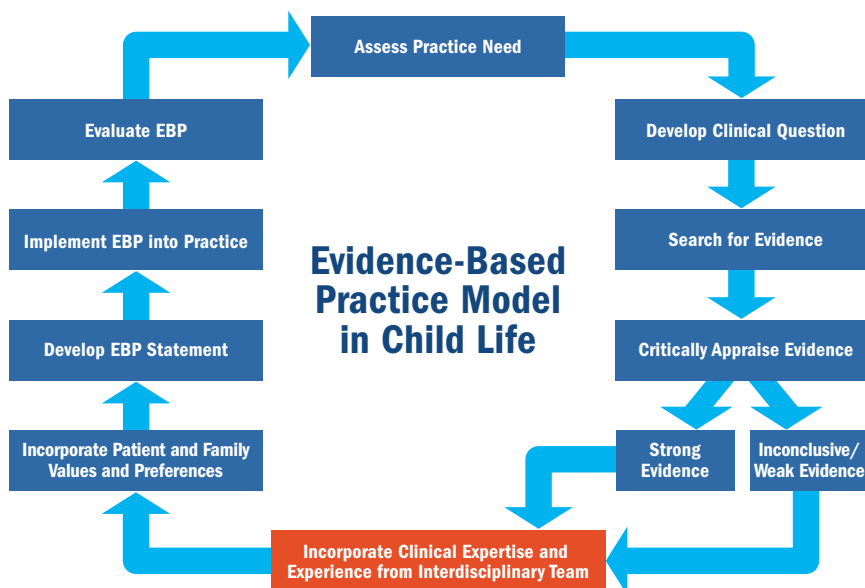
STEP 5:

Develop the Evidence-Based Practice Statement, Incorporating Clinical Expertise and Patient/Family Preferences

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In previous *ACLP Bulletin* articles, the evidence-based practice (EBP) series discussed the first four steps in the EBP Practice Model in Child Life: (1) assess the practice need, (2) develop a clinical question, (3) search for evidence, and (4) critically appraise evidence (Jones & Bonjour, 2016; Jones & Bonjour, 2017; Wittenberg, 2017; Calvert, 2017). After completing these four steps, the fifth step in the EBP practice model is to develop the EBP statement, which includes writing the evidence summary and developing a care recommendation statement, while incorporating clinical expertise and patient/family preferences (Cincinnati Children's Hospital Medical Center Evidence Collaboration [CCHMCEC], 2015). In this article, each of these components are discussed.



Writing the Evidence Summary

The purpose of the evidence summary is (1) to compile and synthesize the research findings from articles that were critically appraised in step four, (2) to demonstrate how these articles answer the clinical question from step two, and, ultimately, (3) to determine how these articles inform and lead to the creation of a concise care recommendation. To begin, review the evidence table from step four and look for themes, similarities, and differences in findings that answer the clinical question (CCHMCEC, 2015). Consider a simplified example: Let's say five articles provided evidence that therapeutic play reduced anxiety in pediatric patients and two articles

provided evidence that therapeutic play had no effect on anxiety in pediatric patients. Two themes were found: (1) therapeutic play reduced anxiety and (2) therapeutic play had no effect on anxiety. Both themes need to be presented and cited in the evidence summary, and the grade of the body of evidence needs to be discussed, which includes the quantity, quality, and consistency of the evidence found to verify the two themes (CCHMCEC, 2015). In this example, let's say the five articles that found therapeutic play reduced anxiety were from high quality studies (e.g., systematic reviews and randomized-controlled trials), and the two articles that found therapeutic play had no effect on anxiety were from low quality study designs or case reports. In this example, the evidence leads to the aggregate theme that therapeutic play reduced anxiety in the pediatric population. An adequate discussion of each theme found in the evidence table needs to be included in the evidence summary. Then, it is time to create a care recommendation statement.

Developing a Care Recommendation Statement

The care recommendation statement is a guideline for best practice that summarizes the body of evidence into one sentence and typically begins with the phrase: "It is (not) recommended that..." or "It is (not) strongly recommended that..." (CCHMCEC, 2015). (See Table 1 to determine appropriate language usage for the care recommendation). The care recommendation should also include an action verb and state: (1) the population being addressed, (2) what is being recommended, and (3) when and (4) where the recommendation will occur (CCHMCEC, 2015).

TABLE 1.
Language and Definitions for Recommendation Strength

LANGUAGE FOR STRENGTH	DEFINITION
It is strongly recommended that... It is strongly recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is high support that benefits clearly outweigh risks and burdens (or vice-versa for negative recommendations).
It is recommended that... It is recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is moderate support that benefits are closely balanced with risks and burdens.
There is insufficient evidence and a lack of consensus to make a recommendation...	

(CCHMCEC, 2015, p. 39)

Two example care recommendation statements are below. Can you identify the four components of each care recommendation statement?

Example 1: "It is strongly recommended that children of all ages receive therapeutic play opportunities during healthcare encounters to reduce anxiety, distress, and negative behaviors, and improve a child's ability to cope" (Liddle, 2014, p. 2).

Example 2: "It is recommended that siblings of actively dying children be involved and prepared for their siblings' death to facilitate appropriate grief responses" (Ulanowski, McGee, & Giambra, 2011, p. 1).

When judging the strength of the recommendation statement, there are six dimensions to consider in addition to the grade of the body of evidence: (1) safety/harm, (2) health benefit to the patient, (3) burden on the patient to adhere to the recommendation, (4) economic impact to the healthcare system, (5) directness in answering the clinical question, and (6) impact on morbidity/mortality or quality of life (CCHMCEC, 2015). To assess the *safety/harm* of the care recommendation, consider the adverse effects on the patient if the recommendation is implemented (CCHMCEC, 2015). Using the previous example, the adverse

effects for providing therapeutic play may include the potential for a patient to get physically hurt while playing. Next, assess the *health benefit of the recommendation to the patient*: How significant is the health benefit if the care recommendation is followed? Does the benefit outweigh the risk for adverse effects on the patient if the recommendation is implemented? Then, assess the *burden on the patient to adhere to the recommendation*. For example, therapeutic play may be painful for a patient to engage in if the patient had two broken wrists; however, therapeutic play would typically have a low burden of adherence to the patient. Next, assess the *economic impact* this care recommendation would have on the healthcare system. Hospital administration may worry about the cost of purchasing play materials for pediatric patients; however, because therapeutic play leads to reduced anxiety in pediatric patients, the use of anxiety medication may decrease with the implementation of therapeutic play, thus reducing the amount (and cost) of anxiety medication required within the hospital system. Therefore, this recommendation could lead to a positive economic impact for the healthcare system. Then, assess the *directness* to which the body of evidence addresses

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the clinical question: Is the body of evidence directly related to the target population described in the recommendation (CCHMCEC, 2015)? Last, assess the *impact the care recommendation has on the morbidity/mortality or quality of life* of the patient. Based on the evidence, engaging in therapeutic play would have a positive impact on the quality of life of the patient.

Incorporating Clinical Expertise and Patient/Family Preferences

In addition to the grade of the body of evidence and the six dimensions to consider when creating a care recommendation, it is essential that interdisciplinary clinical expertise and patient/family preferences are incorporated into the EBP Practice Model in Child Life (Staab, 2012). The incorporation of interdisciplinary clinical expertise and patient/family preferences does not begin when writing the care recommendation. Interdisciplinary staff can assist with the critical appraisal of research articles and are also invaluable when evaluating the six dimensions prior to creating a care recommendation (Staab, 2012). For example, physicians and nurses may consider additional safety risks when evaluating the therapeutic play care recommendation compared with the child life specialist's perspective of safety risks. Because the successful implementation of a care recommendation is comprised of an interdisciplinary team effort, it is vital that interdisciplinary staff and clinical expertise are incorporated into the development of a care recommendation (Staab, 2012).

Furthermore, patients and families need to be incorporated into all steps within the EBP practice model. There has been a recent initiative to actively engage patients and families in all stages of healthcare research, includ-

There has been a recent initiative to actively engage patients and families in all stages of healthcare research, including the development, implementation, analysis, and dissemination of research results (Patient-Centered Outcomes Research Institute [PCORI], 2017; Institute of Patient- and Family-Centered Care [IPFCC], n.d.-a).

ing the development, implementation, analysis, and dissemination of research results (Patient-Centered Outcomes Research Institute [PCORI], 2017; Institute of Patient- and Family-Centered Care [IPFCC], n.d.-a). Some of the benefits of engaging patients and families in healthcare research have been shown to improve the relevance and practicality, as well as the quality and validity of a research study (IPFCC, n.d.-b). Similarly, the concept of engaging patients and families in research can be applied to the EBP practice model. For example, patients and families can be helpful in identifying the practice need for a care recommendation (step 1), developing a clinical question (step 2), and evaluating the care recommendation and complete EBP statement (Staab, 2012). Incorporating patient/family preferences into the care recommendation statement ensures that patient/family characteristics and values are considered when implementing the care recommendation into clinical practice (Staab, 2012).

Once the evidence has been synthesized and a care recommendation statement has been developed, it is time to revise and finalize the formatting of your EBP statement prior to sending it for review at a relevant professional association (i.e., Association of Child Life Professionals [ACLP]) and/or a peer-reviewed journal. For more infor-

mation on the EBP application and development process, please contact the ACLP at EBP@childlife.org.

The remaining two steps of the EBP Practice Model in Child Life include the implementation of EBP into practice and the evaluation of EBP; however, the next series of *ACLP Bulletin* articles brought to you by the ACLP's Scientific Advancement of Professional Practice Committee: EBP/QI Awareness and Networking Subcommittee will be an introduction to Quality Improvement (QI). The QI series will further expand on the implementation and evaluation of EBP care recommendations. Continue to follow this series as we dig deeper into the QI process! ✨

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Writers Wanted!

ACLP Bulletin and *Focus* welcome and encourage submissions from members. Writing for *ACLP Bulletin* or *Focus* is a great way to highlight your professional work, enhance your skills, and build your resume, all while making a valuable contribution to the child life profession. With new columns and a variety of formats, articles can be anything from short vignettes about memorable child life moments, to debates about controversial practices, to extensive research-based work.

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Questions and ideas can be addressed to the managing editor at bulletin@childlife.org.

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THE TRANSFORMATIVE POWER OF DATA:

How the Child Life Professional Data Center is Reshaping the Way We Understand our Profession

Kate Shamszad, MS, MPH, CCLS

ON BEHALF OF THE SCIENTIFIC
ADVANCEMENT OF PROFESSIONAL PRACTICE
BENCHMARKING SUBCOMMITTEE

As child life specialists, every day we can see and feel the impact our interventions have on patients and families throughout the hospital setting. But can we measure it? Is there a way to quantify the positive affect we have? Enter the Capacity for Patient Family Impact (CPFI), a simple productivity measure built on a foundation of published evidence showing the efficacy of psychosocial services.

For the first time, we have the opportunity to simplify and standardize a productivity measure across the profession of child life. Many programs have spent years collecting finite measures, intricate details about our interventions, and tracking our time to show our daily work. And while collection of data through time tracking or counting intervention types was helpful on a program-specific level, it was often incomparable across sites because there was no standardization of what was being captured. Benchmarking has not just been done on the local level, but also through national initiatives, like the past work of the Child Life Council Professional Benchmarking Task Force. And while each variable and detailed data point are part of the story, the immense amount of data being collected on a program level doesn't help to compare the work being done across programs because apples at one hospital may be oranges at another.

The Association of Child Life Professional Scientific Advancement of Professional Practice Committee (SAPPC), made up of three subcommittees, knew there could be an easier way. Over the course of 2016-2017, this group completed a comprehensive literature search to determine the positive impact and efficacy of utilizing child life and psychosocial services for pediatric patients and their families. And not unexpectedly, there is significant support for much of our work in the published literature. Using this evidence-based review as a foundation, the SAPPC Benchmarking Sub-Committee began to build what is now the Child Life Professional Data Center and the standard productivity measure of CPFI.

CPFI is the numerical indicator of what the evidence-based practice review demonstrated: Since we know that child life specialists make a positive impact when engaging with patients and families, how much impact can a child life specialist (or whole child life program) have in a given day? In a given hour? The CPFI measures the number of patient and family encounters that a child life specialist (or team of child life specialists) completes in a particular area on a given day and divides that total by the number of hours in their shift. Over time, even though there is variation to the number of patients and families seen by a child life specialist day to day, there becomes some regularity to the number of encounters tallied. And the best part—there are only two numbers to collect every day by each specialist: the number of patient and family

encounters and the number of hours in their scheduled shift. CPFI is being measured in six areas that have demonstrated, through research, the efficacy and positive impact of psychosocial services: acute inpatient units, critical care units (PICU, NICU, CICU, etc.), radiology, emergency department, ambulatory outpatient clinics, and pre-surgery.

The impact of CPFI becomes exponentially greater when you think about hundreds of programs collecting the same apples to apples measure and their ability to share this data with one another. The SAPPC Benchmarking Sub-Committee, in conjunction with building the CPFI measure, also worked throughout the year to construct the Child Life Professional Data Center (CLPDC). This online database houses advanced program data, including staffing, budget, hospital, and program metrics as part of annual data and the CPFI as part of quarterly data. The CLPDC is built with a robust analytics platform that allows for customized review of program data, allowing you to compare not just apples to apples but Granny Smith to Granny Smith, in order to compare and learn from programs most like your own.

But this platform doesn't stand on its own. Consider this your call, your invitation to participate in something that is worth being a part of and will support our practice and profession in an astounding way! To learn more and get involved, check out the [Benchmarking section](#) of the ACLP website. ★



The Journey of Child Life in Hong Kong

Tammy Sze-wah Loy, CCLS, MSS

CHILDREN'S CANCER FOUNDATION, HONG KONG

Child life was first introduced to Hong Kong in 1997 by a non-profit organization, the Children's Cancer Foundation (CCF). The goal of this organization is to fill the unmet needs of pediatric oncology patients and their families by way of a wide range of psychosocial care while being treated in the city's public hospitals, and child life is one of the services it provides. The government of Hong Kong decided to set up its first children's hospital in 2007, which will be opened in 2018. This first children's hospital will consolidate specific fields of expertise and will concentrate on patients with complex illnesses. This will be a new era of pediatric care in Hong Kong. This article will review the development of child life in Hong Kong in the past two decades and the potential for and challenges of future development.

The Hospital Play Program Before 2010

CCF was founded in Hong Kong in 1989. In the early years, a group of volunteers regularly brought toys to the pediatric oncology wards and played with the patients, forming the mold of a hospital play program. In 1993, the foundation employed several social workers to operate this play program, as the positive results of play in pediatric wards were valued by medical team. In 1997, the foundation sponsored a staff to partake in a child life internship in a children's hospital in the U.S.A. as no similar program was available in Asia. Growing accessibility of the internet allowed the hospital play team to continue to learn more about child life, which had been well-established in the West. They joined the Child Life Council and got access to resources and new

[Continued on page 44](#)



Two CCF child life specialists play with patients in the hospital.

The Journey of Child Life in Hong Kong



A CCF child life specialist engages a child in play.

progress shared by other child life programs. The model of child life in North America became the framework of reference for the team in Hong Kong. Gradually, the team was able to introduce a range of child life practices during the first decade, including medical play, hospital bingo, treatment preparations, etc. Unlike in the early days, when they were called “play lady,” the role of the specialists in the healthcare team gradually gained more recognition. The specialists gave lectures and presentations to healthcare practitioners and students. However, there was still confusion on the role of hospital play specialists and the team was often mistaken as play therapists. Furthermore, the care provided by child life was still viewed as a separate provision apart from standard medical care and not as an allied healthcare which would be integrated into the total patient care protocol.

Integration into Patient Care, 2011 Onwards

The tertiary healthcare of Hong Kong is funded by taxpayer money. It costs just about 3% of the gross domestic product (GDP), but covers the 7.3 million population. This highly efficient healthcare system achieved impressive outcomes. It has the lowest infant mortality rate in the whole world and the second highest life expectancy rates. Our medical care service is renowned internationally for we strive to be at the forefront in medical technology. However, limited government resources are allocated in psychosocial care, and there is no dedicated staff in hospitals providing pediatric psychosocial care. For example, clinical psychologists in public hospitals provide hospital-wide service to patients suffering from all types of illnesses, but just a few of them are specialized in pediatrics.

Being the main advocate of the first children’s hospital, the CCF set forth a mission to raise awareness of the importance of specialized psychosocial care in pediatrics in 2010. It considered that child life should be more widely understood for its role in the total patient care protocol. To take a step further, the foundation piloted two child life projects beyond the pediatric oncology ward in 2011. One is established in a 118-bed pediatric department in an acute hospital, where two child life specialists work alongside the medical team to promote family-centered care. Another one extended child life provision from oncology to a 30-bed general ward with an additional half-time child life specialist. More child life staff were hired and sent to the U.S. and Canada for clinical training. To follow the footsteps of our U.S. counterparts, the child life team made more effort to demonstrate to the hospital staff what positive changes could be achieved if child life interventions were utilized and delivered as an integral part of the total care in pediatrics. Enhanced collaborations and joint research efforts with imaging radiology, operation theatre, and radiation therapy have gained encouraging results. For example, as child life assessments were formally included in the planning of radiation therapy, child life support was valued as it helped to reduce the use of sedation in imaging procedures, and a higher satisfaction rate was reported by patients and families, as well as medical staff.

Our service was officially re-named from hospital play to child life in 2015 to dovetail more smoothly with that in the global field. The team grew from 4 to 11 members, and most of the specialists have been certified by the Association of Child Life Professionals (ACLP). The foundation held the first symposium for the pediatric healthcare community on child life in 2016 and “Integration” was the key message during the symposium.

Potentials and Challenges in Developing into a Standard Provision in Local Pediatrics

During the past two decades, our clinical experience confirmed that child life can be an integral part of the healthcare system the same way in Hong Kong as in any Western society. Child life interventions are proven to be equally effective in Chinese culture.

Hong Kong signed the UN Convention on the Rights of the Child in 1994. It is the collective view among the society to help children tackle the challenges ahead of them and allow them to develop their full potential.

However, high competition for limited resources within the public healthcare system provided many challenges to including child life as a standard provision. Psychosocial needs of patients are at a lower priority in comparison to their medical needs, and most often they are approached in a remedial manner. Though many pediatricians and nurses value the preventive and developmental care given by child life specialists, there is still a lack of consensus among policy makers, hospital administrators, and healthcare professions in Hong Kong to respond to the call of including child life into the official infrastructure of healthcare. Before child life can be officially included as standard healthcare provision in Hong Kong, such service can only be financed by outside money. It will be hard to see a wide application in all pediatric settings at this point in time due to the limited resources.

Another hurdle to the local development of child life comes in the form of training. The foundation requires their child life specialists go through the certification process set forth by the ACLP. Certified Child Life Specialists would supervise and mentor the newly recruited specialists before they complete the child life certification. At present, child life training in Hong Kong still relies heavily on institutions in the U.S. and Canada. In the long run, Chinese child life specialists will build up local knowledge on top of this western foundation, collect evidence in our own context, and modify clinical practices according to our own cultural background. Local tertiary education institutions should be involved in the planning of localization of child life training in Hong Kong.

The Way Forward

The Hong Kong history as a British colony before 1997 resulted in a British-style healthcare system with Western-style educated healthcare practitioners. It is very common in the healthcare community in Hong Kong to introduce a new profession by recruiting trained practitioners from overseas at the initial phase as experts, and subsequently, by establishing local governance bodies, local training programs can be set up. The dietary and pharmaceutical professions are some examples. We hope child life can develop into an established allied health profession in Hong Kong under the same pathway.

Hong Kong has a long history as the go-between for the East and West. It gives us a unique position in China to pioneer new concepts and practices. Meanwhile, the

majority of the people in Hong Kong are of the same ethnicity (Han Chinese) and use the same dialect as Mainland China. The experience in localization of child life practice should be very valuable to healthcare practices in Mainland China. Non-governmental organizations (NGOs) in Mainland China have sought training from CCF in the past years; therefore, this child life group in Hong Kong is of high potential to participate in establishing a training platform for child life in Greater China.



The author (front row, second from the left) at the first symposium on child life in Hong Kong, where directors from child life programs in the U.S. joined the CCF child life team to share their experiences with the local pediatric healthcare community.

The journey of child life in Hong Kong started with a very focused patient's group by a small NGO. In the past few decades, there have been changes in the pediatric healthcare system as well as higher expectations to respond to children's needs in a more comprehensive manner. Despite the vastly different culture and context from that of North America, the journey of child life in Hong Kong demonstrated that the core value behind child life practice is universal. A global mission within child life is to advocate for psychosocial needs, regardless where the child life specialists are. For future growth in Hong Kong, the child life specialists should engage stakeholders, including policy makers, healthcare educators, child health workers, community partners, and families, to have more discussion on the direction of pediatric psychosocial care, and advocacy work should be strengthened to raise the awareness of the needs of children in healthcare settings. ✨



Viewing the Internship Application Process Through Both Sides of the Window

Lynn Sanner, MA, CCLS

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The child life internship selection process is an exercise requiring courage and intricate footwork by participants on both sides of the admission window. Intern selection season is a time of high emotion and painstaking work both for prospective interns and for the selection teams who make decisions for their programs. All participants share the ultimate goal of preparing skilled child life professionals to assist families in distress. However, the inherent elements of competition for available spaces and the necessity of efficiency can result in

anxiety for persons on both sides of the process. Internship candidates want to be understood, recognized, and chosen for program positions. Internship coordinators want to understand what candidates have to offer, recognize those who will most benefit from and fit into their programs, and succeed in shaping effective providers of family health-care. This is a high stakes affair from all perspectives, since the final results will ultimately affect the quality of care provided for vulnerable families. Candidates long to be chosen because they feel called to provide service in a world that needs healing. Already scrambling to meet needs of patients and families, internship selection committee members want to inform and coach new professionals without compromising

their own service to the fragile humanity they encounter every day.

I've become well acquainted with the intern selection process by gathering experience on both sides of the admissions window. I participated as an intern preceptor for more than a decade before moving into the role of internship coordinator at a large children's hospital in the Midwest, where I worked on behalf of both interns and staff for another seven years. I skipped a complicated review and interview process and later worked with a team to completely reshape the intern selection system. Now, retired from the hospital setting, my privilege is to prepare and coach internship candidates as a university instructor. I know that on both sides of the window, people have

tables filled with documents and lists and chocolate and hope, and that people are losing sleep and holding breath.

This article will describe the selection process at a large children's hospital and identify the characteristics that indicate a candidate's readiness to succeed within a program. Since effective communication is the master key that opens the admission window from either side, specific aspects of the application and interview process will be discussed.

We Said/He Said

In the months and weeks before an application due date, participants on both sides of the process have concerns that are similar in nature. Common issues on the minds of selection teams and candidates for internships are illustrated in Figure 1.

One Hospital's Screening Process

The hospital referenced above typically receives 75-90 applications for each of the three internship sessions offered during the year. Four interns are accepted in most semesters. In order to be as fair and as efficient as possible, the selection team instituted a three-tiered screening process. Initially, all applications that arrive complete and on time are scored by a team of up to twelve reviewers who follow a standard grading rubric. Each screener reviews 5-7 applications. Points of review include GPA, amount of experience with children and families in health-care and outside of healthcare settings, number of completed courses pertinent to the work of child life specialists, quality and content of writing on essay questions, content of reference letters, and the organization and clarity of application materials.

FIGURE 1.
Views Through the Window

INTERNSHIP PROVIDERS ARE THINKING:	CANDIDATES FOR INTERNSHIP ARE THINKING:
Do we have adequate staff available to precept?	Will there be adequate variety of learning experiences for me?
We want to choose interns who will become competent CCLS. Our selection process needs to help candidates show important qualities.	Am I prepared? How can I stand out and be noticed? What should I tell about my experience and values? What should I avoid discussing?
Which staff are both experienced with interns and available to help with the large and important task of reviewing (up to 90) applications, interviewing, and communicating outcomes to candidates?	To how many programs should I apply? What are their application requirements in terms of due dates, reference letters, official transcripts, necessity of in-person interviews?
How can we afford this?	How can I afford this?
Can we reserve rooms in the hospital on dates when our staff are available for interviews?	What if two hospitals want me to interview in the same day? What if it's too expensive for me to travel to the interview site?
What is the most efficient way to manage logistics of selection process? Where will we store the applications without losing any of them? How will we keep track of communication we've had with candidates?	What is the most efficient way to manage logistics of selection process? Where will I make a command central for assembling applications? How will I keep track of the individual requirements set forth by different programs? How will I keep track of communication I've had with individual programs?
How can we most effectively recruit interns who bring both diversity and eagerness to participate within a team of colleagues?	What kind of people are programs hoping to recruit? Will I fit the image they seek? What should I wear to the interview? How should I speak?
How can we be sure that candidates feel valued and welcome within our child life community? How can we attract strong candidates who truly want to be in a program like ours? How can we gently decline candidates who appear to be unready or with values that will not fit within our philosophy of care?	Will this program support my professional growth and meet my emotional needs? Will this setting be a positive situation for me? How can I best demonstrate my passion and readiness to join this program? How will I gracefully decline if I decide that this is not a good fit for me?
This is a season of high census at the hospital and annual review documents are due in three weeks and today the activity center flooded.	This is my final semester and my thesis is due. OR This is my second attempt to get an internship and I absolutely must get a job very soon and today the electricity is out in my apartment.

Concerns of internship providers are matched with concerns of internship candidates. Strong points of concern that are typically felt by *all* participants are indicated in bold typeface.

Continued on page 48

Viewing the Internship Application Process Through Both Sides of the Window

In Tier 2, authors of the highest scoring applications are invited to submit video responses to 10 interview questions. Approximately 25-30 percent of applicants participate in this round. They receive interview questions several days in advance of a submission date and have capability to rehearse and amend their recordings. Video interviews are screened by the internship coordinator and scored according to a standardized grading rubric. Here, points of review include general knowledge of growth and development, awareness of child life theory and practice, verbal communication skills, ability to follow directions, cultural competence, readiness to play, and apparent ability to contribute to the success of a team. The twelve highest scoring candidates from this pool of interviewees are invited to a third and final screening event, a Multiple Mini Interview (MMI), which is a *group* interview that occurs on-site at the hospital.

In an attempt to include more applicants in on-site interviews and to enrich the interview experience for candidates, the internship selection team researched systems that worked well in other settings. The very promising MMI approach was presented by Cathy

Humphreys, MSc, CLST.Dipl, CCLS, Allison Sohanlal, MS,MSc, CCLS, and Sarah Patterson, MSc, CCLS, all professors in the Child life Studies Program at McMaster University, at a child life conference in Cincinnati in 2015. Humphreys, Sohanlal, and Patterson generously shared the results of their research about MMI, a technique used for selection of medical students in the USA and Canada. In this plan, often compared to speed dating, multiple candidates come together, on the same day, becoming a cohort of interviewees.

The MMI plan was adopted both because research demonstrated that it reduces interviewer bias (Humphreys et al., 2015), and because it allows a selection team to host a group of candidates simultaneously (see sidebar). A single staff member can lead a hospital tour for the group. Introductions and icebreaking activities are shared by the selection team and visitors in a way that promotes more camaraderie than competition. After interviews, candidates gather for a simple lunch and question and answer time with staff members who interned at this hospital.

Candidates at any on-site interview will likely experience a variety of situations during the interview day. Candidates

may be provided with hospital tours, meet multiple members of the child life team, and they will probably be given an opportunity to ask questions of their own. Strong candidates bring questions that show they've taken time to learn about the child life program in the hospital where they are interviewing and that reflect their knowledge of current issues of universal concern to child life professionals.

Factors Influencing the Selection Process

Internship providers hope to display strong professional practice, an effective, well-organized educational program for students, a climate of warmth and safety for newcomers, and an enticing array of medical and cultural experiences to attract ambitious interns. Wise candidates approach the selection window having already prioritized the aspects of an internship that are most important to them. Additional decision-making points may include cost of living, transportation matters, proximity of a support system, and evaluative statements from mentors and past interns.

Selection teams seek interns who display specific qualities, as discussed above. Most likely, the glimpse of a candidate will be brief, so superior communication practices are necessary at every point of contact. While aspects of a candidate's educational preparation such as GPA and breadth of coursework cannot be altered, other components of one's personal presentation may be enhanced. A strong candidate may communicate readiness for internship by tending to the following:

Follow directions.

- Proofread all application materials,

How the MMI Works

Interviews are conducted in a round robin format, with candidates rotating through a series of single interviewers, answering only one question at each station. To provide a more thorough view of applicants' abilities, additional stations for skills demonstration or written responses to academic articles may be included. Humphreys, Sohanlal, and Patterson (2015) shared research showing that the MMI approach is beneficial for candidates because it eliminates interview bias, as interviewers ask a single question of all participants. Each candidate has a new chance to shine at the next station. Each interviewer is able to assess strength of each candidate's response without positive or negative expectation based on previous statements by interviewees. Total scores are the sum of individual performance scores at each station, thereby giving a fair account of candidates' overall strengths.

edit carefully, and/or ask others for editing help.

- Include all required components of application, including application fee, if required.
- *Check twice before mailing.*
- Type answers to essay questions in readable size and font. Attach extra pages if needed.
- If there's a time limit for interview responses, stay within bounds.

Demonstrate professionalism.

- Protect confidentiality.
- Show ability to understand and appreciate different points of view.
- Refrain from denigrating clients, past supervisors, teammates, self.
- Keep answers succinct, including all pertinent information just once.

Demonstrate humility.

Ask questions, if appropriate.

- Refrain from pretending to know something if you are actually unaware.
- Avoid being a name-dropper.
- Only include reference letters from persons who are directly familiar with your work.

Practice kindness and courtesy.

- Be on time.
- Notice needs of others in the process, addressing if appropriate. "Oh, your pencil broke. Would you like to borrow my extra?"
- Be flexible. If, for example, you are truly able to interview on any day, refrain from demanding special arrangements for yourself.
- Be patient. Understand that those who review applications also have a primary responsibility to patients and families.

- Say thank you in person. Write a thank you note after the interview.

Be kind to yourself during the process.

- Get enough sleep, exercise, nourishment and play. For interviews, wear clothes that let you feel attractive and comfortable. Leave behind shoes that pinch.

Before interviewing, learn about the program and hospital.

- Be curious. Find reasons to be excited about the setting you are visiting.
- Refrain from making negative comments about the city or neighborhood you are visiting.

Show that you are in command of developmental theory and theories of child life.

- Be ready with practical examples to illustrate theories you cite.

After Offer Day: Closed Shutters

By the time internship offer day finally arrives, candidates and program providers have all made significant investments in personal futures of candidates and the programs that will be affected by these future professionals. Certainly, the shared hope is that all worthy candidates will find placement in suitable programs. Unfortunately, some programs miss fine candidates when they fall through the cracks of an awkward offer system or because it is impossible to move every promising applicant through all of the screening steps. When large numbers of applications are received, selection teams are obliged to release a percentage of applicants, and this is done with regret.

After offer day, program coordinators without full rosters are painfully aware that some candidates still wait beyond

their reach. Sometimes viable candidates are released from early rounds of the selection process because their application scores just miss cut off scores that would win invitations to final interviews. A tiny percentage of candidates who seem strongest in all areas tend to be recognized by selection teams nationwide. On offer day, when multiple programs reach out to tap the same select group of high scoring candidates, many programs find that their first, second and third intern choices have been recruited by other hospitals. Therefore, for many candidates without offers, it is appropriate to consider re-drafting and re-applying in the future. In some cases, participating in a child life practicum or course work relevant to child life may significantly strengthen one's presentation. If one approaches with patience and humility it can also be fruitful to seek improvement suggestions from an internship coordinator. Requests of this sort are best received when they show respect for the coordinator's need to rest following the strenuous selection season.

Shutters are closed over admissions windows as Offer Day passes, but these shutters are on well-oiled hinges, ready to open again. Child life specialists promote human growth and development at all points in the lifespan. Just as we recognize and encourage strength and stamina in the patients and families we serve, we honor these attributes when we see them in students and colleagues. ✨

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BOOK REVIEW

Amy Lee, MS, CCLS, CIMI, ITFS

GREENVILLE CHILDREN'S DEVELOPMENTAL SERVICES AGENCY, GREENVILLE, NC

Growing Up Brave: Expert Strategies for Helping Your Child Overcome Fear, Stress, and Anxiety

By Donna Pincus, PhD

Every day, child life specialists around the globe strive to help children cope with fear and anxiety surrounding stressful events to promote and maintain optimal development. In early intervention, my coworkers and I utilize the evidence-based practice (EBP) of coaching to help parents understand that they play the lead role in their children's development ("Coaching in Early Childhood," 2017; Rush & Shelden, 2011; "Coaching - EI Excellence," 2017). Parents are uniquely qualified to encourage their children to continue utilizing coping skills, whether they were gained during an invasive procedure with the help of a child life specialist or with the help of a parent. Donna Pincus, PhD, uses her book, *Growing Up Brave: Expert Strategies for Helping Your Child Overcome Fear, Stress, and Anxiety*, to help parents understand that anxiety is a normal emotion. Pincus utilizes cognitive behavioral therapy (CBT) techniques to teach parents that the ways they interact with their children, from infancy through adolescence, can promote bravery and coping.

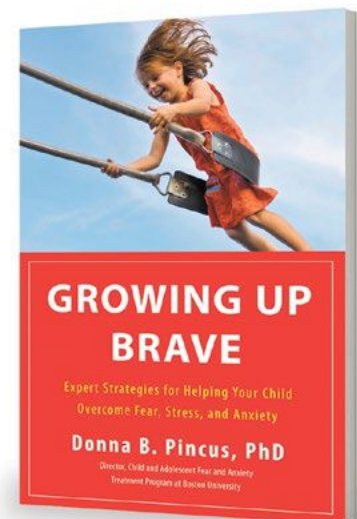
The first of the book's four sections sets out to help parents understand the normalcy of anxiety and how this emotion can affect other areas of development, such as socialization and academics. For child life specialists, the first sec-

tion is likely to be a review; however, for parents, Pincus lays out the typical fears experienced through each stage of development. One point to note is that Pincus further breaks down the school age stage of development into that of early school age (ages 6-10) and middle school age (ages 10-13). This information is quite familiar to a child life specialist, who has a background in child development; however, it provides more in-depth information for a parent who might find it difficult to understand childhood fears. In addition to normalizing anxiety, Pincus describes specific anxiety diagnoses and encourages parents not to worry about placing children under a label. However, Pincus contradicts herself as she goes on to label different parenting styles and how those may affect a child's ability to cope with anxiety.

The second and third sections are the most beneficial for parents, detailing specific strategies they can implement with their children. Early interventionists using EBP promote daily routines as the most effective strategy for helping children make and maintain progress ("Natural Environments/Routines - EI Excellence," 2017). The two daily routine strategies that Pincus encourages are the strategies of "five minutes a day" and "managing bedtime." Child life specialists will see many similarities between the "five minutes a day" strategy and techniques

used to promote play for normalization, including reflecting what the child is saying, imitating what the child is doing, and describing what is happening without asking prompting questions. Pincus promotes "managing bedtime" because of the direct correlation between sleep and anxiety, highlighting research that shows the less sleep a child has or the more disturbed a child's sleep tends to be, the more anxiety a child has and the harder it is for them to regulate their emotions.

Pincus provides many examples throughout the book of strategies she has utilized with clients in her work as director at the Child and Adolescent Fear and Anxiety Treatment Program at the Center for Anxiety and Related Disorders at Boston University. She also includes potential scripts of what a parent might say to their child when implementing some of the strategies. What may concern parents is how Pincus uses technical terminology in describing her methods, yet is very limited in explaining how someone other than a psychology professional may implement these strategies. Parents will definitely be able to use some of the strategies, like "coping cards for brave thoughts," which very simply places sample thoughts that children can use when feeling anxious (I can sleep by myself without feeling scared) on cards for the child to access



as needed. Although such techniques may help children work through fears or anxieties, the book is vague in establishing the appropriate time to seek out professional help.

Child life specialists are familiar with the Association of Child Life Professionals's Code of Ethical Responsibility, which obligates child life specialists to engage only in those areas in which they are qualified and to make appropriate referrals with due regard (Code of Professional Practice, 2012). "Special Considerations," the fourth section of *Growing Up Brave*, includes information regarding finding professional help, using medications, and maintaining progress. This is where a reader would expect to find detailed information about the importance of seeking professional help when parents or child life specialists are outside their realm of expertise. Yet this section is a single chapter. The portion dedicated to seeking professional help is a list of

websites for specific anxiety treatment centers rather than a clear description of when to seek professional help or a discussion of the importance of not working outside one's expertise. Pincus also retracts from the emphasis on seeking professional help as she ventures off topic towards things to consider, such as questions to ask when seeking help. While questions a parent might ask when seeking a therapist is helpful information, Pincus gives "What to Ask the Therapist" its own section in that chapter, making it redundant. For parents who may already find it difficult to seek professional help for psychological issues, this book may make them less inclined due to the confusing information in that section.

Child life specialists may utilize the information in *Growing Up Brave* as a refresher in that it highlights what we already know about the well-researched need for play. The book could also

serve child life students as they prepare for work in the field. For those in alternative settings (i.e. early intervention), it promotes, albeit briefly, the EBP of daily routines and natural learning environment practices ("Natural Environments/Routines - EI Excellence," 2017). For parents, the intended audience, it provides strategies they can consistently use to prevent fears or anxieties from moving outside the normal range of emotions. With all the aforementioned strengths, the next edition of *Growing Up Brave* should seek to de-emphasize how Pincus as a clinician implemented the strategies, while further exploring parental implementation and expanding on the appropriate time and importance of seeking professional support. ✨

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

RESOURCES

Coaching - EI Excellence. (2017). EI Excellence. Retrieved from <http://www.eiexcellence.org/evidence-based-practices/coaching-interaction-style/>

Coaching in Early Childhood. (2017). *Coachinginearlychildhood.org*. Retrieved from <http://www.coachinginearlychildhood.org/ccoaching.php>

Code of Professional Practice. (2012) (1st ed., p. 2). Retrieved from <http://www.childlife.org/docs/default-source/certification/code-of-professional-practice-final.pdf?status=Temp&sfvrsn=0.3181392027678561>

Natural Environments/Routines - EI Excellence. (2017). EI Excellence. Retrieved from <http://www.eiexcellence.org/evidence-based-practices/natural-environments/>

Pincus, D. B. (2012). *Growing up brave: Expert strategies for helping your child overcome fear, stress, and anxiety*. New York, NY: Little, Brown.

Rush, D., & Shelden, M. (2011). *The early childhood coaching handbook* (1st ed.). Baltimore, Md.: Paul H. Brookes Pub. Co.



BEYOND THE CLASSROOM

Views of Emerging Professionals

Our Profession's Past as an Inspiration for Our Future

Alexis Plumb

EDGEWOOD COLLEGE, MADISON, WI

“Who we are in the present includes who we were in the past.”

— (Mister) Fred Rogers, *Life's Journeys According to Mister Rogers: Things to Remember Along the Way*

For those studying to become child life specialists, the educational curriculum is primarily constructed upon a foundation of developmental theories, intervention methods, and practice for future clinical experiences. As a child life student at Edgewood College, I was given the opportunity to take a course focusing on the history of the child life profession taught by an experienced child life specialist and member of the ACLP Archives Management Group. In this class, I learned about the formation of child life practice, the agents of change for child life, and the many struggles faced to advance the profession to where it is today. Learning from the lives and experiences of these pioneers of change made me recognize that all of the work done in the past has directly impacted our present and will impact our future. For example, as we studied the founding of the child life field, Emma Plank's *Working with Children in Hospitals* (1962), opened my eyes to the advocacy needed to provide children with appropriate staff to support them while in the hospital. Plank justified that children experiencing hospitalization need consistent, daily staff to support them and provide opportunities to engage their emotional and intellectual processes. When learning about Plank's work, I was struck with a feeling of gratitude. I felt overwhelmingly thankful for her advocacy for children,

and her energy to establish the need for what would become the child life profession. This gratitude remained with me as I continued to learn how others diligently shaped this field.

As a student recognizing the trials that these men and women faced, I was able to gain a deeper appreciation for the profession of child life. The dedication of those who came before inspired me to discover my own passions within the field and determine my path as a future child life specialist. During my time as a practicum and then intern student, I have been able to experience how the growth created by the pioneers impacted opportunities for current students and professionals. During my internship, I saw how permission to play transformed the medical experience for many children. One toddler patient I interacted with began treatment displaying reserved, fearful, and disengaged tendencies. Throughout many interactions, he began to search for play opportunities, was able to be redirected, and was positively coping through his medical experiences. Reflecting on how this experience may have gone differently for a similar patient in the past, I am grateful that the pioneers of child life pushed for a supportive, playful role to be present within the hospital, and for playfulness to be welcomed and supported during these challenging medical experiences.

I continue to see the power of this play, and hope that we will continue to work, as the pioneers did, to advocate for this playfulness in various medical and stressful environments. Today, child life specialists in alternative settings such as medical camps provide

child life services to children outside of the hospital. As a practicum student at one of these camps, I recognized the impact that medical teachings, therapeutic activities, and companionship between peers facing similar experiences had on campers. An overall sense of positivity, camaraderie, and pride in lessons learned was present, as a community was established that encouraged an understanding of medical experiences and self-advocacy. Just as pioneers years ago paved the way for child life within hospitals, currently we can see a reflection of this same growth in the development of child life in alternative settings. Additionally, becoming involved and more informed about the Child Life Council, the first independent organization to serve as a support for the child life profession, allows me to understand the impact of current growth as we transition from the Child Life Council to the Association of Child Life Professionals.

I encourage professionals and fellow students to ask themselves the questions that I have also pondered: “Am I aware of the steadfast efforts of those before me, that have paved a way for this profession?” “Do I recognize the impact of our history on the present and the future?” “How will I tirelessly advocate for this profession and ensure that growth is continuing to be made?”

As we work in the present and prepare for the future, may we continue to reflect and carry the journey and achievements of those pioneers of change with us. ✨

Plank, E. (1962). *Working with children in hospitals: A guide for the professional team*. Cleveland, OH: Press of Western Reserve University.



MOMENTS FROM THE PAST

The Brazelton Files: Developmental Rounds

Claire M. White, MS, CCLS

WHEELLOCK COLLEGE, BOSTON, MA

During the 1980's and 1990's, I had the privilege to work at Boston Children's Hospital (BCH) as a child life specialist on the infant and toddler medical unit. During my initial orientation to the unit, the nurse manager informed me that the playroom was used for monthly developmental rounds, taught by Dr. T. Berry Brazelton, for the house staff (medical students, interns, residents, and fellows) to learn about child development.

Dr. Brazelton was a catalyst for change at BCH since he began his work as patient care coordinator in 1967 (Brazelton, 2013). He was a powerful voice, supporting the need to focus on the strengths and needs of the *whole* child, and not just the medical diagnosis, with an emphasis on the developmental and psychosocial aspects of the child's healthcare. He was also an early advocate for patient- and family-centered care.

Dr. Brazelton invited me to attend developmental rounds. The patient selected was an infant with whom I had developed a trusting and supportive relationship. The baby had been recently diagnosed with a life-threatening chronic illness. Dr. Brazelton asked me to play with the infant while he commented on the infants' behaviors and engaged the parents in sharing what they felt were their child's strengths and what their concerns and questions were.

After this, Dr. Brazelton and I met to discuss how best to support this infant and family during the hospitalization. I shared that several healthcare



Dr. Brazelton plays with a young patient.

team members were involved in the care of this infant and that it would have been helpful for them to participate; Dr. Brazelton agreed, and the rounds became interdisciplinary. Dr. Brazelton also requested to the nurse manager and to the director of child life that I become the coordinator. This was a significant change and elevated the role of child life. In the role of coordinator, I collaborated with families, nurses, and doctors in selecting an infant or toddler to participate in developmental rounds, which became known throughout the hospital as Brazelton Rounds.

There were many benefits and significant outcomes after Brazelton Rounds. Families would share that they felt as if they were the only ones in the room with Dr. Brazelton, even though there may have been up to 50 people in the playroom. His listening skills and understanding that they knew their child best was highlighted. After

Brazelton Rounds, medical students, interns, and residents increased their focus on the developmental and psychosocial aspects of care and their desire to learn more about the role of child life. They would ask to spend time in the playroom to observe and participate in play! Communication among members of the healthcare team became stronger, and the care plans included a focus on development and became strength-based rather than problem-based. What was most significant was the power that was given to the family. Brazelton Rounds helped to support the family and empowered them to be viewed as a member of the healthcare team.

For further research, go to the [ACLP Archives Finding Aid](#) to identify and request items related to Dr. Brazelton. ✧

RESOURCES

Brazelton, T. B. (2013). *Learning to listen: A life caring for children*. Boston, MA: Da Capo Press.



Expressions: Journaling from the Heart

“Journaling provides a quiet time and space to write and draw freely and to process important thought and feelings”



Mary Pat Benning
Creator of Heartfelt Books

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ACLP Calendar

OCTOBER

- 6 Deadline to apply for the [ACLP Mentor Program](#)
- 27 Deadline to register for the November administration of the [Child Life Professional Certification Exam](#)
- 31 Deadline to apply to [recertify through PDUs](#)
- 31 Deadline to apply for [International Scholarships](#) for the 35th Annual Conference on Professional Issues

NOVEMBER

- 1-15 [Child Life Professional Certification Exam](#) administration testing window

DECEMBER

- TBD Announcements of [Distinguished Service Award](#) and [Mary Barkey Clinical Excellence Award](#) winners
- 31 Last day to reinstate lapsed CCLS credential

JANUARY

- TBD ACLP Annual Conference registration opens
- TBD Call for committee volunteers
- 1 Submission deadline for [ACLP Bulletin and Focus articles](#) for consideration for Spring 2018
- 1-31 Start planning your Child Life Month events and activities for March!
- 5 Deadline to submit [internship applications](#) for Summer 2018
- 15-30 [Child Life Professional Certification Exam](#) Administration testing window
- 31 Deadline to submit 2018 Annual [Certification Maintenance Fee](#)



Upcoming Events

OCTOBER 10-15, 2017

Association for Play Therapy – 34th Annual Conference
Minneapolis, MN

Visit the [APT website](#) or email info@a4pt.org for more information.

OCTOBER 21, 2017

Great Lakes Association of Child Life Professionals –
12th Annual Conference
Detroit, MI

Visit the [GLACLP website](#) for more information.

OCTOBER 23, 2017

New England Child Life Professionals – Annual Conference
Ashford, CT

Visit the [NECLP website](#) for more information.

NOVEMBER 4-5, 2017

Midwest Child Life – 22nd Annual Conference
Madison, WI

Visit the [UWHealth website](#) for more information.

NOVEMBER 13, 2017

Greater New York Child Life – 24th Annual Conference
New York, NY

Visit the [CLGNY website](#) for more information.



ACLP Webinars

There are a few opportunities left this year to join an ACLP webinar, learn alongside your colleagues, and earn PDUs in a variety of areas, including ethics and assessment. Webinars are a convenient way to complete your professional development by logging into your home or work computer. ACLP 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 ACLP website.

We're excited to announce that the selection of On-Demand webinars has been added to [ACLP's Online Education System](#). Please check back frequently, as new offerings will be added regularly.

OCTOBER 4

**Talking to Children About the Tough Stuff:
Suicide, Violence, Parent Incarceration, and More!**

OCTOBER 18

**NICU ABCs: Child Life Assessment and Intervention
in the Neonatal Intensive Care Unit**

OCTOBER 25

**Everyday Ethics:
Identifying the Impact of Ethical Decision-Making
on the Delivery of Compassionate Clinical Care**

NOVEMBER 8

**The Patient Experience and You;
It's What You Already Do**

NOVEMBER 15

**When Grief Alters Hope:
Anticipatory Grief Support for Children
of Adult Patients**

Presenting an ACLP Webinar

The Association of Child Life Professionals supports its members by providing opportunities for sharing their knowledge and expertise with the child life community. One popular avenue for teaching and learning is through ACLP webinars, which are regularly scheduled throughout the year. If you have a presentation in mind that you think would make a good webinar, you are encouraged to submit a proposal for consideration. Presenters earn PDUs for presenting an ACLP webinar.

Please keep in mind:

- The content of the webinar must relate to one of the [child life domains](#).
- If you offer a product or service related to the topic of your webinar, an ACLP webinar is not a platform for selling.

Submitted proposals should include:

- Title of presentation
- Presenter names, credentials, job titles, and workplaces
- One child life domain and associated tasks addressed by this session
- Learning outcomes
- Summary of presentation
- Projected level of presentation: Foundational, Intermediate, or Advanced
- Presenter bios

Proposals are considered on a rolling basis. Please direct proposals and/or questions to webinars@childlife.org.




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