In Focus:
POP IT: Standardizing Pain Management in the Emergency Department to Improve the Healthcare Experience

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CHILD LIFE FOCUS:
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Field of Dreamers

When I was five, my father built a small playhouse for me in our backyard. As my thinking became concrete operational, the playhouse transformed into a school and my stuffed animals (my students) would line up in perfect rows awaiting the day’s lesson. I was a creative teacher. We made art projects, went on field trips, and even hosted a guest lecturer or two (I had human friends). But I was also a stern grader and would reserve my A’s for a few select animals. My favorite stuffed animal, Big Blue Bunny, was a rogue student but still maintained a perfect grade point average. While following the rules was difficult for him, the content of his work was so innovative, it had to be rewarded. Turns out, my current work looks quite similar to my childhood escapades. Teaching child life courses is creatively rewarding. Child life professionals are natural innovators. When grading reflections, research proposals, even literature reviews, I find myself sifting through stacks packed with inventive thinking. Big Blue Bunny beams with pride, certain that his learning style paved the way for my love of teaching child life. I try not to stroke his ego, but he undoubtedly helped.

I feel similarly about the papers we review for our quarterly issues. Preparing this fall’s issue of ACLP Bulletin was creatively rewarding and the outcome reflects the imaginative inclination of both our patients and our professionals. “Fantastical Play and Imaginary Companions: A Potential Tool for Child Life Intervention” by Melissa M. Brown, PhD, and Elizabeth McCarroll, PhD, CCLS, provides an in-depth look at the value of adding fantastical play to our toolbelt. While Big Blue Bunny would argue that he is very much not imaginary, he has provided me with the “confidence and courage” described in their article. This issue’s Focus article by Meredith Church, MS, CCLS, and Dana Burnett, MS, CCLS, exemplifies the power of imaginative program design. Their manuscript chronicles the evaluation of an education program aimed at standardizing pain management care for children in the emergency department at Golisano Children’s Hospital of Southwest Florida. As a result of their creative thinking, patients are receiving more consistent care; their research details the program that led to families reporting improved experiences in the emergency department. We are proud to share their work as the final Focus article of the insert’s twenty-year history. Lastly, our Alphabet 2.0 article, “S is for Sibling Programming: The Next Level” by Kathryn “Kat” Davitt, OTR, CCLS, presents a range of original and comprehensive ideas for sibling support. Her paper brings to life the famous Field of Dreams (1989) quote: “If you build it, they will come.”

Our managing editor Anne Mohl, PhD, CCLS, recently referenced this above quote when discussing our anticipation for The Journal of Child Life: Psychosocial Theory and Practice. As a new space for hosting our creative thinking, we hope that the journal will pave the way for more contributions to our field of inquiry. In 1999, the first Focus article set the stage for two decades of innovation. Focus, and the hundreds of volunteers who have supported it, helped create the evidence base that we use today. We are not saying goodbye to this level of professional contribution; instead, we are saying see-you-in-March-with-a-fresh-new-name. The Journal of Child Life will be accessible to a larger audience, and eventually scientifically indexed like other pillars in pediatrics. With its launch, more readers across disciplines will be able to consume our creative thinking. Ready to help us build? The Journal Review Board is eager to share your creativity.
On Being a Catalyst for Change

I am so excited to be writing my first column for ACLP Bulletin as your association president, and feel honored to be able to serve in this capacity. As we’ve moved into fall with the change of seasons, I’m reminded that change is quintessential in healthcare, to the point of almost taking it for granted as a constant. We are consistently impacted by changes in our work environment, which provide opportunities to balance challenges, demonstrate flexibility, and promote personal and professional growth. I firmly believe that child life professionals are catalysts for change within our organizations and practices. Our expertise and competence, combined with our integrity, passion, and focus on children, youth, and families, compel us to be strategic agents of change on a daily basis. We have the ability to drive change that will improve the quality of care and the patient/family experience, as well as increase the understanding and value of child life services.

A true example of this ability is being demonstrated in the upcoming Emotional Safety Summit to be held in November. As the Patient and Family Experience Committee has continued to plan the Summit, there has been a shift in recognizing where there is the greatest opportunity for influencing change and a realization that it is primarily within the work of ACLP membership. As child life specialists, we understand firsthand where there are gaps in emotionally supportive care and have the expertise, knowledge, and experience to identify best practices and standards of care. Utilizing techniques designed by clinically-based groups, the focus will be to design best practice recommendations—a grouping of interventions—that when implemented, will create capacity for a more emotionally safe environment for patients and families. We have the ability to lead that change in practice within healthcare. The Summit will include external professionals who have expertise in trauma-informed care, quality initiatives, family-centered care, and more and we look forward to incorporating these perspectives as well.

Within ACLP, there is a significant momentum for change relating directly to our current strategic plan and the focus on successfully completing the key performance indicators, the measurable outcomes that have been identified to be accomplished in the first 12 months of the three-year plan. There is always some slight shifting in an association when a new strategic plan is developed, especially in the first year when there is the potential for refocusing with new priorities. As an association, we are extremely fortunate to have Jen Lipsey, MA, and Bailey Kasten, CAE, leading the way, as they are both focused, transparent, and committed to the successful implementation of our strategic plan. I am excited to see the year-end report, which will outline the successful achievements accomplished with the hard work and dedication of so many.

Since the strategic plan is organized into pillars of focus, that structure provides a way to look at some of our current initiatives. PILLAR 1 of the strategic plan is focused solely on membership, and many of the exciting changes which have occurred over the last 5 to 6 months have been in response to increasing the value of ACLP to you, the members. A new structure was recently released with added membership categories to better meet the needs of members. Has this positively impacted your membership renewal this year? Digital badges for Certified Child Life Specialists are a visual representation of the accomplishments and achievements within your professional identity. Have you claimed your badge yet? The upcoming separation of ACLP Bulletin and Focus and the creation of The Journal of Child Life: Psychosocial Theory and Practice, a professional journal focusing on research, program development, and theory analysis, will add value to the publications you count on for updates in the field. The editors are reporting that they already have over 10 submissions they will be reviewing for this new journal, which demonstrates the phenomenal momentum to increase

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recognition of members’ work, most especially in academics and research! The Governance Committee is working diligently on revising our Official Documents, so stay tuned for a new look and feel!

PILLAR 2 provides our focus on certification, whose most recent work was the summer’s feasibility study which assessed the potential for an advanced credential above entry-level in the field. While the results of the study did not support moving in the direction of an advanced credential or certification, there is still the potential for the development of advance certificates in some areas of clinical practice and leadership development. I hope you have had the opportunity to review the outstanding infographic created by Meagan Roloff detailing information from the study. The Child Life Certification Commission is also working to update the Child Life Professional Code of Ethics.

In PILLAR 3, the focus on education and opportunities for life-long learning have propelled us to introduce an enhanced learning management system that is extending more education opportunities than ever before. Are you registered for an upcoming webinar? The Conference Planning Committee met in August in Washington, DC, to review over 100 abstract submissions in preparation for next year’s conference in San Antonio. The Practicum Task Force is hard at work with feedback from surveyed programs, and is currently working on practicum standards as well as potential curriculum modules.

In PILLAR 4, which focuses on partnerships and non-dues revenue, the Partnership Development Committee finalized the ACLP Relationship Guidelines, which the board of directors approved at their August meeting. These guidelines are to be used when we consider potential relationships with outside entities, including corporations and privately-owned businesses, academic institutions, nonprofit organizations, associations, and government agencies. These guidelines are posted on the ACLP website, along with a listing of entities with which we have established a relationship.

As you can see, it’s been a busy summer, and the work has continued into the fall! As these new initiatives bring change and opportunity to ACLP and to you, as members, I remind us all to stay mission and vision focused. I encourage you to become familiar with these statements, and know how they continue to drive our strategic plan and impact change.

Together we can accomplish so much, as together we are child life!

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Milestones

After almost 19 years at Yale New Haven Children’s Hospital and 38 years in the child life profession, Ellen Good, MSEd, CCLS, retired in May. She previously served as director of child life at Children’s Hospital of Pittsburgh and Winnipeg Children’s Hospital, and established child life programs at Oklahoma Children’s Hospital and Fletcher Allen Medical Center in Vermont. In addition to her positions directing child life services, Ellen made many contributions to ACLP most notably serving as chair of the Child Life Certifying Committee and as president of the Child Life Council. Ellen has lectured nationally and internationally and has served on numerous civic, local, and national committees. Ellen considers herself fortunate to have worked with so many wonderful people and to have learned so many amazing lessons from the children and families who have been a part of her life.

In retirement, Ellen will continue in her role as board president of the Ronald McDonald House Charities of Connecticut and Western Massachusetts, and will remain an active volunteer in her community. She also plans to spend time with friends and family and looks forward to doing some traveling.
Applause for our Academics

Today marked the first day of fourth grade for Jane and first day of kindergarten for Emily. I’ve spent the entire morning churning over whether I packed enough food, comforted their nerves, and gave enough hugs to get them through the day. My arms itch with the need to be reunited with them both; to hear how wonderful their day was and how awesome the school year will be! I have no idea if such hopes are pure fantasy, but I know one of the largest impressions from school will be left by their teachers.

I, like most parents, put faith and confidence in the teachers who will welcome my children into their classrooms and establish a strong, positive academic experience that will (ideally) hold their attention and engage them in the various forms of learning necessary to develop academically and socially. I’ve come to accept that their teachers will spend more time with my children than my husband or myself in any given workweek. I’ve come to marvel at the expansion of teaching responsibilities that goes beyond preparing students for standardized tests, developing curriculum, and holding parent/teacher conferences to include intervening in social dynamics, preventing bullying, and supporting the choreography of shifting family dynamics that affect their students’ development.

I’ve had the honor of engaging with a number of the academic leaders in our child life community. Listen to any of these academic leaders speak and you’ll hear tones of genuine concern, admiration, and frustration each has for his/her students and their ability to succeed in the child life profession. Some have created and maintained full programs of child life curricula in recognition that a successful path includes lessons steeped in foundational theories, opportunities for critical thinking with peers and mentors, and a Certified Child Life Specialist advisor to process with them and redirect their passion if or when it becomes apparent that the student will not perform strongly as a child life professional.

Not everyone who wants to be a Certified Child Life Specialist can (or should), despite completing the required courses, volunteer hours, and practicums. Success comes as the result of a complex combination of academic performance, critical thinking, and experiential learning obtained through exposure to sick and well child engagements. It’s more than completing a “to do” list of requirements; it’s not about what you’ve done, but who you are, and who you’ve become. But in an academic environment where success is defined by a passing grade and completing a “to do” list of required curricula, our academic child life leaders look their students in the eyes and must articulate the tough reality: “You’ve done everything you’re supposed to; it still doesn’t guarantee you’re closer to becoming certified or gaining employment.”

To all of the academic child life leaders, yours is a specialized responsibility and focus within the child life community. You expose the next generation of child life professionals to the substance of the field and navigate turbulent waters with parents, students, and administration officials who turn to you for answers, for guarantees. Unfortunately, there are no guarantees, and most often it is you who must articulate that, or witness your student’s disappointment when it’s understood. Yours is not an envious position and is ripe with chronic stress, and yet you persevere to ensure that the community receives its next generation of emerging professionals. The association and the child life community would not exist without your dedication; your strong assessments of strengths and deficiencies to warrant continuation in or redirection from the field; your research contributions; your critical reflections on the state of the profession; and your effective modeling of advocacy, compassion, and grit—all of which highlight you as a valuable Certified Child Life Specialist, mentor, and VIP to the community.
When I grow up, I want to live next door to you,” said a young child to his mother. She thanked him for being so sweet without realizing that she had interrupted him. He continued, “because you’ll need my help caring for [my brother].” The mother cried as she shared this story, saying, “My first thought was that I have the sweetest child. My second thought is I’ve broken [my young child].” This exchange illustrates the immense responsibility that siblings of children with chronic conditions or life-changing injuries often feel.

Siblings of chronically ill or injured children face what Meyers and Vadasy (2015) term “unique concerns,” including overidentification with an ill sibling, embarrassment, guilt, shame, isolation, loneliness, resentment, increased responsibilities, and pressure to succeed. Conversely, siblings are also presented with “unusual opportunities,” including increased maturity and responsibilities, increased self-concept and social competence, empathy, tolerance, and opportunities to explore potential career opportunities (Meyer & Vadasy, 2015). They also may have a strong appreciation of their ill siblings’ abilities and their families’ and their own health and wellness (Meyer & Vadasy, 2015). Thus it is logical that programming for siblings is most effective when minimizing the impact of these unique concerns while maximizing the benefit of the unique opportunities.

The need for sibling programming is evidence-based. Incledon and colleagues (2013) summarized much of the research on siblings of chronically ill children and validated many of the elements of programmatic support for this population, including group-based support programs, diagnosis and procedural education, advocating for control and predictability, emotional support, and educating parents on the need for consistent and open communication as well as balanced family time.

Many hospitals offer some support for siblings through groups or a sibling playroom; individual support may be provided through play, creative arts, or preparation/medical education. Yet there remain areas for growth in the services that child life professionals can provide for siblings and the goals for which we can advocate. I have worked in child life for 30 years and continue to become distressed when I hear a physician or a nurse say, “Why are these siblings here? They are just in my way,” or a child life specialist who complains, “I am not a babysitter! I got stuck with siblings again.” These attitudes illustrate our own perceptions of our role, as well as how we believe others perceive our role. As child life specialists, we need to embrace the role of sibling support as a core part of our job. When defining our role as providing psychosocial and developmental support to children impacted by chronic conditions, it should be clear that this includes the siblings. While other disciplines are still learning to include parents and caregivers as part of family-centered care, child life may be the only profession focusing on the needs of the siblings. I was once told by a mother after her child’s six-month admission to a rehab unit, “You were the only one who knew my other children’s names.” Let’s take that responsibility seriously, and step out of our tightly defined “sibling support” box, or even worse, our “sibling avoider” box, in order to offer creative and meaningful programming.

Sibling Programming at Cook Children’s Medical Center

For many years, the child life department at Cook Children’s Medical Center tried various after school programs to address the needs of siblings of inpatients. Typically one to two children would participate, and then eventually, after their siblings were discharged, the group would fall apart. Twelve years ago in a staff retreat, the department set an intention to increase both the quantity and the meaningfulness of our sibling program. Our new re-energized sibling program, Cook Children’s Sib2Sib Program, started with a single
annual day camp for 6- to 12-year-old siblings. Over the years, it has grown to include highly successful Sibshops programs with trained facilitators, an active Facebook community, a teen support program and camp, a college support program, a sibling mentor program, a day camp, activities designed to include the entire family, and a parent think tank. There is no charge for any of our activities. Originally, the committee overseeing the sibling program did fundraising to offset the costs, but the program was added to our operating budget several years ago.

The Sibling Committee is led by a clinical child life specialist and comprised of child life specialists from around the medical center. Staff from outside of the department are also welcome to participate; they participate as volunteers. Participation in sibling programming is part of each individual’s clinical responsibilities, and since activities occur on weekends and evenings, adjustments are made to the weekly schedule as needed to allow for supervision of the various activities. It is the responsibility of all child life specialists to invite families to participate in sibling programming. A registration form is completed for each family and this information is placed in a database so that invitations to sibling events can be made based on the siblings’ date of birth.

In our experience, there isn’t a correct age to begin and end offering sibling support. Our original Sibshops programming accepted siblings as young as age 6. However, families continued to request support for their younger children, especially if older siblings were involved in Sibshops. We have noticed that children as young as preschool age are already processing the potential of being a caregiver and what their role will be in their sibling’s life in the future, so we widened our services to include younger siblings. Currently, group programming begins with 5-year-olds, while individual support, including play, education, and emotional support, is available for siblings of all ages. On the other end of the developmental spectrum, older teens and young adults who had grown up involved in the sibling program were not only reluctant to leave, but many were also eager to give back.

We currently offer group programming to meet the needs of various ages:

- **School Age:** Sibshops are group workshops designed to meet the needs of siblings of children and teens with special needs. They are led by trained facilitators and include games, peer support, and processing activities. Our program currently offers two-hour group workshops for 5- to 7-year-olds and three-hour group workshops to 8- to 12-year-olds. These are offered every other month. Families are invited to attend one or all of the sessions, based on their needs.

- **Teen Programming:** Initially we offered a teen Sibshop, but attendance was sporadic. Teens indicated that they wanted less structure but more depth; fewer meetings but higher quality time. A “field trip” model was adopted, which allows teens to take more of a lead in identifying peers with whom they connect. Field trips include developmentally-appropriate locations away from the hospital; for example, a scavenger hunt in downtown Fort Worth, followed by hamburgers, is a holiday-season favorite. Other field trips include volunteer opportunities, sporting events, and “self-care retreats” (at the hospital) consisting of mindfulness activities. Camp Courage is an overnight camping trip for this age group, which takes place at Camp John Marc, a medical camp used by our facility, and includes both structured and unstructured peer support opportunities.
Young Adult Programming: The transition to college is very difficult for many siblings, as they fear that their parents will be overburdened with the care of their sibling or with the financial aspects of sending them to college while caring for the child with the special needs. There are also significant fears about childbearing in this age group. These topics are addressed in a more casual setting. Programming for this age group is 2-3 times a year and scheduled during typical college breaks.

Family Programming: Family activities are offered to engage families in our programming in the hopes of encouraging participation in our regularly-scheduled activities. Families who have participated in a sibling activity in the six months prior to the family event are invited to a special celebration designed to help build positive connections between healthy siblings and siblings with special needs, as well as to encourage parent-to-parent support related specifically to sibling needs. These events include special field trips to family-friendly locations like Legoland, or simpler events like a movie night or an evening where families can create a piece of art together. In addition, we offer a parent think tank, hosted on a Sibshop day, where parents are encouraged to participate in a facilitated discussion about sibling needs and sibling programming. Lunch is provided, as well as sitters for children. Currently we offer think tanks once a year. We also offer parents the opportunity to share information with each other through the Facebook page.

How we “Grow” Siblings

Much of the programming we’ve created has been designed to “grow” siblings, or to help them benefit from the unusual opportunities that come from their experiences. With this goal in mind, we design our programming to include the following:

- Opportunities for teens to engage in real and deep conversations, especially at weekend camp. Developing these moments has been a very intentional process, as we realized that many of the teens were not talking about their fears because we weren’t opening the door to these discussions. “Discussion Group Saturday Night” has become one of the most popular events at camp with dialogues on various topics. One of our most successful nights was part of a “Fear Factor” themed weekend, where teens could choose their discussion groups from topics like: “I’m afraid I’ll have to care for my sibling,” “I’m afraid my sibling might die,” or “I’m afraid of what my friends might think about my sibling.” Another successful structure was dividing the teens into small groups of three or four to develop their own sets of questions for discussion by the entire group.

- Panel discussions for community groups and hospital staff where the teen and young adult siblings are the experts. These have been provided for hospital staff, parent groups, and at conferences for families living with special needs. These offer a chance for honest exploration of topics such as the strengths developed by being a sibling, the challenges, the ways that parents or staff can positively influence the sibling experience, and frank discussions about panel members’ role as a potential caregiver for their sibling.

- Sibling mentor program. Siblings aged 16 and older are invited to participate in volunteer training so that they are able to assist with programming for younger siblings, as well as with projects such as informational videos for other siblings or sibling-focused hospital tours.

- The Mentors video program. This program is produced by our broadcasting studio and generally highlights teen and young adult patients who have coped successfully with a chronic illness. Their stories are shared through video to encourage and inspire younger patients. Sibling Committee members have advocated for sibling participation and videos are being created to share their unique stories as well.

In addition to our commitment to increasing programming for siblings at our medical center, our team set an intention to be seen as experts in our community on sibling issues. This has been self-fulfilling. We are often invited to speak at events throughout the community and we have helped launch several Sibshops in our area by hosting facilitator training and mentoring others who are interested in starting sibling programs for special populations. Several school districts in our area are now offering Sibshop programs as part of their family support. MHMR, a community organization providing support to children and adults living with mental health challenges and cognitive differences, is in the process of developing a program. These have been amazing additions that meet other needs in the community, since our sibling program is very specific to children with medical needs. Staff from our program have collaborated both formally and informally with staff from these groups.

Where Do Bereaved Siblings Fit into the Picture?

Providing appropriate care for bereaved siblings in our program has been one of the biggest challenges we’ve faced...
as the program has evolved. We continue to explore ways to transition siblings to a different type of programming after the death of a sibling. Typically, support is provided through resource sharing, referrals to bereavement centers and camp programming, and referrals to clinical therapists and creative arts therapists as needed and appropriate. The unique challenge with the sibling programming is that many people participate in our sibling program for years and derive significant support from their peers in this group. After a death, this support disappears. This has primarily been an issue for the high school population. In discussion with the participants, we have elected to allow siblings to return to one or two additional activities as they transition to bereavement programming. We have explored several options for providing support after a death, such as a remembrance ceremony for siblings, a day camp-style support program, and a group similar to Sibshops, but none of these have fully met the needs of the bereaved siblings. The need identified by bereaved siblings is for support from an older participant who has experienced the death of a sibling before the death occurs and immediately following the death. Most programs for children or teens who have lost a sibling begin to offer support after the death, but participants in our program have shared that they need the support before. To address this need, we are creating a bereavement mentor program where young adults who have lost a sibling can receive special training to support younger siblings experiencing a potential death.

Sibling Involvement on an Institutional Level

The ACLP Vision Statement includes a promise to embrace the concepts of patient- and family-centered care (Association of Child Life Professionals, 2017). The American Academy of Pediatrics also includes support for family-centered care in their related position statement (American Academy of Pediatrics Committee on Hospital Care & Institute for Family-Centered Care, 2003). Despite these strong statements supporting the need to care for all children impacted by illness, injury, or treatment, the effects that these have on siblings are often overlooked. This is especially true on a system-wide level. Part of our programming has involved advocating for siblings’ increased involvement in family-centered care initiatives. Ways that hospitals can involve siblings in family-centered care include the following:

- include adult siblings on family advisory councils or committees,
- include sibling representation on youth advisory councils or committees,
- institute liberal sibling visitation policies,
- ensure inclusion of siblings in day-to-day programming,
- educate staff on how to involve siblings in clinic appointments and hospital stays to the degree desired by the sibling and the family, and
- educate siblings on how to participate in clinic appointments and hospital stays.

These steps are foundational in providing support for siblings and can be used as building blocks for future programming.

Dreams for the Future

Our program is both dynamic and fluid. We continue to dream big when it comes to meeting the needs of siblings. Currently we are trying to create a “Sibshop To Go” program that will allow us to travel with the program to areas too far away from the hospital for families to easily participate in programming. We are working on genetic classes for siblings with concerns about reproductive issues. We continue to work on creating materials by siblings for siblings and about siblings for caregivers. Though we’ve faced some challenges, growing this program has been a professional labor of love. The benefits of increased support are immense, including stronger relationships with patients and families as they realize that their whole family is being seen and supported.

REFERENCES


The child life profession is distinctive in the way it specializes in the psychosocial care of sick and dying children. The profession delivers exceptional psychosocial care to children and their families when they need it most. Because child life is uniquely valued and appreciated within pediatrics, progress and growth are necessary in order to maintain relevance in evolving healthcare environments. As per the Child Life Certification Commission (CLCC), part of this process involves a critical examination of theoretical paradigms to ensure currency and effective practices in the field (CLCC, 2019; Lookabaugh & Ballard, 2018; Woodhead, 2005).

The purpose of this article is to explore a way forward for the child life profession by drawing attention to some concerns regarding foundational theories in child life that derive from developmental psychology. In addition, I propose a more progressive theoretical stance that addresses present-day clinical needs and evolving views of childhood.

The Role of Theories in Practice
Essentially, theories are big ideas supported by strong explanations and evidence. Theories are especially powerful because they can influence everything we think and do, even when we may not know it. Despite substantial growth in the field of psychosocial care, there has been little to no attention paid to child life foundational theories. How can this be?

Developmental Stage Theories: Reasons to Think Differently
Theories are imperfect, but they should, for the most part, guide and support our work. If developmental theories do not always resonate with us, we should consider why. For too long, we have relied on a “developmentalist approach” that positions children according to age and stage (Burman, 2017). Piaget’s (1959) cognitive theory and Erikson’s (1963) psychosocial theory imply that all children evolve and grow at the same rate across cultures, and yet we know this not to
be true (Deyhle & LeCompte, 1994; Freedman & DeBoer, 1979; Hughes, Devine, & Wang, 2018; Jordan & Tseris, 2018). These theories are largely informed by middle-class Eurocentric and colonialist perspectives that promote a singular and standard view of childhood (Callaghan, Andenæs, & Macleod, 2015; Miller & Scholnick, 2015; Pacini-Ketchabaw & Taylor, 2015; Robinson & Jones Díaz, 2016; Woodhead, 2005).

Studies have found several inconsistencies with developmental stage theories. In particular, key concepts from developmental psychology have been refuted in cross-cultural research and other recent studies. For example, the process of language acquisition can differ greatly between children, as can the age at which children recognize their image in a mirror (Broesch, Callaghan, Henrich, Murphy, & Rochat, 2011; Kidd, Donnelly, & Christiansen, 2018). Research has also shown that sympathy arises in children as young as ten months, which is in opposition to Piaget’s claims that young children are predominantly egocentric (Kanakogi, Okumura, Inoue, Kitazaki, & Itakura, 2013; Oakley, 2004). Piaget’s research on conservation with preschoolers has been challenged in that children’s errors were found to be linked to how the questions were asked (Rose & Blank, 1974; Samuel & Bryant, 1984; Winer, Hemphill, & Craig, 1988). We should, therefore, be careful when applying developmental theories to all children and all situations.

For hospitalized children, developmental theories are particularly problematic. Developmental theories offer no guidance in terms of explaining or predicting behaviors in these children, and they do not tell us how to interpret the sequencing and timing of stages. These theories infer that “sick” children are aberrations from the norm because many of them do not fit neatly in a stage that aligns with an age (Black, 2013; James, 2004; James & Curtis, 2012). The “standardization” of the hospitalized child is often difficult to achieve because children’s abilities can vary tremendously across age groups (James, 2004; Koller, 2017). Furthermore, developmental theories applied to children in hospitals do not represent how these children perceive themselves and what they are experiencing (Alderson, Sutcliffe, & Curtis, 2006; James & Curtis, 2012). Finally, dominant theories of child development depict children as immature and passive objects, creating distance between adults and children that can inhibit active youth participation (Berman & MacNevin, 2017; Brady, Lowe, & Lauritzen, 2015; Burman, 2017; James & James, 2012; James & Prout, 1997; Koller, 2017). Despite all these concerns, the predominance of child development theories informed by developmental psychology has had a powerful and significant influence on policy, pedagogy, and practice (Robinson & Jones Díaz, 2016).

In the field of child life, we continue to revere developmental theories without any apparent critical appraisal. Questions regarding developmental theories are included on certification exams, and many child life textbooks focus almost exclusively on developmental frameworks as foundational to child life practice. While we may not need to entirely discard these theories from our teaching and practice, we must acknowledge their impenetrable stance and invite students to “problematize” the premise of stage theories (Blaisdell, 2019; James, 2004; James & James, 2012). Student engagement in the evaluation of theories promotes critical thinking and reflective practice over time—two essential skills for health-care professionals. At the same time, educators in child life have an ethical responsibility to identify the benefits, risks, and limitations of all theories that inform practice. For child life pedagogy, this means that we must teach students how to think rather than just what to think.

The over-reliance on developmental theories has led to the practice of developmental assessments and the use of screening tools. While assessment tools can offer helpful information about a child’s abilities, we must be explicit about their benefits, risks, and limitations. These assessments impose power dynamics between the adult and child, predominantly because the child is forced to “perform” a range of skills required by the screening tool. For example, the Denver Developmental Screening Test appraises a child’s pincer grasp—a fine motor skill that involves picking up a raisin with two fingers. While fine motor skills are important, child life should remain focused on psychosocial care that emphasizes strengths and risks associated with a child’s social and emotional well-being. Let’s leave pincer grasp assessments to the occupational therapists!

A New Theoretical Vision for Child Life

Professionals have the responsibility to challenge dominant discourses and to be open to alternative ways of knowing. This notion is consistent with the Code of Ethics (Association of Child Life Professionals, 2019), revised by the Association of Child Life Professionals’ Child Life Certification Commission to guide and enforce the

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ethical standards for Certified Child Life Specialists. These regulations are communicated through 13 fundamental principles that are directly related to professional development and the implementation of best practices within the field. Specifically, Principles 5 and 6 state that Certified Child Life Specialists have a duty to maintain competencies in order to provide high-quality programs; this can be accomplished by “continually seek[ing] knowledge and skills that will update and enhance their understanding of all relevant issues affecting the children and families they serve” (Association of Child Life Professionals, 2019, p. 1).

**Sociology of Childhood**

Developmental theories are woven into the fabric of our society; these paradigms have shaped the ways in which children are understood (James & Prout, 1997). Because developmental frameworks are not always helpful in our work with children and families, professionals have looked elsewhere for theoretical relevance (Penn, 2014). For the past several years, the sociology of childhood and research involving child participants have shifted the focus from developmental stages to a strengths-based model that views children as autonomous rights-holders (Alderson, 2007; Brady et al., 2015; James & James, 2012; Woodhead, 2005).

This alternative narrative emerged in the 1990s in response to dominant child development discourses (James & Prout, 1997). It posits that childhood is a social construction that is influenced by historical, political, and cultural contexts (Coyne, Hallström, & Söderbäck, 2016). Therefore, children are expected to develop differently based on a multitude of factors. Sociology of childhood “allows us to see the individual child as a social actor in the collectivity of children and allows us to recognise both the uniqueness of his/her childhood as well as its commonality as a life course phase” (James & James, 2004, p. 27).

**Social Determinants of Health**

Because the sociology of childhood accounts for differences in how children develop, the social determinants of health are viewed as a way of understanding disparities in health outcomes (Johnson, Dickinson, Mandic, & Willis, 2011). Social determinants can include risk factors such as poverty, disability, racial minority, homelessness, and immigrant status (American Academy of Pediatrics [AAP], 2010; Carter, 2018; Ferraro, Schafer, & Wilkinson, 2016; Johnson et al., 2011; Newland, 2015). The greater the number of risk factors, the more devastating the effects on health (Ferraro et al., 2016). In practice, acknowledging that poverty has an insidious effect on children’s health demands a clinical approach that advocates equitable care for marginalized children and families. This approach differs drastically from a focus on whether a child’s behavior is “developmentally appropriate” or whether a child has a “developmental delay”—two terms that I propose should be eliminated from the child life vocabulary. Acknowledging diversity and the social determinants of health are key to ethical pediatric care (AAP, 2010; AAP, 2018; CLCC, 2019; Wheelwright, 2018), and current foundational theories in child life do not explicitly address these issues in practice.

**Children’s Rights**

Children as rights-bearers is another central premise of the sociology of childhood (Brady et al., 2015; Mayall, 2000). In child life, we have always believed that young people are experts in their own lives and are capable of communicating their perspectives with others. Indeed, child life specialists are often involved in promoting the inclusion of children in decision-making processes (Koller, 2017). These principles are consistent with Article 12 within the United Nations Convention on the Rights of the Child (UNCRC; United Nations General Assembly, 1989) and with Article 24, which advocates for the availability of quality healthcare. These tenets are represented in the “Position Statement on Child Life Services in Health Care Settings” (Child Life Council, 2011). The right to play and leisure—described in Article 31 of the UNCRC—constitutes the essence of child life practice. In summary, childhood is constructed as a unique period of life comprised of valuable “beings” with rights, rather than “becomings” who require control and protection (James & James, 2004; Mayall, 2000).
Inviting Discourse on a Way Forward

The sociology of childhood acknowledges that young people are constantly constrained by societal structures, and yet, if given the opportunity, can navigate these systems to enact change (Coyne & Gallagher, 2011; King & Cross, 1989; Koller & Farley, 2019; Koller & McLaren, 2012). In addition, the sociology of childhood offers contemporary views of what it means to be a child in today’s world and affords greater applicability in complex care environments than standardized theories of development. The sociology of childhood, therefore, offers a strengths-based model and should be considered a central feature of foundational theories in child life.

As a community of child life professionals, we need to engage in meaningful discourse around how we understand childhood and what it means to our work. Do our current theories capture the essence of what we do today? How do we combat against social determinants such as racial discrimination that often impede ethical care in pediatrics? Are children autonomous rights-holders or vulnerable patients in need of developmental assessments?

Critical discourse on theoretical foundations can create new purpose and stimulate growth in the child life profession. We should make deliberate attempts to scrutinize our assumptions about how children develop and decide which aspects of developmental theories are worth keeping. We should also be prepared to embrace a strengths-based model that more adequately depicts the resilience and agency we see in children every day.

We should make deliberate attempts to scrutinize our assumptions about how children develop and decide which aspects of developmental theories are worth keeping. We should also be prepared to embrace a strengths-based model that more adequately depicts the resilience and agency we see in children every day. ✩

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New Ways of Thinking and Doing: A Theoretical Vision for Child Life


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ACLP Honors the 2019 Research Recognition Award Recipients

Brittany Wittenberg, Ph.D., CCLS, CFLE
LOUISIANA STATE UNIVERSITY, BATON ROUGE, LA

Professional Research Recognition Award
The 2019 Professional Research Recognition Award recipient is the Salt Lake City, Utah-based research team of Marissa L. Deiner, Abigail Owens Lofgren, Russell A. Isabella, Sydney Magana, Chansong Choi, and Chelsea Gourley, for their article, “Children’s Distress During Intravenous Placement: The role of Child Life Specialists,” published in Children’s Health Care. Both Abigail Owens Lofgren, MS, CCLS, and Chelsea Gourley, MS, CCLS, are child life specialists at Primary Children’s Medical Center and were present to accept this honorable recognition during the Awards Breakfast and Research Discussion at the 2019 ACLP Annual Conference in Chicago, Illinois.

With the guidance of her thesis chair, Dr. Marissa Deiner, Abigail developed this research study as part of the requirements for her Master of Science in Human Development and Social Policy degree at the University of Utah. This randomized-controlled study tested the effectiveness of child life specialist intervention at reducing distress in pediatric patients during intravenous (IV) catheter insertion. Deiner et al.’s (2018) abstract states:

The purpose of this study was to assess the effectiveness of child life specialists’ intervention to minimize distress for children undergoing IV placement procedures. We hypothesized that regardless of child age or gender, children who received child life services during IV placement would exhibit less distress than would children undergoing the procedure absent a child life specialist (i.e., those with standard care). Ninety-five children were observed during IV placement at a children’s hospital, and children’s level of distress was rated by observers during the placement. Presence of child life specialist occurred randomly. Results indicated that children who had child life intervention during IV placement \( n = 45 \) exhibited less distress than those children with standard care \( n = 50 \), controlling for child age and typical distress during procedures.

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They were also more likely to have a J-Tip used during IV placement. The most common strategy employed by child life specialists was distraction, which was used for every IV placement. The results support the use of certified child life specialists (CCLS) for reducing children’s distress during painful and invasive procedures such as IV placement. (p. 103)

Several factors contributed to this article being chosen for the 2019 Professional Research Recognition Award. First, this study included an intervention group (children who received child life specialist intervention during IV insertion) and a control group (children who received standard care, without child life specialist intervention during IV insertion). Having a control group helps to isolate the intervention being tested (child life specialist services for IV insertion) and make sure the effect on children’s distress is solely a result of the intervention and not other variables. Second, this study included an element of randomization for the child life specialist intervention: Two IV teams were used within the hospital, one of which included a child life specialist and one of which did not include a child life specialist. The IV teams went to the next patient in need of an IV regardless if they were the team with or without the child life specialist. This element of randomization helps to minimize the amount of bias that can occur when testing an intervention. Third, this study had a relatively large sample size (n = 95) for an intervention study that occurred within a live clinical site. When the sample size is large, the study results are more generalizable to the population (e.g., all pediatric patients having an IV insertion at a pediatric hospital). In addition, one of the most interesting elements of this research study was that the child life specialist’s behavior was observed and coded at 15-second intervals during IV insertion. Five child life specialist behaviors were found to be prominent during patient IV insertions, including explanation, distraction, providing choices, providing support, and position of comfort (Deiner et al., 2018, p. 109-110). The observation and coding of child life specialist behaviors has helped to unpack and academically conceptualize the role of the child life specialist during daily interactions with children and their families.

Student Research Recognition Award

The 2019 Student Research Recognition Award recipient was Justin Petkus, MS, CFLE, CCLS, for his project, “Parental Holding to Manage Children’s Anxiety with Venipuncture: Experiences from Qatar.” Justin has been a Certified Child Life Specialist since 2012 and is a doctoral candidate at the University of Luxembourg Institute for Health and Behavior within the Integrative Research Unit on Social and Individual Development. Justin is also the co-founder, vice-chair, and director of partnerships for Pediatric Potential Inc., a 501(c)(3) organization in the U.S. committed to strengthening the well-being of children and families around the world through research, teaching, and outreach to improve pediatric healthcare experiences (J. Petkus, personal communication, July 4, 2019). Justin was present to accept his award during the Awards Breakfast and Research Discussion at the 2019 ACLP Annual Conference in Chicago, Illinois.

From 2015 to 2018, Justin was part of the team that implemented the first child life service in Qatar, at Hamad Medical Corporation. While working in the pediatric emergency center, Justin observed that most children were restrained during venipuncture procedures, including blood draws and IV starts. The purpose of this randomized controlled trial was to compare the effectiveness of comfort positioning and restraint on child distress during venipuncture in the pediatric emergency center. The diverse sample (n = 110) includes children and families from 13 countries thus far; data collection is nearing completion and this number may increase before the study ends. Preliminary results indicated that children had lower distress scores when held in a comfort position by their parent or family member when compared with children who were not held in a comfort position and were restrained during their blood draw or IV start. Caregivers also preferred comfort positioning to restraint. This study is impactful because it demonstrates the effectiveness of comfort positioning as an intervention in a diverse Middle-Eastern setting, thus advancing the possibility of comfort positioning being a globally accepted intervention for enhancing venipuncture experiences for children, families, and staff. Justin is completing data collection for this study and plans to publish the final results.
Congratulations to our 2019 ACLP Professional and Student Research Award winners! If you have published a research study or know of a child life specialist or child life student who has published a research study, please nominate them for the 2020 ACLP Professional and Student Research Recognition Awards.

**REFERENCES**


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 awards were presented at ACLP’s Annual Conference in Chicago, in April. 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 (unpublished research is eligible for the student award). 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 are evaluated on how well the research demonstrates the value and effectiveness of child life, increases knowledge, improves techniques, or advances the field of child life. In addition, the research design, implementation, and analysis are carefully evaluated.

The 2019 Professional Research Recognition Award Student Research Award recipients are profiled in the accompanying article, and we congratulate them on their outstanding contribution to the body of child life knowledge. 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 2020 awards will be available in early fall.
Play is a vital and necessary component of typical child development (Singer, Golinkoff, & Hirsh-Pasek, 2006). A recent clinical report from the American Academy of Pediatrics strengthens the Academy’s previous position on play, and even encourages pediatricians to write a “prescription for play” at every well-child visit during the first 2 years of life (Yogman et al., 2018). In this report, Yogman and colleagues (2018) emphasize how developmentally-appropriate play fosters a multitude of healthy child development outcomes, mitigates toxic stress, and builds social-emotional resilience, and assert that “in the presence of childhood adversity, play becomes even more important” (p. 1). Researchers have recently studied how fantastical play might serve as a platform for children to develop and practice certain cognitive, emotional, and social skills (Thibodeau, Gilpin, Brown, & Meyer, 2016). Given these connections, fantastical play might serve as a useful addition to a child life specialist’s toolkit.

**Fantastical Play and Imaginary Companions in Childhood**

Research indicates that engaging in pretend or fantastical play has been related to a variety of cognitive, social, and emotional benefits (Copple & Bredekamp, 2009; Hirsh-Pasek, Golinkoff, Berk, & Singer, 2009; Thibodeau et al., 2016; Tomlinson, 2009). Recently, researchers have focused on the special benefits seen in children who prefer fantasy-oriented play over reality-oriented play (Pierucci, O’Brien, McInnis, Gilpin, & Barber, 2014; Thibodeau et al., 2016). Children who prefer more fantasy-oriented play frequently engage in both representational play (i.e., pretend
play that involves everyday experiences, like pretending to be a doctor) and fantastical play (i.e., pretend play that involves unrealistic or impossible experiences, like pretending to be a superhero or creating an imaginary companion) and prefer games, toys, and media that involve fantastical elements (e.g., Dr. Seuss or Harry Potter books; Pierucci et al., 2014; Sharon & Woolley, 2004; Singer & Singer, 1990; Taylor, 1999). Importantly, recent work has documented how children who participate in more fantastical pretend play demonstrate better emotion regulation skills than their peers (Gilpin, Brown, & Pierucci, 2015), and researchers argue that a child’s imagination serves as a safe environment that allows and encourages children to display and practice a variety of emotions, ultimately helping them develop control and mastery (Bretherton, 1989; Hoffman & Russ, 2012).

A specific type of fantastical play, the creation of an imaginary companion, is known to be a healthy and common form of pretend play in early childhood (Taylor, 1999). Although frequency estimates vary across the literature, approximately one-third to one-half of children—and possibly more—between the ages of 3 and 12 create imaginary companions, with the preschool years serving as the high season (Pearson et al., 2001; Singer & Singer, 1990; Taylor, 1999). Such companions can serve a myriad of functions, and these functions often depend upon the special needs of their child creators (Hoff, 2005; Nagera, 1969; Taylor, 1999; Taylor, Shawber, & Mannering, 2009). Although two of the most important functions of imaginary companions appear to be fun and companionship (Taylor, 1999), other research has indicated that they also function to assist in self-regulation, enhance self-esteem and life quality, and serve as a safe environment in which to practice various social scenarios (e.g., practicing how to make up with a real friend; Hoff, 2005). Research has documented various positive traits that are often associated with having an imaginary companion, such as increased emotional understanding (Lindeke & Kavanaugh, 2007), cooperativeness with peers and adults (Singer & Singer, 1990), and perspective-taking skills (Taylor & Carlson, 1997). Children who have an imaginary companion are rated as more outgoing (Roby & Kidd, 2008), and by their parents, as better communicators with adults (Manosevitz, Prentice, & Wilson, 1973). Although some might be worried about imaginary worlds and their inhabitants serving as a form of dissociation, the results of studies on imaginary companions and psychopathology have indicated that imaginary companions can serve an adaptive purpose and assist in coping with psychopathology and various life traumas (e.g., childhood abuse; Klausen & Passman, 2007).

Although no causal link has been established between imaginary companions and these positive traits, relevant experimental work has addressed the causality and directionality of the relationship between fantastical pretend play and higher-order skills called executive functions (e.g., working memory, inhibitory control, cognitive flexibility; Thibodeau et al., 2016). In this study, preschool-aged children were randomly assigned to one of three conditions: fantastical pretend play intervention, non-imaginative play intervention, or business-as-usual control. In the fantastical pretend play intervention, research assistants worked with small groups of children to come up with and act out various fantastical scripts (e.g., going to the moon and interacting with space creatures). Results indicated that those children in the fantastical pretend play intervention condition demonstrated an improvement in executive functions, whereas children in the other conditions did not. Additionally, data on intervention engagement revealed that those children in the fantastical pretend play intervention who were highly engaged in the play and who were highly fantastical exhibited the greatest gains in executive functions.

**There are several hypothesized reasons as to why fantasy-oriented play helps children. One, this type of play allows children to engage in focused and often complex tasks that are unlike those they encounter in their everyday experiences, particularly because they allow children to engage in counterfactual or “would-be” thinking...**

Other relevant experimental work has found causal links between dramatic pretend play games and social and emotional abilities (Goldstein & Lerner, 2018). In this study, 4-year-old children were randomly assigned to one of three conditions: a dramatic pretend play games intervention and two control conditions, block building and reading stories. In the dramatic pretend play games intervention, research assistants led children through common improvisational exercises designed for preschool-aged children that included a variety of pretend play activities (e.g., dressing up, making a birthday cake, becoming a statue and being posed by classmates). Results indicated that only those children participating in the dramatic pretend play games intervention had improved emotional control (e.g., how well they could calm their own distress in the face of others’ distress, how often they reported being overwhelmed by emotions). Thus, participating in the dramatic pretend play games intervention caused children to become better at controlling their emotions. Although these two studies (Goldstein & Lerner,
Fantastical Play and Imaginary Companions: A Potential Tool for Child Life Intervention

2018; Thibodeau et al., 2016) are two of the only recently published experimental studies on the effects of pretend play on developmental outcomes, this work is encouraging and supports long-held theory.

There are several hypothesized reasons as to why fantasy-oriented play helps children. One, this type of play allows children to engage in focused and often complex tasks that are unlike those they encounter in their everyday experiences, particularly because they allow children to engage in counterfactual or “would-be” thinking (Bretherton, 1989; Gopnik & Walker, 2013; Vygotsky, 1967). Two, it provides children a myriad of ways to practice identifying, managing, and expressing emotions, which ultimately helps them develop control and mastery (Bretherton, 1989). And three, a child’s imagination is a safe environment that permits, and often encourages, creative expression of a variety of emotions and provides many opportunities for learning more about themselves and others (Hoffman & Russ, 2012).

Incorporating Fantastical Play and Imaginary Companions into Child Life Intervention

A population that could potentially be greatly served by engagement with imaginary companions—and increased involvement in fantastical pretend play in general—is children with chronic illnesses who spend a great deal of time in the hospital. Research has demonstrated that chronic illness may affect the quality of children’s interactions with others, especially peers. For example, children who are frequently hospitalized might have limited social experiences due to reduced time with peers, physical limitations, or altered appearances and abilities (Drotar, 1981). Additionally, research has also indicated that children are aware of the frequency of their classmates’ absences from school and that children who miss a lot of school are often less preferred as playmates because they are seen as unreliable (Graetz & Shute, 1994).

Child life specialists could potentially use fantasy-oriented play—specifically imaginary companions—as a tool to help children cope with their illness and the often scary and confusing medical procedures associated with it, as well as to improve quality of life in the hospital. Imaginary companions can be used to start conversations, particularly those that might be uncomfortable, and help illuminate what a child is thinking or worrying over. A child might not want to talk about how they are feeling, but they might not mind explaining how their companion is feeling instead, allowing the specialist to pick up on certain thematic clues. This process is similar to what child life specialists already do when they engage in medical play with children using puppets, dolls, or stuffed animals as pretend patients (McCue, 1988). Through medical play, children often reveal the misconceptions and fears they have about medical procedures, allowing an opportunity for the specialist to clear up confusion and alleviate fears (Burns-Nader & Hernandez-Reif, 2016). Imaginary companions can also help make transitions and difficult routines easier. For example, the companion can help talk through unfamiliar situations and processes before they happen. Finally, imaginary companions can help inspire creativity and help child life specialists build rapport and establish bonds with the patients in their care.

As one example of this process, specialists could encourage patients to use an existing companion or a personified transitional object (e.g., teddy bear), or to create their own companion who could help them through their time spent at the hospital. Although the authors are currently investigating ways to systematize the creation process, it will be open-ended and likely unique to each child. After dedicating time to developing and elaborating the companion together—with the specialist providing appropriate scaffolding, while still allowing the child autonomy in directing the overall creation—the specialist could incorporate the companion into various role-playing scenarios that allow the child to work through aspects of their hospital stay that they find concerning. Other organizations have already caught on to this idea. The Pediatric Brain Tumor Foundation (www.curethekids.org) has created an “Imaginary Friend Society” website (www.imaginaryfriendsociety.com), which hosts an animated film series that uses imaginary companions to help give kids confidence and courage as they navigate their cancer diagnoses. Additionally, children are encouraged to...
donate drawings of their own imaginary companions, and the foundation not only publishes them in a gallery on the website, but also turns them into motivational posters, coloring books, and journals.

**Important Considerations and Next Steps**

There are several important considerations to keep in mind when implementing the creation and utilization of an imaginary companion with a child. First and foremost, the specialist should rely on sound professional judgment and discussion with the patient’s parents if there is ever any concern over the activity or its direction. Second, the main focus of the activity should be child-directed. If it is not child-directed, children are not exercising their cognitive skills to the same extent and their interest will likely wane. And finally, the specialist should provide scaffolding that encourages positive engagement, highly imaginative play, and emotional expression.

Currently, the authors are working to develop a consistent methodology for child life specialists to implement in a variety of healthcare settings to support children through the process of creating their own imaginary friend. The methodology, designed as a series of fun activities, creates opportunities for a child life specialist to build rapport with a child while facilitating the creative process. Engaging in fantastical play interventions, such as creating an imaginary companion, has the potential to improve coping by providing the child with the various cognitive, social, and emotional benefits afforded by fantastical play as well as to improve quality of life by providing a meaningful play opportunity that can serve as a fun distraction from a stressful environment.

**REFERENCES**


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Becoming a SUPERvisor: The Positive Aspects of Hosting an Intern

Kerri Baker, MS, CCLS
HASBRO CHILDREN’S HOSPITAL, PROVIDENCE, RI

Supervising interns can be a daunting task; whether the first or fifteenth time, there are consistent obstacles, realizations, and learning curves. As both a direct supervisor of interns and the co-coordinator of an internship program, I can empathize with all parties involved. During a semester, supervisors may reflect on personal experiences, using memories to shape their approach and teaching styles. Supervisors also need to adjust to the ever-changing needs of interns and mold an internship based on how interns identify themselves as learners. Often, “supervising” is viewed as an opportunity to teach, instruct, and impart wisdom and knowledge. There is also usually a burdensome feeling associated with hosting an intern. But how often is supervising viewed as a chance for personal growth and change? How often are students viewed as the teacher, bringing new ideas to the forefront, and how often are their ideas seen as innovative, rather than intrusive? When one becomes a supervisor, there is an opportunity to not only support growth and development of an intern’s abilities, but to further develop one’s own skill set. With reflection, supervisors can learn and implement patience, gain perspective, and reignite passion.

Patience: Just as co-workers and family members are unique, interns bring their own expectations and diversity to placements. During an internship, it may become quickly apparent that one intern requires more observation and time to ask questions, while another benefits from increased independence and autonomy. Both individuals may be considered successful at the end of the internship, but need different avenues to complete their course. Supervisors should patiently observe interns and ask questions that encourage positive communication. Supervisors can also assess their own behaviors: Am I reluctant to share personal stories of failure, or am I willing to be honest and forthcoming? Am I allowing the intern to observe my interactions because I am hoping for praise for my work, or am I doing this for the genuine goal of teaching? Experience cannot be taught, but lessons learned from those encounters can shape the context of a student’s internship. Many interns also come with relevant previous experiences, and can bring fresh ideas to the internship. Welcoming this knowledge validates their capabilities, and allows interns to draw their own judgements and conclusions.

Perspective: What unique perspectives can I bring as a supervisor? How was I treated as an intern? How has my work changed/developed since supervising interns? How am I viewed by interns? These questions highlight just a few areas where interns can assist supervisors in self-reflection. At Hasbro Children’s Hospital, the child life team asks interns to evaluate all aspects of our program. Feedback from these reports are shared directly with supervisors. Supervisors can use this information to adjust their practice and to feel validated in the amount of time and effort that was dedicated to the intern’s experience. Evaluations are used not only for growth, but to recognize the commitment needed to be an effective, supportive supervisor.

Am I reluctant to share personal stories of failure, or am I willing to be honest and forthcoming? Am I allowing the intern to observe my interactions because I am hoping for praise for my work, or am I doing this for the genuine goal of teaching?
As humans, it’s always possible that we are unaware of our behaviors, but intentionally examining them can highlight “blind spots” and allow for personal development. With this feedback tool, interns can share their perspective of our team, and we can reflect on how our choices either helped or hindered our interns’ growth.

**Passion:** The role of the child life specialists can be hectic, and taking on a supervisory role can increase stress. If identifying as a supervisor feels like having “one more thing to do,” it can compromise the success of the internship. However, if the mindset changes to view supervision as empowering and enlightening, both parties are likely to have a more positive experience. Ask yourself: Which aspects of my practice do I enjoy the most, and can I begin there in order to teach interns how to keep joy in their practice? Are there parts of my job that are challenging, and can I express this to interns in a way that allows them to see it’s acceptable to identify personal or professional limitations? Allowing interns to see the true scope of practice builds an open, authentic relationship. As an internship co-coordinator, I notice that honest discussions of all aspects of the field foster increased independence for students. Interns demonstrate a greater awareness of their contributions, no longer afraid to make mistakes or say the wrong thing. I start to recognize that they “get it,” and are learning who they will be as a professional. In turn, I realize that I’ve had some impact on their experience, and my passion as a professional revs back into high gear.

Susan Abrams Milligan eloquently showcases the relationship of supervisor and intern by saying “We are all students and teachers, and often at the same time. We each have our own greatness, gifts that can be shared to assist another, if we choose” (2012, para. 3). When we accept an intern to our unit, floor, or institution, supervisors ultimately have two choices: Remain closed in our ways and trudge through each semester unchanged, or decide to walk with our interns, each on our own path, but together enjoying the journey.

**REFERENCE**
Paying it Forward: A Tribute to Past Editors of Child Life Focus

Joan Turner, PhD, CCLS
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The transition of Child Life Focus from the inaugural issue in 1999 into The Journal of Child Life: Psychosocial Theory and Practice in 2020 represents a monumental step in the history of child life. The notion of paying it forward—whereby the beneficiary of good deeds in turn opts to share their good fortune with others—aptly describes the experience of a long line of contributors to ACLP Bulletin/Focus. Many volunteers chose to carry on the legacy of their mentors through service as executive editors, associate editors, or members of the Focus Review Board. This long tradition of volunteerism has reaped benefits for the growth of the child life profession and will continue to do so in the future.

“The greatest achievement of my time as editor has been the shift from Focus as an insert in ACLP Bulletin to a separate publication, The Journal of Child Life: Psychosocial Theory and Practice.”
— Kathryn Cantrell, PhD, CCLS

Twenty years in the making, this accomplishment shifts the dissemination of the extant knowledge of our profession from an ACLP membership benefit into a journal open to subscription beyond the membership. The vision of a theory, research and practice initiative has its roots in the original members of the Child Life Council, and has been furthered by the efforts of many, many dedicated and motivated contributors. These important players include members of the executive board, ACLP (and CLC) committee constituents, Bulletin Committee and Focus Review Board members (many whom have served multiple terms), authors and contributors to the publication, and of course, the loyal readers. However, it is the ensemble of executive editors and associate editors who are responsible for the heavy lifting required to deliver a quality publication. As one former editor notes, “Since my time working with Bulletin and Focus, I have become a much stronger advocate of writing, in general, and can frequently be heard asking a colleague “are you planning to write this up?” (K. Bennett, personal communication, July 4, 2019)

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“What is written is what lasts.”
— Katherine L. Bennett, MEd, CCLS

Diane L. Demarest was the Bulletin editor at the time the initial Focus issue was published in 1999 and served until 2002, when Jane Darch, CCLS, was named editor. The professional networking that took place was a highlight for Jane, during her term. As she notes, “It did create the opportunity to really be a part of ACLP/CLC” (personal communication, July 2, 2019). Karin Duggan, MS, CCLS, was editor when Focus was printed as a distinct feature of each Bulletin issue in the form of an insert, beginning with the Winter 2004 issue.

The role of associate editor was introduced during the next phase of the publication; I had the distinct pleasure of taking this role under the guidance of Kathleen Murphy, MS, CCLS, in 2006. Upon reflection, I now recognize the ease with which Kathleen took on the executive editor role without the benefit of gaining experience under the mentorship of the past editor. For me, the issue of Bulletin that celebrated the 25th anniversary of the Child Life Council and featured the Focus article “From Vision to Reality: The Expansion of the Child Life Role” (McCue & Hicks, 2007) was an ambitious accomplishment led by Kathleen. This extended Summer 2007 issue of 28 pages required the compilation of a series of articles and authors solicited specifically to capture historical aspects of child life. The fundamental team effort of the executive editor, associate editor, Focus Review Board, and managing editor (then CLC staff member, Genevieve Thomas) working together was essential for the establishment of an organizational core motivated to move child life publications well beyond the initial slim newsletter established in the early days of the Child Life Council.

For the next major innovation, executive editor Jessika Boles, PhD, CCLS, associate editor Katherine Bennett, MEd, CCLS, and managing editor Anne Mohl, PhD, CCLS, managed the conversion of the delivery mode from print to the dynamic digital platform, allowing for greater volume of content for both Bulletin and Focus beginning with the first digital issue in the spring of 2015. As Jessika recalls, “Our voices came together with member feedback to manage the transition from print to digital formatting, which opened the doors for a wealth of content (including multimedia) that had been inaccessible before” (J. Boles, personal communication, July 3, 2019).

“Seeing my first issue come together was much like how it feels when a patient successfully copes with a procedure—there’s so much pride in seeing each author be able to bring their thoughts, experiences, and passions to life on the page for others to see.”
— Jessika C. Boles, PhD, CCLS

<table>
<thead>
<tr>
<th>YEARS</th>
<th>EXECUTIVE EDITOR</th>
<th>ASSOCIATE EDITOR</th>
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<tbody>
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<td>Kathryn Cantrell, PhD, CCLS</td>
<td>Kathleen McCue, MA, LSW, CCLS</td>
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<td>Jaime Bruce, DrPH, CCLS</td>
<td>Jessika C. Boles, PhD, CCLS</td>
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<td>2010-2012</td>
<td>Anne Luebering Mohl, PhD, CCLS</td>
<td>Jaime Bruce, DrPH, CCLS</td>
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<td>2008-2010</td>
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<td>Anne Luebering Mohl, PhD, CCLS</td>
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<td>2006-2008</td>
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The past and current associate and executive editors share remarkably consistent thoughts, each commending the mentors from whom their own skills as editors and as colleagues were enlightened. The expressed pride of Bulletin/Focus editors is palpable when they communicate reflections on their experiences. So too is their admiration for contributing authors, acknowledged in their commentary on favorite Focus articles. Kathryn Cantrell, PhD, CCLS, noted “Celebrating Differences: Improving Psychological Well-Being in Children and Young People Living with Chronic Illness” (Shea, Robertson, Rylatt & Gibbs, 2019) as “a strong model for others wishing to evaluate their group interventions and the authors are international, a trend we’ll see more of as we gain more visibility” (personal communication, July 3, 2019). Katherine Bennett shared two favorites: “Re-Constructing the Play Lady,” by Divna Wheelwright, MA, CCLS (2018), because it “prompted lots of reflection on what it means to be a female and in a helping profession,” and “You Can’t Pour From An Empty Bucket,” by Katie Krog, MEd, CCLS (2016), due to it being “a deeper dive, specifically for child life specialists, about what the evidence says about working in an emotionally heavy profession” (personal communication, July 4, 2019).

“The transition of Focus into The Journal of Child Life can be attributed to the dedicated work of a long line of hard-working volunteers who have spent countless hours getting Focus to the point where the dream of a child life journal is now a reality.”
— Anne Luebering Mohl, PhD, CCLS

Over this twenty year period, roughly 80 Focus articles have been archived for access by the ACLP membership. The establishment of The Journal of Child Life: Psychosocial Theory and Practice as ACLP’s first empirical journal will over time allow the profession to share theory, research, and practice scholarship beyond the membership. This advancement will not only raise the bar for future scholarship, but will also provide greater opportunities for child life advocates to “pay it forward” through increased accessibility and equity of child life publications to a greater community. The current executive editor, Kathryn Cantrell, put it this way: “Our voices can be hard to find for those who don’t know where to look” (personal communication, July 3, 2019). Starting in 2020, The Journal of Child Life will make that easier.

REFERENCES

POP IT: Standardizing Pain Management in the Emergency Department to Improve the Healthcare Experience

Meredith Church, MS, CCLS
GOLISANO CHILDREN’S HOSPITAL OF SOUTHWEST FLORIDA, FORT MYERS, FL

Dana Burnett, MS, CCLS
SHREVEPORT, LA

Child life specialists sometimes struggle with advocating for patients and their best interests while in the hospital. The POP IT program (named for the first letters of the components of the program: Pain management, One Voice, Positioning for comfort, Involve family, Telephone child life) was initiated to address the lack of a standardized process to utilize local anesthetics and collaborate with child life services during painful procedures in the pediatric emergency department (ED) at Golisano Children’s Hospital of Southwest Florida. This lack of standardization led to inconsistencies that negatively impacted patient care, resulting in low scores on patient satisfaction surveys. Additionally, there was no auditing process in place to validate staff compliance with current process expectations. To address these inconsistencies, the POP IT program was created in the summer of 2016 to standardize the process of care for pediatric patients during painful medical procedures, as well as to improve patient and family experiences in the ED.

Components of POP IT

Pain management

By its nature, an ED visit can be a stressful and anxiety-provoking experience for pediatric patients and their families. Many of the sick or injured children who visit the ED undergo painful invasive procedures, including venipunctures/intravenous (IV) access, intramuscular injections, sutures, staples, fracture reductions, lumbar punctures, and catheterizations. Even minor painful procedures, such as needle sticks, can affect children’s long-term emotional well-being. Timely administration of pain management...
comfort positions during invasive procedures, including intramuscular injections, IV placements, nasogastric tube placements, sutures, or staples, and can be initiated as soon as a child has gained head and trunk control (3 to 5 months of age). The goals for comfort positioning include promoting a sense of control for the child, allowing the caregiver to participate in a positive way, providing comfort through close contact with the caregiver, limiting the number of people needed to complete a procedure, and successfully immobilizing an extremity for a procedure (Cavender et al., 2004).

**One Voice**

One Voice is a method used during procedures to reduce a child’s anxiety due to noise and overstimulation, and to increase coping for both the patient and the caregiver. When a child has multiple people giving directions or words of encouragement at the same time, the child may become more anxious or agitated due to selective listening (Wagers, 2013). To help children focus their attention and to facilitate better coping skills, the One Voice philosophy recommends that only one person communicate with the child during a procedure. The one person speaking can be a parent, child life specialist, doctor, nurse, technician, etc. The voice can be selected prior to the procedure and can change during the procedure as needed (Boles, 2013).

Utilizing the One Voice method during invasive procedures along with other interventions, such as alternative focus, can help manage a patient’s fear, anxiety, and pain, allowing the patient and family to have the best experience possible (Cohen, 2008).

**Positioning for comfort**

Positioning for comfort is a support measure used to incorporate reassurance, comfort, and control for patients during medical procedures. Children may feel a loss of control if they are put in a supine position during a procedure, resulting in fear for the child. The child may associate this fear with invasion of privacy and body space and not understand why a staff member is inflicting pain on them (Lacey, Finkelstein, & Thygeson, 2008).

Comfort positions allow the caregiver to hold the patient during a procedure, for example, in a chest-to-chest or back-to-chest position (Cavender, Goff, Hollon, & Guzzetta, 2004). Comfort positions can be used during a variety of procedures, including invasive procedures. IV placements, nasogastric tube placements, sutures, or staples, and can be initiated as soon as a child has gained head and trunk control (3 to 5 months of age). The goals for comfort positioning include promoting a sense of control for the child, allowing the caregiver to participate in a positive way, providing comfort through close contact with the caregiver, limiting the number of people needed to complete a procedure, and successfully immobilizing an extremity for a procedure (Cavender et al., 2004).

**Involving family**

The Agency for Health Care Policy and Research insists that parents or caregivers accompany their child throughout an entire procedure (Cavender et al., 2004). Although many healthcare professionals do not consistently include parental involvement during procedures, it is reported to be beneficial for both the child and parent(s) (Cavender et al., 2004). Caregivers know their child best, and when present for the care of their child, they can provide support to the child, help the child communicate with staff, assist with positioning the child, reduce the need for sedatives or restraints, and provide essential medical information (Dudley, Akerman, Brown, & Snow, 2015). Involving family can also improve medical decision making, patient care, and communication between healthcare professionals and family. Children with special healthcare needs will benefit from parental presence because parents are knowledgeable about their complicated medical history and potential strategies to assist with coping (Dudley et al., 2015).

**Telephone child life**

Child life specialists provide services to aid with the psychological, social, and coping needs of pediatric patients (Bandstra et al., 2007). These services, including the provision of play and normalizing activities, psychological preparation and alternate focus for procedures, and the encouragement of family support, help reduce children's anxiety and clear up misconceptions. Child life specialists also provide coping support and diagnosis education during the patient’s hospitalization. Studies have shown that child life interventions not only help decrease children’s fears but also increase parent satisfaction ratings of the hospital experience (Bandstra et al., 2007).

**Program Implementation**

To launch the POP IT program at Golisano Children’s Hospital of Southwest Florida, two ED child life specialists led a team including an ED nurse and the ED director in drafting a strategic “Plan, Do, Check, Act” (PDCA) cycle and protocols/guidelines for staff accountability. PDCA is a process improvement model which outlines a project, its desired and measurable outcomes, future recommendations, as well as an implementation/action plan for the project. Following the creation of the PDCA draft, a brief presentation was given by the ED child life specialists at an Executive Quality Council meeting to discuss the purpose of the POP IT project and its short-term and long-term goals. After this presentation, ED management staff approved a 6-month trial period for the project to begin in the ED.

At the start of the trial period, each nurse and ED technician was provided individual education by the ED child life specialists. In addition to the individual education sessions, a presentation regarding each component of POP IT and the benefits and goals of the project was conducted as part of ongoing staff education. POP IT buttons (see Figure 1) and Wong-Baker FACES Pain Rating Scale/I-Spy badge cards were given to staff after completing their POP IT education.

*continued on page 30*
Implementing POP IT components

For the pain management component, the ED child life specialists advocated for the use of pain management strategies for each patient, regardless of age. The options available in the ED at Golisano Children’s Hospital of Southwest Florida include Sweet-Ease (also known as sucrose or sugar water used on pacifiers to help soothe babies), J-Tip (needle-free injection system that uses air to inject buffered lidocaine into the skin prior to IVs or intramuscular injections for children 12 months old and older), Pain Ease Spray (topical anesthetic skin refrigerant for children 4 years and older), and Synera patch (patch with lidocaine and tetracaine that is placed on the skin for 20 to 30 minutes prior to IV placement for children 3 years and older). Child life shared patient assessments with nursing staff and these assessments were utilized by nursing in making the most appropriate pain management decisions for each patient.

For the One Voice component of POP IT, staff viewed two videos of an invasive procedure involving a pediatric patient during their education sessions. One video depicted the use of the One Voice method, while in the other video One Voice was not used. Staff were able to observe and identify the benefits of using this method from these videos. As part of the POP IT program, the ED child life specialists advocated for One Voice during all invasive procedures. Prior to each procedure, the ED child life specialists discussed the One Voice method with caregivers as part of establishing the coping plan.

Positioning for comfort was introduced by educating staff on specific examples of comfort holds and the importance of using these holds during invasive procedures. ED child life specialists modeled these comfort holds for staff, and as a reinforcement of the concept they created education sheets illustrating these holds and posted these in staff bathrooms. ED child life specialists instructed families on comfort holds prior to a procedure in order to make it more successful.

Prior to the implementation of POP IT, the ED at Golisano Children’s Hospital of Southwest Florida did not consistently involve family during procedures. In order to implement the “Involve Family” component of the POP IT program, staff were provided verbal reminders in the moment of the event. In addition, ED child life specialists conducted meetings with nursing directors to discuss the importance of involving family during invasive procedures. All ED staff members were educated on the role of child life specialists and benefits of child life services. Staff were encouraged to call child life team members to provide procedural education and support, sibling and family support, and play and normalization. Diversionary activity boxes were created for use by staff in the procedure rooms when a child life specialist was not present. These boxes contained a variety of items such as musical light up toys, I-Spy books, bubbles, handheld games, and rattles to be used for alternative focus for all age groups (infant/toddler, preschool-school age, and adolescent) during invasive procedures.

Documentation of compliance with POP IT

In order to document staff compliance with POP IT protocols and guidelines, child life specialists recorded quantitative data on three of the POP IT components through the use of a spreadsheet (see Figure 2). Each work day, the ED child life specialists logged whether or not nursing staff were utilizing pain management, using comfort holds, and calling child life specialists for support during invasive procedures. To gather this information, child life specialists actively read patient charts and were present for procedures. These three components were specifically recorded due to high inconsistencies in nurses’ use of these practices prior to the implementation of the POP IT program. After obtaining and analyzing this data for several months, ongoing verbal education was provided to staff members who were continuing to display inconsistencies in care (those utilizing POP IT components 79% of the time or less).

Program Evaluation

Measuring the success of the POP IT program involved analyzing both qualitative and quantitative data, including data collected from nursing staff implementing POP IT, survey data, and informal interviews and general comments from both ED staff members as well as patients and caregivers. As shown in Figure 2, incidents in which nursing staff utilized pain management, implemented positioning for comfort, and called child life during invasive procedures were recorded by the ED child life specialists each day. Data was recorded at the beginning of the POP IT project (July 2016) through the end of the trial period (January 2017). Table 1 shows the total tracking data for the months of July, October, and January during the POP IT project trial period. This data appears to show an increase in nursing staff using pain management strategies, utilization of comfort...
After training, two surveys were sent to ED staff members via their work e-mail addresses, both at the start and halfway through the 6-month trial period. The first staff survey (see Appendix A) was sent to all ED nurses (N = 12) just prior to the start of the POP IT project; seven responses were received. This survey asked for staff members’ opinions regarding the components of POP IT and whether or not they perceived that POP IT would be beneficial to patients’ and families’ experiences in the ED. The majority of the survey responses revealed that staff held positive opinions regarding all aspects of POP IT. The question that resulted in the most divided response was “Do you feel that pediatric patients of all ages and developmental levels should be offered pain relief options (i.e. Synera, J-Tip, Sweet-Ease) prior to painful procedures/interventions?” 57.14% of respondents answered Yes, and 42.86% answered No. The ED child life specialists addressed this question with nursing staff and discovered that many staff members felt that older children/teenagers did not need pain relief strategies due to their age.

The second staff survey (see Appendix B) was sent to 20 staff members halfway through the POP IT trial period, and 10 responses were received. The questions in this survey focused on how staff perceived the POP IT trial and whether or not they believed it was beneficial to patients and families. The responses to this mid-trial survey were overwhelmingly positive; for example, 80% of respondents agreed that the POP IT program was helping to improve patient satisfaction and making patients’ experiences more positive, and 90% agreed that POP IT had improved teamwork and promoted a culture of caring in the ED. These positive responses illustrate staff’s acceptance and support of the POP IT initiative and the opinion that it was a beneficial program to continue not only in the ED but to expand hospital-wide.

In addition to staff surveys, 10 random parents and caregivers whose child had an IV placed during their ED visit were surveyed regarding their child’s experience. These surveys (see Appendix C) obtained parents’ feedback concerning the use of pain management techniques, comfort positioning, and child life services during IV placements, including whether or not these POP IT components benefited the patients and their overall improvement of their child’s ED experience. Ten completed surveys were received.

As shown in Table 2, 100% of caregivers indicated that their child benefited from the three POP IT components indicated, and all caregivers rated their child’s overall experience as either very good or excellent. The positive results of this survey supports the use of the POP IT protocol to enhance patients’ experience during an invasive procedure.

Golisano Children’s Hospital of Southwest Florida’s patient satisfaction survey results (Catalyst scores) were analyzed to evaluate the efficacy of the POP IT program. These surveys are sent out to the family of each patient seen in the ED, and contain two questions regarding pain management: “How often was your child’s pain well controlled?” and “How often did the hospital staff do everything they could to help your child with his/her pain?” For fiscal year 2016 (October 2015 – September 2016), prior to the implementation of POP IT, the top-box score (how many times the respondents chose the most positive response) for these questions was 65%, which ranked in the 43rd percentile nationwide. For fiscal year 2017, which covered the POP IT trial period, the score increased to 70%; a 70th percentile rank. For fiscal year 2018, after POP-IT implementation, scores rose to 76.9%; an 88th percentile rank. This increase in scores over the period illustrates how pain management programs, such as POP IT, can have a positive impact on patients’ pain in the ED, thus improving their overall hospital experience in a way that is meaningful to hospital administration.

Discussion
After trialing the POP IT project for six months in 2016 these authors found:

- An overall positive reception from staff regarding the purpose of the project, as exhibited in staff survey responses.
- An overall increase in staff compliance with POP IT protocols, resulting in more standardized and consistent care.
- A positive response from patients and families regarding patients’ coping and overall experience, as exhibited in family survey responses.
- An increase in teamwork and an improved culture of caring, as shown in staff survey responses.
- Interest shown by other child life specialists within our hospital in implementing this project hospital-wide in the near future.
- Improvement of Catalyst scores regarding patient pain control.

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In 2018, the POP IT program was presented at four different conferences throughout the United States, including child life and nursing conferences. With the success of the POP IT program in the Golisano Children’s Hospital of Southwest Florida ED, we are now in the process of expanding it hospital-wide. We will be trademarking POP IT and hope to educate other hospitals in the future on the importance of standardized patient care programs such as POP IT.

Limitations
The main limitation of our study is the small sample size. Our initial staff surveys and tracking data included a small number of staff members. Likewise, the parent survey was given out to only ten families. This small sample size can limit generalizations about the effectiveness of the POP IT program in the ED, and a larger sample size should be recruited for future research. This study did not track data of nursing staff’s usage of One Voice and involvement of family. Future research should analyze the potential benefits of all of the components in POP IT. An additional limitation of our study involved the use of raw self-reported survey data. This data could potentially be biased and can be difficult to verify.

Conclusion/Relevance to Child Life Practice
A program such as POP IT not only standardizes the role of the child life specialist in invasive procedures, but it also helps incorporate child life into the multidisciplinary team. This helps to establish a beneficial culture of caring, creating a better overall experience for patients and families. The success of the POP IT program also illustrates how a pain management program can demonstrate to staff the value of child life and the importance of our practices with patients to decrease stress and anxiety and increase coping during invasive procedures. Due to the lack of research, however, future studies should be conducted to continue to raise awareness of the importance of child life services and utilizing practices like those in POP IT. Even after implementing programs like POP IT, as child life specialists we will need to continue to advocate for our role and work as a team to educate staff about best practices in order to provide the best care for our patients and families. 

Table 1. Tracking Data totals

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<td></td>
<td>% OF CL USE</td>
<td>TOTAL CL USES</td>
<td>TOTAL INCIDENTS</td>
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<tr>
<td>Pain Management</td>
<td>75%</td>
<td>77</td>
<td>102</td>
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<td>Called Child Life</td>
<td>72%</td>
<td>97</td>
<td>134</td>
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<td>Used Comfort Position</td>
<td>79%</td>
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Table 2. Parent Survey Responses

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<th>YES</th>
<th>NO</th>
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<td>My child benefited from the use of pain management.</td>
<td>100%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>My child benefited from the use of comfort positioning during procedure.</td>
<td>100%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>My child benefited from the use of child life services.</td>
<td>100%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>How would you rate your child’s overall experience?</td>
<td>VERY GOOD</td>
<td>EXCELLENT</td>
<td>GOOD</td>
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REFERENCES


Cohen, L. (2008). Behavioral approaches to...


### Appendix A

**Staff Survey #1**

1. How often do you utilize pain management techniques (i.e. Sweet-Ease, Synera patch, J-tip)?
2. What pain management technique do you prefer?
3. Do you feel that patients benefit from comfort positioning (i.e. sitting with parent on bed)? Do you feel comfort positioning improves patient’s overall experience?
4. How often do you utilize child life services?
5. Do you feel patients would benefit from the use of One Voice (a technique designed to increase coping by minimizing the chaos which can occur as multiple staff members speak during procedures)?
6. Do you feel that family involvement at the bedside is beneficial to patients?
7. Do you feel that the use of pain management techniques increases patient satisfaction/improves their overall experience?
8. Do you feel that pediatric patients of all ages and developmental levels should be offered pain relief options (i.e. Synera, J-Tip, Sweet-Ease) prior to painful procedures/interventions?
9. Do you provide any procedural preparation or distraction to patients when child life is not present or available?
10. What are your thoughts on how to improve the patient’s overall experience while in the emergency department? (Please describe.)

### Appendix B

**Staff Survey #2:**

1. Do you feel that you have incorporated POP IT techniques (such as pain management, One Voice, positioning for comfort, calling child life) more often in patient care since the POP IT trial began?
2. What do you feel is going well with the POP IT project? Please elaborate. What do you feel needs improvement? Please elaborate.
3. How do you feel about One Voice?
4. Do you use pain management for all age groups when appropriate?
5. Do you call child life for procedural education and support?
6. Do you use comfort positioning when appropriate?
7. Do you feel the POP IT project is improving patient satisfaction and making patients’ experiences more positive?
8. Do you feel the POP IT project has improved our teamwork and promoted a culture of caring in our ED?
9. Have you utilized distraction box items when child life is not present?
10. Is there anything you feel that we should change about POP IT? What else can we do to improve patient experience? (Please describe.)

### Appendix C

**Parent Survey**

1. My child benefited from the use of pain management (Synera patch, J-tip)
   - Yes  No  N/A
2. My child benefited from the use of comfort positioning during procedure (i.e. sitting in your lap)
   - Yes  No  N/A
3. My child benefited from the use of child life services (i.e. procedural education, distraction during procedure, emotional support)
   - Yes  No  N/A
4. How would you rate your child’s overall experience?
   - Poor  Fair  Good  Very Good  Excellent
   - 1  2  3  4  5
5. What else could be done to improve your child’s experience? (Please elaborate.)
BACK TO SCHOOL:
Child Life Interventions in the Education System

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With the recent release of the Association of Child Life Professionals’ (ACLP) new position statement supporting child life practice in community settings, it is becoming clearer that “the skill set of the child life professional [is] applicable to other environments in which children are exposed to challenging life events” (ACLP, 2018, para. 2). For example, a school environment can be the site of a child’s initial experience with significant life changes, such as separation from their parents in kindergarten or their first needle poke during immunizations. Stressors hide behind every school corner, from the first day jitters, to making friends at recess, to final test anxieties. Unlike a single brief visit to a hospital, these stressors can happen daily for some students. What better place for a child life professional to promote resilience by teaching coping and calming strategies, while also minimizing stress and anxiety? These skills can lay a foundation for students to cope with significant events throughout their lives and may even be generalized to future healthcare experiences.

Research suggests that minimizing pain and distress during childhood immunizations can prevent subsequent healthcare avoidance behaviours and foster trust in healthcare providers (Taddkio et al., 2010).

My master’s level training in child life and pediatric psychosocial care has prepared me for a natural transition from the hospital setting into the education system, where I support the social and emotional well-being of students. Essentially, I am a Certified Child Life Specialist in a school, but my official title is an emotional behavioural specialist (EBS). I provide school-based interventions, support, and services to preschool, elementary, and junior high-aged children in an inclusive setting, where students who may need more individualized services are integrated into mainstream classrooms. Individualized strategies are integrated with small-group or even whole-class activities. In particular, I work from a psychosocial approach with students who have severe behavioural or emotional challenges that impact their ability to cope and learn. The psychosocial approach can be summed up as follows:

A psychosocial approach moves away from focusing on individual clinically based diagnoses to focusing on holistic, broad-based preventative programmes that promote resilience and develop coping strategies across the entire affected group. This leads to improvements in general stress related symptoms among those with and without specific disorders, and can thereby significantly reduce the numbers of those that do require any specialist intervention. (Mattingly, 2017, p.3)

As an EBS, I assess the psychosocial needs and coping responses of students through applied behaviour analysis, functional behaviour assessment, and ecological risk assessment. By gathering background information and data, an individualized and developmentally-appropriate behaviour intervention plan can be created and universal strategies for the whole class can be implemented. This process is accomplished in collaboration with the students, their families and teachers, as well as members of a multi-disciplinary team made up of social workers, speech language pathologists, occupational therapists, and therapy assistants.

Traditional Child Life Interventions
As I work in classrooms instead of at the side of a hospital bed, I have found that traditional child life activities and services have been applicable and beneficial to the students, as well as helpful to their families at home and other professionals in the school. My experiences in the education system have greatly aligned with ACLP’s Position Statement on Child Life Practice in a Community Setting:

Child life intervention minimizes both the immediate and potential long-term effects of stress, anxiety and psychosocial trauma, ultimately empowering children,

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1 In Canada, some childhood immunizations are school-based, which may not generally be the case in the US. Immunizations are voluntary but require parental permission before being administered in the school by a public health nurse (BC Health Link, 2018).
families and their support systems to reach their full potential. Child Life professionals are uniquely educated and trained to provide children, families and their support systems opportunities to cope, gain a sense of mastery, engage in self-expression, and promote resiliency. (ACLP, 2018, para. 1)

Child life specialists typically work to address specific health-related issues through individualized interventions. With advances in modern medical science, research, and technologies, there are more children with special healthcare needs (chronic illness, developmental disabilities, cognitive impairments, psychiatric disorders, etc.) entering the school system and creating diversity in the classroom (Weiner, Hoffman, & Rosen, 2009). By employing the unique and proactive child life perspective in my EBS role, I have incorporated a number of traditional child life interventions into our school setting. Take note of the commonalities the following school-based interventions have with the hospital setting:

**Poke Preparation**

Nurses came into our school to administer immunizations, so I created a “waiting room” for students that included bubble wrap, stress balls, and focus tools to help decrease needle anxiety. Students and I discussed coping plans as they waited (Will they look or not look? Do they need a distraction or prefer that I sit with them?) After their poke, students approached me in the hallways saying how much fun they had blowing bubbles and playing tricks on the nurses with whoopie cushions. Older students were upset that they didn’t have the “waiting room” last year.

**Normalization**

Students often show behavioural signs of separation anxiety on their first day of kindergarten, much in the same way that patients worry about going to the OR without their parents. To minimize this anxiety, I initiated “happy visits” to help normalize the school environment. In collaboration with the early learning multi-disciplinary team, we invited next year’s students for an hour-long kindergarten test run. I helped transition some of the more anxious students into the classroom by getting on their level and playing (e.g., driving a truck to the classroom). This initial school experience of reading books, dancing, and free play was a positive one for most of the students and they were excited to come back in September.

**Therapeutic Relationships and Rapport**

A student in Grade 2 required accommodations to complete his work without becoming frustrated and violent. However, the teacher expected academic achievements similar to the other students in the class. To help, I first needed to build rapport with the teacher and create a therapeutic relationship with the student to better understand both
parties' needs and vulnerabilities. To establish a safe and understanding environment, I provided developmentally appropriate explanations of the student’s multiple diagnoses and life experiences to both the student and the teacher. We discussed the student’s motivators and strengths to create optimal interventions and interactions. I encouraged the teacher to employ a child-centered approach and help the child identify feelings rather than just sending him to the office. Surprisingly, winning over teachers is very similar to winning over nurses!

**Diagnosis Explanation**

A student in Grade 1 was diagnosed with autism spectrum disorder. I reviewed the psychological assessment with his mother to help with comprehension and direct her focus towards his strengths. With the help of the family school liaison worker, we also connected her to community resources for further support. The student and I discussed his new diagnosis by watching a video and reading some books so that he would have a better understanding of his own diagnosis and we could then present our findings for his class to cultivate awareness and empathy in his peers as well as his teacher.

**Developmentally Appropriate Education**

A student was developmentally at a Grade 3 level but was cognitively functioning at a kindergarten level. By encouraging the student to voice what he wanted to learn about to his teacher, we all came up with tactile-based learning strategies and fewer learning objectives so that he could complete similar projects to those of his peers. Learning through play promoted inclusion, empowerment, mastery, and fewer challenging behaviours in the classroom.

**One Voice**

In preschool, one child got upset during clean-up time and would scream, cry, or sometimes flop to the floor and bang his head. The child was often overwhelmed by the large number of staff in the room helping to support the teacher and students. I introduced the idea of only having one person handle a situation at a time, similar to the One Voice concept used in procedures (Wagers, 2013). Everyone was informed about the individualized behaviour plan to follow so that the same message could be communicated to the student every single time he got upset.

**Hospital to School Transition**

In addition to providing the traditional interventions described, I have also been able to focus on the hospital to school transition in my role. When I was a child life specialist in the hospital, I did not see myself playing an important role in the transition of a patient back to the school setting. Looking further into evidence-based practice, research reflects the benefits of school reintegration programs for children, which are associated with fewer behaviour problems, higher social self-esteem, higher rates of student adjustment, and increased knowledge gains for both teachers and classmates (Heffer & Lowe, 2000). Now that I have taken a step into the school system, I see a large gap in this important transition, both in the reintegration from hospital to school, but also from school to hospital.

Lightfoot, Wright, and Sloper (1999) conducted semi-structured interviews of secondary students with a variety of illnesses and disabilities. The students felt excluded from school life due to teacher’s negative reactions and strains placed on relationships with their peers. The role of a health professional in the school should be to provide direct support for the student and more information for teachers. However, these students did not see the school health services as a potential source of support as they were not readily accessible. The following examples are how I tried to change that perspective in our school:

**Teddy Bear Clinic**

Many child life specialists who deliver services within the school system run “teddy bear clinics” to help prepare students for going to the hospital or other healthcare related settings. By playing and experimenting with medical sup-
plies, students work through misconceptions and become familiar with healthcare related topics. Similarly, I brought in my medical play supplies to our preschool classroom after they expressed an interest in having a hospital play center. I went into the classroom to initiate medical play and support them in trying out the doctor and nurse roles with teddy bears. Next year we are planning a field trip to our local children’s hospital for a “happy visit.”

**Medical Play and Mastery**

A number of students at our school have medical issues (cerebral palsy, scoliosis, a cancer survivor, emergency surgeries, etc.) and have returned to school after a hospital visit; however there was no plan in place to support this transition. I initiated a medical play group that utilizes therapeutic play opportunities (puppets, medical play, sand tray worlds, projective drawings) to promote mastery, control, understanding, and emotional expression. This group allowed these students a safe place to interact with peers who have experienced similar life events, and in response we have seen positive changes in these students’ classroom behaviours.

**Cancer in the Classroom (Diagnosis Explanation)**

A girl in junior high was having surgery to remove a tumor in her leg, so we made a cake with a “tumor” and performed the “surgery” in front of the class. A junior high boy had a brain tumor, so we made Jello “brains” with marbles in them. By showing how hard the marbles were to cut out, his peers understood why he had to get radiation instead of surgery. A Grade 1 girl had leukemia, so we read a book about losing hair and played a movement game (where children moved differently depending on the type of cell they were pretending to be) to show how chemotherapy works to help clean out her blood. These presentations made cancer less scary and more approachable because the students had more information to understand. Making the unknown known resulted in a more accepting attitude towards their peers with cancer.

**School-Based Interventions**

Some psychosocial needs are not necessarily related to a child having a health-related issue; however that does not mean that the skill set of a child life specialist cannot attend to these types of needs and childhood challenges. The benefit of being a child life specialist in a school is that I can proactively prepare hundreds of students with coping skills before they even reach the hospital. The following school-based interventions encompass child wellness and behavioural health, playing a critical role in how students generalize and adapt skills to challenging life events.

**Self-Advocacy/Calming Strategies**

A girl in Grade 6 found her school work too difficult and did not know how to ask for help, so she often tried to escape doing it at all by leaving the classroom. We practiced calming techniques like grounding and muscle relaxation for her to use at her desk. We also came up with a plan that she would check in with an adult before starting an assignment. If the academics were still challenging, she would close her eyes, visualize the beach, and go over everything she sensed. Once calm, she would raise her hand and ask for help.

**Regulation**

Many behaviours in the classroom stem from a student being dysregulated due to sensory overload, overstimulation, or a stress response. Ideally we want students to regulate independently at their desks, but they may need a quiet space in the classroom or another room altogether. I collaborated with the occupational therapy team to create a regulation room with sound machines, crash pads, alternative seating, bubbles, fidgets, and feeling visuals from Generation Mindful’s *Time In Toolkit* (Tucker, 2019). Regulation bins will be available this year in all early learning and elementary classrooms, which include items like handstamps, bubbles, pinwheels, *I Spy* books, kinetic sand, etc. Teachers can use an item of the student’s choice to help calm them before trying to problem solve. I also recently received a grant to upgrade our regulation room to a multi-sensory room for students with disabilities. The equipment is now being set up for the students to use in the upcoming school year.

**Stress Response**

I ran a district-wide professional development presentation that focused on the brain functioning behind a stress response, sharing how sometimes a student’s frontal lobe “switches off” and therefore needs to be calmed down before their “rational brain” will start working again to problem solve. Teachers now have a better understanding that students cope differently based on their previous experiences with stress, and that their behaviour is affected by other ecological variables as well.

continued on page 38
Psychosocial Teaching
A Grade 4 student with conduct disorder had challenges with keeping his hands to himself, as well as with social skills and problem solving. My assistant and I were able to teach his whole class about whole body listening, ignoring muscles, personal space, respect, “I” messages, and problem solving. I have also collaborated with the school social worker to present on healthy friendships and boundaries. By including the whole class in these lessons, the student was not singled out and everyone benefited from the lessons.

Universal Language
At a staff meeting, I spoke to the teaching staff about the importance of the language we use with students, highlighting the difference between using responsive rather than reactive language. By creating positive, strength-based rules, all teachers speak the same universal language and students know what they can do instead of focusing on what they can’t (e.g., “walking feet” instead of “no running”).

Priming
Preparation for a test or upcoming change in a student’s daily routine is similar to preparing a child for a surgery, since both interventions increase certainty and coping while decreasing uncertainty and stress. Self-regulation theory suggests that accurate preparation information can help children regulate their behaviours appropriately. If the situation is predictable then students are more likely to perceive themselves as being able to cope. They will then utilize problem-focused coping to have an enhanced sense of control over the perceived stressor (Jaaniste, Hayes, & von Baeyer, 2007).

Schools, Communities, and Beyond
According to ACLP’s position statement, “there is significant value in including child life professionals in a variety of community based settings” (ACLP, 2018, para. 4), which is not only limited to school systems. No matter where you find yourself working as a child life specialist, remember that we are all trying to accomplish the same thing: We assess psychosocial needs, promote resilience, minimize stress, and ultimately help families and their children cope with new or stressful situations. Our child life tools can be used in multiple settings and environments.

Sometimes our work will be carried out in reaction to a child’s problem; however, generally our child life expertise assists us in being proactive, thus preventing the problem from ever manifesting itself behaviourally in the first place. If our profession continues to reach beyond the hospital walls and out into the community, think of how many more lives our profession will positively impact, leaving a lasting imprint of resiliency and proactively preparing children for any change, challenge, or crisis they may face.

REFERENCES
PERFECTLY POLISHED:

Student Professionalism Before the Internship

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The child life career path can be a tricky one to navigate. Students are trying to balance coursework, volunteering, and part-time or full-time jobs, all while pursuing practicum and internship programs. One important component to the application process, and throughout your child life career, is professionalism. As professionals working in a medical environment, child life specialists are always engaged in communication with patients, families, and interdisciplinary team members. As a result of that constant communication, we learn how to identify cues based on verbal and nonverbal behaviors. These behaviors are also an important part of professionalism within child life networking. Students spend a significant amount of time dedicated to communication with college advisors, course professors, mentors, child life specialists, and child life student coordinators. As child life specialists who not only have assisted in the selection of interns, but who have also been through the internship process and learned from our mistakes, we have some helpful tips for students navigating the application process.

General Tips to Consider:

■ Confirm appointment times, in the correct time zone.

■ Contact the program if you need to cancel a phone or in-person interview. Make sure to speak with an individual and confirm they received your cancellation, rather than cancelling via an email or voicemail.

■ Verify the location of an in-person meeting, as well as where to park.

■ Put thought and time into your appearance for an interview, whether it is in person, through video conferencing, or on the phone. You will present yourself in a more professional way by doing so, and first impressions are key!

■ Be on time. The phrase “If you aren’t early, you’re late” may sound familiar. If you are not able to show up on time to something as important as an interview, one may question your ability to be timely in the professional setting. Allow extra time to ensure that you are prompt, and if you are running late, call the appropriate program contact to alert them of your delayed arrival.

■ Maintain eye contact, as culturally appropriate. Demonstrating focus is a desirable trait in future interns and employees.

■ Identify your nervous behaviors and try to avoid them. For example, people who nervously tap their feet may want to consider wearing quiet shoes and positioning their feet in a specific way to remind them to keep their feet still.

Verbal and Written Communication, Including Email and “Snail Mail”:

Communication skills are an important component of professionalism. As technology and online applications continue
to grow, it is important to demonstrate competence in both verbal and written communication. A few tips to help with these types of messages include:

- In electronic communication, it is important to proofread every email message, edit every document, and correct all spelling and grammatical errors. It is best practice to exclude slang or text message lingo. Double check that the document you have attached to send is the final draft. You do not want to send an unedited version of your draft.

- Proofreading is also essential when posting on the ACLP Forum. Each ALCP Forum post has the potential to be viewed by a variety of medical and non-medical professionals. For example, a child life student coordinator may be a member of the Students and Interns Forum, to gain a better understanding of the questions or concerns that new students have related to practicum and/or internship programs, and will notice errors or lack of professionalism in posts.

- Resumes, cover letters, and applications should also be proofread. It can be helpful to have a friend, roommate, or co-worker review the information, even if they are not in the same career field.

- When contacting a child life specialist at a facility to discuss practicum and/or internship programs, please know that this first communication can leave a lasting impact. While the first e-mail exchange may not be an official interview, an individual should treat it as such.

- If you receive your contact's voicemail box, clearly leave your contact information. If you provide your name and phone number at the beginning of a voicemail, it can be helpful to repeat it at the end, too.

- Rely on email and phone calls as your continued professional presentation instead of text messaging or social media.

- If you receive a message from a program, it is important to call back in a timely manner. Many child life specialists who work with student programs have additional clinical responsibilities. In order for you to get the most applicable information, call back when you have enough time to dedicate to the phone call.

- Being positive during your interview process is a must. Show interest in your voice by smiling through the phone.

**Maintaining Boundaries:**

Boundaries are essential to establish at the beginning of any professional relationship, especially the relationships between a student and their preceptor, instructor, and manager or director. A boundary is a limit defining you in relationship to someone or to something. Boundaries protect the individuals involved, clarify everyone’s role within the relationship, and identify personal limitations (Gionta & Guerra, 2015). Setting boundaries at the beginning of any relationship is key in order to establish expectations about appropriate behaviors. A few tips for setting and maintaining boundaries include:

- Ask clarifying questions about your role and the role of your professor, coordinator, preceptor, or department leadership. This may include exactly what is expected of you as a student in a clinical setting with patients, as well as what is expected of you as a student on the team. Examples of student boundaries could include not spending time in break rooms with the rest of the team, not spending personal time with team members outside of clinical rotations, not texting or calling team members’ personal phones, and not communicating with team members outside of clinical hours.

- Clarify boundaries as needed. If there is a doubt or a question about whether you might be crossing a boundary, then you probably are. Have someone on your team help you look at your situation in a different way to be able to provide professional insight.

- Check with your policies and procedure guidelines to make sure you are not crossing any boundaries; hospitals and healthcare institutions have policies and procedures for legal and liability reasons.

- Facilities will also have an ethics department; if you are concerned about an ethical dilemma, please contact your student coordinator and department leadership. They can direct you to ethical considerations and guidelines.

Everyone goes through a professional growth curve. In our experience, professionalism has become easier over time as we became more embedded in the hospital culture. We hope these tips are useful and help reduce the stress of applying to practicum and internship opportunities.

**REFERENCE**

Integrating Animal-Assisted Therapy into Self-Care Support for Medical Professionals Who Care for Critically Ill Children and Their Families

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Hospitals have been bringing dogs into pediatric patients’ rooms for years, and as it turns out, patients are not the only ones who look forward to and benefit from these visits. Hospital staff on pediatric intensive care units can benefit immensely from interacting with dogs in the clinical setting.

The Child Life and Creative Arts Therapy Department at Mount Sinai Kravis Children’s Hospital launched the “Paws & Play” facility dog program in March 2017 to provide Animal Assisted Therapy (AAT). Facility dogs can provide a unique form of AAT as they work with trained clinical handlers to address clinical goals in the hospital setting. This effective modality, designed to help patients, families, and staff cope and heal, is a goal-directed intervention in which an animal meeting specific criteria is integrated into the treatment process. Working alongside a professional, the dog is recognized as a therapeutic form of treatment.

Facility dogs and handlers are referred by physicians and other clinicians to engage patients around movement after surgery, pain management, procedural support, anxiety, and socialization during extended admissions. As part of Paws & Play programming, three facility dogs were brought onto the child life and creative arts therapy team and paired with handlers to provide a variety of therapeutic interventions, including critical staff support interventions.

Identified Staff Needs in the PICU and PCICU
The pediatric intensive care unit (PICU) and pediatric cardiac intensive care unit (PCICU) at Mount Sinai Kravis Children’s Hospital contain 25 beds located within a larger medical institution and treat a wide range of medical diagnoses, including organ transplant, metabolic and genetic disorders, cardiology, and many other...
diagnoses requiring intensive care. The Critical Care Societies Collaborative issued a statement recognizing medical professionals’ burnout syndrome as relevant, and called for action to increase awareness, conduct research, and find strategies to improve job satisfaction and mental health of intensive care staff (Moss, Good, Gozal, Kleinpell, & Sessler, 2016). Furthermore, studies have found nurses in intensive care units and pediatrics are at high risk for emotional exhaustion, burnout, and stress due to exposure to environmental stressors such as pain, suffering, death, and challenging ethical dilemmas (Kravits, McAllster-Black, Grant, & Kirk, 2010; Maytum, Howard-Ruben, & Whitaker, 2004; Verdon, Merlani, Perneger, & Ricou, 2008).

Child life specialists working in critical care settings, as well as staff members from other disciplines such as social work and spiritual care, often play a unique role in offering staff support in the context of working with critically ill children and their families (Brown, 2009). The child life skillset can offer much needed support for medical staff using creative and therapeutic tools, such as AAT. Research has shown that the presence of dogs in the workplace may impact employees’ stress level in a positive manner (Randolph, Knisely, Barker, Cobb, & Shubert, 2012) when done with careful considerations to address potential challenges (Foreman, Glenn, Meade, & Wirth, 2017).

**Professor’s Office Hours**

In an attempt to support staff working in stressful intensive care units, the child life team implemented, “Professor’s Office Hours,” a pilot program designed to provide ICU staff self-care through AAT, from November 2017 through January 2018. Two Certified Child Life Specialists facilitated bi-weekly AAT staff support sessions with a Paws & Play facility dog named Professor, in the PICU/PCICU nurses’ lounge and at the workstations on the unit to provide opportunities for unit staff to partake in play, as well as pet and interact with Professor. The child life specialists also engaged with staff around their current mood and coping, self-care techniques, and general rapport-building conversations.

The child life specialists solicited feedback utilizing a written survey at the beginning, middle, and end of this 3-month pilot program. The first survey asked about timing of staff AAT sessions, and results revealed a general preference to have AAT sessions on the unit, in the afternoons, and on a bi-weekly basis. The second survey asked if AAT sessions were having a positive impact on staff members’ day, how likely they were to recommend that a co-worker access AAT for self-care, and the frequency at which they would like to have AAT for staff on their unit. Staff responded overwhelmingly positively, with 87% of respondents saying that AAT had a positive effect on their day, 80% indicating that they would recommend it to a coworker, and 86% stating they prefer weekly sessions. The final staff survey at the end of the 3-month pilot asked similar questions and resulted in similar responses.

Over the 3-month period, 75 staff members participated in Professor’s Office Hours. There were six planned group sessions, 15 individual sessions with staff, and four unplanned group sessions based on staff need. Participants included nurses, residents, attending physicians, fellows, respiratory therapists, physicians’ assistants, and pharmacologists. Stressful days, end-of-life situations, critical patient caseloads, and general staff business were primary reasons for seeking or participating in AAT. When asked to describe their time with Professor, staff responded with positive feedback, using words such as “relaxing,” “wonderful,” “joyous,” “peaceful,” “the best,” and “very pleasurable when I am having a bad day.” When asked about Professor’s impact on the work environment, staff said, “He removes all stress in a stressful environment,” “His presence makes us smile,” and “He lightens the environment.”

According to Dr. Howard Seiden, then Director of Pediatric Cardiac Critical Care and Inpatient Services at Mount Sinai Kravis Children’s Hospital, “The Paws & Play program has had a meaningful and positive impact on the PCICU.” He added that seeing children smiling and enjoying Professor’s company is “very gratifying for the staff.” Doctors and nurses, he continued, also relish their time with Professor. “Even healthcare profes-
professionals need the occasional calming diversion from the stressful environment of an intensive care unit.”

Outcome of Pilot and Future Growth of Staff Support for Paws & Play

The feedback from healthcare professionals who participated in Professor’s Office Hours indicated that this pilot program achieved its goals. The theme of the comments that emerged from the surveys included relief from stress, relaxation, and increased communication with others in playful and joyful contexts. Almost all staff who participated in one AAT session made use of this distinctive support multiple times. The overall success of this program lies in both the therapeutic aspects of AAT and the recognition of medical staff’s self-care needs.

While the impact on the care of patients and families is not directly measured in this program, it does effectively recognize the role that a child life specialist and AAT program can play in providing self-care opportunities for multidisciplinary team members. This impact on staff self-care does, in turn, have the potential to shape patient care.

The results of this pilot program have led to significant facility dog program expansion for staff support through AAT. Professor’s Office Hours has expanded to cover other units in addition to the PICU/PCICU. With the addition of the program’s second dog, Amos, in November 2017, the team introduced “Amos’s Cookie Break” which models Professor’s Office Hours on the inpatient medical/surgical unit. Due to the overwhelming success of the program in providing staff support to pediatric units, our program received combined hospital and grant funding in 2019 to onboard a new full-time facility dog, as well as a creative arts therapist handler, to provide staff support on the adult units. Moby, the program’s first dog dedicated exclusively to staff support, now provides therapeutic sessions to staff throughout the Mount Sinai Hospital system. The team is planning to do research assessing the impact of AAT sessions on coping and resilience for medical professionals.

Overall, the implementation of this pilot program led to a large increase in AAT staff support sessions at Mount Sinai led by child life department staff; in 2018, the team provided AAT to 447 staff members. The facility dog teams have become a vital part of patient debriefs, end-of-life processing sessions, and a valued resource for responding to critical events on patient units.

REFERENCES


I imagine the chaotic afternoon in the emergency department with multiple consults for procedures. Or the nurse from the floor who calls to say that their patient “is bored” while you’re in the midst of a bereavement intervention in the PICU. Perhaps it’s a restless sibling whose mother forgot to bring activities while he waits for his sister to complete an MRI. How many times a day do we as child life specialists wish we could do it all—split ourselves into the unrealistic number of individuals it would take to provide quality therapeutic interventions for each of these scenarios? While we can prioritize and reach out to our colleagues for assistance, the reality is that at some point during our careers, we have to acknowledge we can’t do everything at once. We eventually learn to give ourselves grace and accept the limitations. However, that still doesn’t change the fact that needs will occasionally slip through the cracks. The procedure we hurried to will be over by the time we arrive 30 minutes later because the one we were previously in took multiple attempts. The patient waiting for us to provide therapeutic play on the inpatient floor will be asleep. The backup of charting will be overwhelming. We’ll have a deadline we have to meet by the end of the day. The child life specialist might then feel inclined to provide an iPad in order to meet the needs of our patients when we are unable to be in multiple places at once. Pretty soon, we start receiving pages and calls not for our expertise in coping and developmentally appropriate interventions, but for our iPad. This piece of technology, although a helpful tool for child life practice and an occasional “lifesaver,” should not be viewed as a replacement for a child life specialist.

“I Just Need the iPad” IDENTIFYING A HEALTHY BALANCE OF IPAD UTILIZATION IN CHILD LIFE PRACTICE

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Where is the boundary between letting the iPad supplement child life practice and allowing it to replace the vital roles of a child life specialist? How do we educate staff to acknowledge the difference and appropriateness of an iPad being provided as opposed to a child life specialist being consulted? And how do we maintain professional integrity if iPads continue to be loaned out for alternative focus and play when child life specialists aren’t able to be present?

In an article that was published when digital technology made its debut at Kravis Children’s Hospital at Mount Sinai Medical Center, one important distinction was described: “The device is not used as a play modality outside of the intervention; reserving the tool only for instances when a child needs diversion, procedural support, or medical education magnifies the effect” (Borges, Huber, & Lugo, 2011, p. 88). While acknowledging that the utilization and opportunity for iPads to assist child life specialists in their practice has greatly evolved over the past eight years, it is important that we remain intentional about how, when, and why technology should be used to enhance positive coping and the overall experience of our patients during stressful medical experiences. In the book Play-Based Interventions for Childhood Anxieties, Fears, and Phobias (2018), authors Drewes and Schaefer highlight specifically the benefit of children being given the opportunity to engage in medical play experiences for mastery and coping as “indispensable and highly effective” (Drewes & Schaefer, 2018, p. 20), as opposed to being handed an electronic device for mere distraction.

An informal departmental survey was conducted by this author to gain insight into how the child life specialists in one program utilized and were consulted for their services regarding the iPad. Of the 22 child life specialists who completed the survey, 59% worked in an outpatient setting such as the emergency department, surgery, radiology, or outpatient clinics, while 41% worked in inpatient acute and critical care units. Participants reported interacting most often with school-age patients, then preschool children, infants/toddlers, and least often, adolescents.

A large portion (86%) of participants reported the experience of being consulted by medical staff solely for the iPad without additional child life support, noting that it occurs between 25% and 75% of the total number of consults received. Participants identified preparation and procedural support/alternative focus being the most frequent and child life specialist-preferred interventions provided with support of their iPads. A surprising 68% of participants reported feeling that their medical team was excessively reliant on the child life specialist’s iPad. When asked about their own utilization within their child life practice, 77% of participants stated that they use their iPad as a tool to increase efficiency and engagement within their practice, while 18% believed they did not need their iPad to provide quality child life intervention, and 5% used their iPad as a last resort within their practice.

It can be difficult to advocate for ourselves when the iPad in our hands is how staff, patients, and families might define our role. Providing education about a child life specialist’s role, including the assessment and intervention processes, can increase staff’s accurate understanding and perceptions of iPad utilization. Specifically, it is important for staff to understand how child life specialists use the iPad as a tool to enhance coping and provide developmentally-appropriate play opportunities during stressful medical experiences. Modeling thoughtful iPad utilization and distribution will educate not only the interdisciplinary team, but also child life students who need to develop basic intervention skills without depending on technology. By incorporating the benefits of technology appropriately and sparingly, child life specialists can demonstrate how technology enhances therapeutic interventions and positive coping outcomes without replacing the physical presence of a child life specialist during a stressful experience. If we assess we aren’t able to support a child during a procedure and provide an iPad instead, we remove the opportunity for a child to discover alternative coping strategies such as deep breathing, guided imagery, or other therapeutic interventions that could set them up for success with future experiences. The advantages that iPads and technology provide to our practice are numerous, but only if we continue to reflect and evaluate how to be intentional in meeting psychosocial goals using them as a tool, instead of as a crutch.

REFERENCES
As child life specialists, we often bear witness to the direct effects of trauma (both sudden and long-term) in pediatrics. We understand that there is an underlying biological process that connects trauma experiences to behavior and physiological response. In her book, *The Deepest Well: Healing the Long-term Effects of Childhood Adversity* (2018), Dr. Nadine Burke Harris, a pediatrician at The Bayview Child Health Center in San Francisco and the recently-appointed Surgeon General for the state of California, explores this process while focusing on the effect that exposure to toxic stress in childhood has on development and long-term health. Dr. Burke Harris’s engaging anecdotes, research, and recommendations for mitigating the effects of trauma (building resilience!) underscores the necessity of the child life profession while also validating its effectiveness, power, and impact.

As the ACE study reports, the impact of chronic stress goes beyond affecting a child’s mental health in the short term; it affects their physical health as well. A person with four or more adverse childhood experiences is more than twice as likely to develop heart disease and three and a half times as likely to develop pulmonary issues. Additionally, chronic stress exposure is also correlated with an increase in drug and alcohol use, behavior issues, and learning disorders (Felitti et. al, 1998).

Of particular interest is Dr. Burke Harris’s shift in focus from the what (ie: high ACE scores correlating with poorer health outcomes) to the how and why (exactly what internal physiological process causes this correlation). Burke Harris illustrates how the body’s stress response system, when faced with repeated and severe stressful situations, can backfire and become maladaptive. This process leads to a cascade of internal physiological responses that are so powerful they can actually recode our genetic make-up. Furthermore, she explains, “Environment and experience play a huge role in determining which parts of your genetic code are read and transcribed in each new cell your body creates . . . These epigenetic notations are subject to experience, to being rewritten by your environment” (Burke Harris 2018, p. 83). Burke Harris also emphasizes that without intervention, as found in the ACE study and subsequent research, exposure to chronic stress can permanently alter genes and lead to increased disease and potentially early death (Burke Harris, 2018).

While Dr. Burke Harris never directly discusses the profession of child life, she does dedicate the second portion of her book to discussing potential interventions to mitigate or reverse the overactive stress-response cycle, many of which echo the goals of the child life profession. In the chapter “The ACE Antidote,” she discusses the vital importance of integrating mental health services within primary healthcare settings. Dr. Burke Harris also introduces the work of Dr. Alicia Lieberman, founder of Child Parent Psychotherapy, a model that is evidence-based and now the leading trauma treatment for young children (Burke Harris, 2018). The model, which focuses on treating the child and family as a team, will resonate with...
child life specialists since it directly correlates with providing child- and family-centered care.

While reading Dr. Burke Harris’s insights, child life specialists will glean relevant information that reinforces why their specific skillset and expertise are so imperative when helping children cope. Of note is the strong support the book shows for the child life competencies, in particular competency I.E. “The ability to support infants, children, youth, and families in coping with stressful events” (Association of Child Life Professionals, 2016, p. 3) and competency I.B. “The ability to initiate and maintain meaningful and therapeutic relationships with infants, children, youth, and families” (Association of Child Life Professionals, 2016, p. 2). As Dr. Burke Harris mentions, the key to fighting adversity is building resilience and developing positive, affirming relationships, the core of the child life profession.

Dr. Burke Harris concludes by calling for a public awakening of the importance of psychosocial support for children exposed to traumatic experiences. She recognizes that progress has occurred, but it is not enough. Armed with this information, schools, healthcare organizations—anyone working with children—need to advocate for services and interventions that minimize the impact of these effects. Dr. Burke Harris states,

> When you compare toxic stress to pediatric cancer, its treatment is still nascent—we are just beginning our response. If the global crisis of childhood adversity were a book, we would be in the second chapter. In a lot of ways, this book is the story of that first chapter—the discovery of the biological mechanisms. We have not yet perfected our response. But we are working on it. (2018, p. 207)

Ultimately, Dr. Burke Harris’s book affirms the power that child life specialists have to impact change. As Burke Harris concludes:

> The cause of harm—whether that’s microbes or childhood adversity—does not need to be totally eradicated. The revolution is in the creative application of knowledge to mitigate harm wherever it pops up. Because when you know the mechanism, you can use that understanding in countless ways to drastically improve the human condition. That is how you spark a revolution. (2018, p. 211)

Dr. Burke Harris has latched onto a concept that connects deeply with the mission, vision, and goals of the child life profession. In joining with Dr. Burke Harris’s revolution, child life specialists will find clearly written information they can use to educate others on the power, impact, and efficacy of reducing stress, increasing coping, and building resilience in children and families. 

**REFERENCES**


Specialized Resources is a column designed to share books, websites, apps, and other resources that may be helpful for child life specialists working with a specific population. This column represents only the personal views of the author, and the Association of Child Life Professionals does not endorse or sponsor the products or services mentioned. In addition, the authors of this column verify that they have no affiliation with the companies or organizations related to the products and services mentioned in this article.

School Re-entry with a Chronic Illness

Elizabeth Anderson, CCLS
HUNTSVILLE, AL

Children living with chronic illness face several different challenges when attending school. Chronic illnesses affect at least 10-15% of American children (U.S. Department of Health & Human Services, National Heart, Lung, and Blood Institute, 2014). Addressing and attending to the needs of students with chronic conditions in the school setting requires a thoughtful, multidisciplinary approach. While child life specialists are not always present in the school to assist with school re-entry, there are many resources available to guide the process and help support parents and caregivers as they prepare for their child’s return to school.

REFERENCE

RECOMMENDED RESOURCES

Books: These resources include children’s books that can be utilized by parents, caregivers, and teachers to educate both the child with a chronic illness and their peers, as well as a guide for parents and teachers on educating children with cancer.

These colorfully-illustrated books are intended to teach elementary school children about students who have been diagnosed with chronic illness, and how these illnesses are managed in school. These books help foster empathy among children who may have a classmate with a similar diagnosis.

Organizations and Resources for Patients, Parents/Caregivers, Educators, and Medical Personnel: This is a wide range of resources for anyone working with school-age children who have chronic illnesses. These resources are meant to provide information, guidance, helpful tips, and emotional support.
- 14 Things that can Make High School with a Chronic Illness Easier. This list of items, suggested by members of The Mighty community, an online resource for those with health challenges and their caregivers, aims to help make attending school with a chronic illness easier. https://themighty.com/2018/01/high-school-disability-illness-supplies/
- American School Health Association. The American School Health Association is a multidisciplinary organization that aims to create safe and healthy school environments for all children. www.ashaweb.org
- Cancer.Net: Doctor-Approved Patient Information from American Society of Clinical Oncology. This organization offers several resources, including: Cancer and School. This article includes information for school-age children and adolescents on navigating school with a cancer diagnosis. https://www.cancer.net/navigating-cancer-care/teens/family-friends-and-school/cancer-and-school
- Just for Teens – Cancer and School. This podcast for teenagers with cancer focuses on balancing school and treatment. https://www.cancer.net/blog/podcasts/just-teens-cancer-and-school
- CF and School. This section of the Cystic Fibrosis Foundation website is an instructional guide with additional resources intended for teachers working with a student who has CF. https://www.cff.org/Life-With-CF/Daily-Life/CF-and-School/
- Crohn’s Disease and Ulcerative Colitis: A Guide for Teachers and Other School Personnel. A comprehensive guide from Crohn’s and Colitis Foundation, for educators to provide information, guidance, and resources related to the student with Crohn’s or colitis. http://www.crohnscolitisfoundation.org/resources/guide-for-teachers.html
- Epilepsy Foundation. The Epilepsy Foundation offers many programs and resources to support students with epilepsy, including:
  - Epilepsy In High School. This article provides helpful advice to students with epilepsy about navigating high school with this diagnosis. https://www.epilepsy.com/living-epilepsy/youth/epilepsy-high-school
  - Managing Students with Seizures: School Nurse Training Program. This program provides education about epilepsy to school nurses as well as strategies and resources needed to better manage its care. https://www.epilepsy.com/living-epilepsy/our-training-and-education/managing-students-seizures-school-nurse-training-program
  - Seizure Training for School Personnel. This free, interactive course provides education to school personnel and promotes a positive social and educational environment for students with an epilepsy diagnosis. https://www.epilepsy.com/living-epilepsy/our-training-and-education/seizure-training-school-personnel
Take Charge: Classroom Epilepsy Education Programs. Take Charge offers three different programs for K-12 students designed to help them understand and support their classmates who live with epilepsy. Each program uses age-appropriate language and teaching tools, educates students about epilepsy and seizures, helps students identify and learn about different types of seizures, and teaches students what to do and not to do when someone is having a seizure. [https://www.epilepsy.com/living-epilepsy/our-programs/take-charge-classroom-epilepsy-education-programs]

Genetics Education Materials for School Success (GEMSS). GEMSS is an organization that provides resources for and encourages collaboration between families, schools, and medical professionals to help all children with genetic health conditions succeed in school. [https://www.gemssforschools.org/]

HEAL: The Hospital Educator and Academic Liaison Association. HEAL is a professional organization that supports and connects multi-disciplinary professionals who work with students with medical and mental health needs. Their overall goal is improving educational outcomes for these students. [https://www.healassociation.org/]

HopeCam. HopeCam uses technology to help children in Pre-K to 12th grade stay connected to their classmates. HopeCam works with both the family and school to make sure all necessary technology elements are provided. [www.hopercam.org]

KidsHealth. This is an extensive website with age-appropriate information for children, teens, and parents to learn about many different medical conditions and health issues. [www.kidshealth.org]

LearnWell. LearnWell works with hospitals and school districts to facilitate academic instruction for children who have a prolonged absence from school due to health concerns. [https://learnwelleducation.com/]

LIVESTRONG at School. These are age-appropriate lessons for grades K-12 to help educators teach their students about cancer. [https://www.livestrong.org/what-we-do/program/livestrong-at-school]

Monkey in my Chair. Monkey in my Chair is an organization that helps preschool and elementary aged children with cancer stay connected to their classmates. [http://www.monkeyinmychair.org/]

National Heart, Lung, and Blood Institute. Several resources are available through this organization for supporting children with asthma in school:

Asthma and Physical Activity in the School. An easy-to-read booklet for teachers, coaches, and families who want to help students with asthma participate in sports and physical activities. [https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/asthma-and-physical-activity-school]

How Asthma-Friendly is your School? This is a two-page resource that helps determine how well a school can manage the needs of a student with asthma. [https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/how-asthma-friendly-your-school]


Returning to School after Cancer Treatment. The American Cancer Society shares helpful information for parents/caregivers about their child’s return to school after a cancer diagnosis. [https://www.cancer.org/treatment/children-and-cancer/when-your-child-has-cancer/after-treatment/returning-to-school.html]

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Specialized Resources: School Re-entry with a Chronic Illness


- **Sickle Cell Disease: A Practical Guide for Teachers.** This resource provides an easy-to-understand overview of sickle cell disease for educators. [https://www.aboutkidshealth.ca/Article?contentid=652&language=English](https://www.aboutkidshealth.ca/Article?contentid=652&language=English)

**IEPs and 504 Plans:** This section includes helpful websites that provide information on the laws that require schools to meet the individualized learning needs of children who have special needs and/or disabilities.

  This article gives an overview of the civil rights law Section 504 and answers basic questions about its implementation in school settings.

- **Understood.** Understood is an organization that offers support to parents of children with learning and attention issues. Their website provides many helpful resources, including the following:
  - **Learning about IEPs.** This article explains IEPs, which are individualized programs and written plans for children with special education needs in school settings. IEPs are required under the special education law, the Individuals with Disabilities Education Act (IDEA). [https://www.understood.org/en/school-learning/special-services/ieps/what-is-an-iep](https://www.understood.org/en/school-learning/special-services/ieps/what-is-an-iep)
  - **The Difference between IEPs and 504 Plans.** This chart provides an overview of the similarities and differences between IEPs and 504 plans, both of which offer formal help for children in Grades K-12 who have individualized learning needs. [https://www.understood.org/en/school-learning/special-services/504-plan/the-difference-between-ieps-and-504-plans](https://www.understood.org/en/school-learning/special-services/504-plan/the-difference-between-ieps-and-504-plans)

**Child Life/Professional Resources:** The following resources are for child life professionals who support the importance of thoughtful, individualized planning for children attending school with a chronic illness.

  This article explores the effectiveness of interventions for children re-entering school with a chronic condition, specifically looking at efforts to increase knowledge of teachers and peers and encouraging positive attitudes towards children with chronic illnesses.

  This study shares responses from children with cancer and their guardians about their school re-entry experiences.

  This is a literature review, completed by a multidisciplinary team, about school re-entry support for children and adolescents with cancer.

  This article in the *Child Life Council Bulletin* outlines the ways child life specialists can support children and families as they navigate their child's schooling while in the hospital and deal with a diagnosis or illness.

Liz Anderson has been a child life specialist for 9 years, working with a variety of populations. She currently lives in Huntsville, AL. Liz previously worked with several different chronic care populations, including oncology, hematology, gastroenterology, and endocrinology, and has experience helping children within these populations navigate school while dealing with their chronic illness. She can be reached at andersone0813@gmail.com.
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PATHWAYS TO PROFESSIONAL INQUIRY
Locating, Navigating, and Evaluating Empirical Literature

This is the second article in a three-part series about finding and utilizing journal articles in your child life practice.

Navigating the Different Types of Empirical Literature

By Megan Cassani, MA, CCLS, CIMI
RANKEN JORDAN PEDIATRIC BRIDGE HOSPITAL, MARYLAND HEIGHTS, MO

The first article in this series, “Just Like Where’s Waldo: The Search for Journal Articles,” was published in the Summer 2019 issue of ACLP Bulletin and addressed the steps involved in searching for and locating journal articles (Barnhart, 2019). Once you have put in the work and found the journal article you have been searching for, you may be wondering what comes next.

Before beginning to read, start by identifying what type of article you are reading. There are several types of articles, including literature reviews, case studies, program descriptions, and empirical research. This article will focus on empirical research, of which there are two types: quantitative and qualitative. Both quantitative and qualitative articles have an abstract, introduction, literature review, methods, results, and discussion sections (University Libraries at Rider University, 2019). The first step as you read is to look at the abstract at the beginning of the article. Typically, the abstract includes the topic of study, a summarizing statement about the literature review, the aim of study, a summary of the methods and participants, and a brief discussion of the findings. Following the abstract, the introduction sets the tone for the rest of the paper and aims to explain why the current study is taking place.

The literature review outlines the studies that have already been conducted with similar populations or in the same environment with the purpose of providing the rationale for undertaking the current study. The methods section explains the research protocol, and you can determine whether the article is qualitative or quantitative by examining the research design, participants, data collection, and analysis (Povilaitis, 2017).

Quantitative Research
Quantitative research is objective and scientific. It aims to test a hypothesis and emphasizes measurement and data collection to explain and predict behavior. The hypothesis typically aspires to answer questions that address how often, to what extent, how much, why, how, or in which way something happens. The goal of the hypothesis is to predict the outcome of the study or predict a relationship between two variables based on an educated guess or formal theory (Wittenberg, Barnhart, and Cassani, 2019).

Research Design
There are four types of quantitative research designs: descriptive, correlational, quasi-experimental, and experimental. The difference between the designs relates to the amount of control the researcher has over the variables. Descriptive and correlational designs do not control variables; a descriptive design is intended to record observations of “what is,” while correlational designs explore and observe relationships among variables (Center for Innovation in Research and Teaching, n.d.). On the other hand, quasi-experimental and experimental designs have an intervention applied. Quasi-experimental designs attempt to test for causality with some variable control; however, the element of randomization may not be present. For example, half of a clinical floor may be given an intervention, such as medical play post-procedure, while the other half of the floor is provided regular treatment. Experimental designs test for causality with maximum variable control where the independent variable is manipulated. For example, research employing an experimental design may randomly assign patients to the intervention group (medical play post-procedure) or the control group (regular treatment; Center for Innovation in Research and Teaching, n.d.).

Participants
In quantitative research, the researcher’s goal is to remain as objective as possible, so that the results can be generalizable to the population of participants. Typically, quantitative research has a large number of participants to ensure enough statistical power to confirm that the outcome can be attributed to
the intervention. Optimally, participants are selected to be a representative sample, mirroring the larger population from which the sample was drawn (Patten & Newhart, 2018).

Data Collection
Data collection in quantitative research most often utilizes standardized data collection instruments and procedures that have been found to be valid and reliable (Patten & Newhart, 2018).

Analysis
Quantitative research analysis is entirely statistical in nature. Descriptive statistics (e.g., averages, standard deviations) may be used to describe the sample, and inferential statistics (e.g., t-tests, analysis of variance) are used to compare groups (Patten & Newhart, 2018).

Qualitative Research
Qualitative research is subjective and phenomenological. Typically, qualitative research is not undertaken to support a particular hypothesis and is not generalizable. The goal of qualitative research is to answer questions about why people behave the way they do, how opinions and attitudes are formed, how people are affected by the events that go on around them, how and why cultures have developed, or to note the differences between social groups (Wittenberg, Barnhart, and Cassani, 2019).

Research Design
There are four types of qualitative research designs: phenomenology, ethnography, grounded theory, and case study. Phenomenology aims to describe something that exists as part of the world; it may not provide definite explanations about the phenomenon, but raises awareness and increases insight (Holloway, 2005). Ethnography is the study of cultures and groups of people from within; the researcher describes the culture/group from the point of view of a group member (Patten & Newhart, 2018). Grounded theory is a method of data exploration that can lead to theories of behavior: Typically without previous assumptions, data is examined for patterns that can be developed into theories that are grounded in the data (Patten & Newhart, 2018). A case study is an in-depth analysis of a single or small number of subjects on a phenomenon of interest (Wittenberg, Barnhart, and Cassani, 2019).

Participants
Differing from quantitative research, qualitative researchers work to become immersed with their setting and participants. Sample size is typically small and depends on the number of participants required to fully explore all elements important to the study. Participants are selected for their ability to best inform the research question and enhance understanding of the phenomenon (Sargeant, 2012).

Data Collection
Data collection in qualitative research typically includes formal and informal interviews and observations. A common approach in qualitative research is utilizing semi-structured interviews, which ensure the collection of data in key areas while allowing flexibility for participants to bring their own perspective (Sargeant, 2012).

Analysis
In qualitative research, analysis typically occurs concurrently with data collection. This allows researchers to identify new and existing themes that require further exploration. Unlike with quantitative data, analysis is partially subjective and could vary from researcher to researcher (Sargeant, 2012). Rigorous analytic protocols have been developed to promote objectivity in qualitative research (Sargeant, 2012).

As the number of research articles that are relevant to the field of child life increases, it is not only important to be able to find and understand the articles, it is important to evaluate and make use of the information provided. Stay tuned for the final article in the three-part series about evaluating research articles!

REFERENCES


Kristine Angoff: An Early Leader in Hospital Play Programs

Andrea Colliton, MS, CCLS
THE FLOATING HOSPITAL FOR CHILDREN AT TUFTS MEDICAL CENTER, BOSTON, MA

Documenting the history of play in the lives of hospitalized children would be incomplete without recognition of the significant contributions that were made by Kristine Angoff of the Boston Floating Hospital for Children from the 1940s into the 1980s. Kris was one of the founding playroom teachers in the United States and made important contributions to the creation of the child life profession. Today, the role of the child life specialist is grounded in much of the evidence-based practice that was established in the work outlined by Kris Angoff.

Kris’s career started off in the 1940s in the field of education. With a significant love for children and a strong value in play, she was hired as the first playroom teacher and play program coordinator for the newly created psychiatric services at the Boston Floating Hospital for Children (FHC) in September of 1948. The play program was developed through the psychiatry department that was established at FHC in 1947 in order to minimize the trauma placed on all hospitalized children (Tisza & Angoff, 1956). Kris worked very closely with child psychiatrist Dr. Veronica Tisza, who led the psychiatry department at FHC. This collaboration resulted in the expansion of the play program for hospitalized children, as well as the publications of two educational articles published in the journal Pediatrics in 1956 and 1961.

Before there was extensive research surrounding children and hospitalization, Kris worked tirelessly to support the psychosocial and emotional well-being of children by promoting developmentally-appropriate play. The key functions of the play program were to reduce fear of hospitalization, to use the experiences that occurred within the hospital to help educate children, to look more closely at the effects of psychosocial and emotional factors in the illnesses of childhood, and to identify and treat the physical, mental, and emotional needs of the whole child (Tisza & Angoff, 1956). The play program was incorporated into the daily routine of the patients’ hospital stay Monday through Saturday.

Kris and her team would manage the playroom and visit children at their bedsides to provide them with developmentally-appropriate play materials, build therapeutic relationships, and assess their level of anxiety (Tisza & Angoff, 1956). The playroom was used as a location where children could express themselves through play and gain back some control within a very unpredictable environment. Kris specifically made sure that the playroom was viewed by all as a safe place for children and that no medical interventions were allowed to occur in this space (Prinz & Van Schaik, 2012). The children would eat their lunch all together in the playroom to promote routine and normalcy, and Kris would also bring the children outside for fresh air and play sessions on the rooftop terrace during the warmer summer months.

Kris was an early advocate of the need for socialization while hospitalized. At that time, families were only allowed to see their children during the designated visiting hours; therefore, additional social interaction became a necessity.
To encourage peer interaction, children would be gathered together in the playroom in the hope of reducing the likelihood of long-term distress (Tisza & Angoff, 1961). Kris also believed that children needed to interact with “mother like” figures, and advocated for more support, hiring and supervising additional paid playroom teachers. She developed a staff educational program and oversaw students from nursing and teaching colleges.

All of the information Kris was able to gather from her interactions and observations of specific children were found to be very significant to the medical team. She would chart on patients and write daily notes that described their individual mood and behavior, and would note her recommendations for further support. Kris encouraged families, physicians, and nurses to observe and interact with the children at play in order to be able to evaluate how they were coping with their illness (Tisza & Angoff, 1956). The playroom even had a one-way mirror built in for observation purposes. Kris would pay special attention to those children who seemed significantly withdrawn and would prioritize her time accordingly. She truly cared about the well-being of hospitalized children and advocated for them to have as many positive experiences as possible through sight, smell, sound, touch, and human contact in order to have a positive impact on their emotional and mental outlook about their experience (Tisza & Angoff, 1961).

For nearly 40 years, Kris worked as the director of the FHC play program before retiring in October of 1987. She made significant contributions not only to the world of child psychiatry and child life, but she also functioned as a key member of the interdisciplinary team at FHC. She collaborated with members of the organization to design new updates to the hospital environment, creating additional child-friendly spaces throughout the organization, and she organized celebrations for significant holidays and children’s birthdays. Kris was able to collaborate with the psychiatry department and work on research, write professional papers, and ultimately improve the quality of care for the hospitalized child. She was viewed as a creative and energetic leader who placed significant value in the healing power of play.

Even though a great deal of the work Kris did with hospitalized children seems very typical of current child life programs, during her time it was considered revolutionary. The child life profession would not be what it is today if it was not for innovators and pioneers such as Kris Angoff, one of our founding “play ladies.” Kris passed away in 2003 at the age of 86; however, her legacy still lives on far beyond the walls of FHC.

**REFERENCES**


ACLP Calendar

OCTOBER

18  Deadline to submit your coursework documents for review in time to register for the November Child Life Professional Certification Exam

27  Deadline to register for the November administration of the Child Life Professional Certification Exam

31  2019 International Scholarship applications due

31  Deadline to apply to recertify through PDUs

NOVEMBER

1-15  Child Life Professional Certification Exam administration testing window

  1  Research Award applications available

  15  Applications due for 2020 winter/spring Diversity Scholarships

DECEMBER

20  Deadline to submit transcripts and other documentation in time to apply for the 2020 Summer Internship

31  Last day to reinstate lapsed CCLS credential

JANUARY

Start planning your Child Life Month events and activities for March!

1-31  Call for Innovators for the Innovation Fair at the 2020 Annual Conference

  1  Submission deadline for ACLP Bulletin for consideration in the Spring 2020 issue

  5  Application deadline for the 2020 Summer Internship

  31  Deadline to pay 2020 certification maintenance fees

Upcoming Events

OCTOBER 11-12
Mountain West Child Life Association — Annual Conference
Visit the Mountain West Child Life Association website for more information.

OCTOBER 21
New England Child Life Professionals (NECLP) — Annual Conference
Visit the NECLP website for more information.

OCTOBER 25-27
California Association for Child Life Professionals (CACLP) — 15th Annual Conference
Visit the CACLP website for more information.

OCTOBER 26
Texas Association of Child Life Professionals — 3rd Annual Conference
Visit the TACLP website for more information.

NOVEMBER 2
Great Lakes Association of Child Life Professionals (GLACLCP) — 14th Annual Conference
Visit the GLACLCP website for more information.

NOVEMBER 9-10
24th Annual Midwest Child Life Conference
Visit the Midwest Child Life Association website page for more information.

NOVEMBER 12
Child Life of Greater New York (CLGNY) — Annual Conference
Visit the CLGNY website for more information.
Webinars

The 2019 webinar programming is wrapping up, but there are still opportunities to join some exciting sessions in the coming months. Visit ACLP’s learning management system (LMS) to learn more about the offerings for the rest of the year, and keep an eye out for the 2020 lineup, which will be posted soon.

If you haven’t attended a webinar since we launched the LMS, we think you’ll be excited by the customization and flexibility it provides. The search functions allow you to hone in on presentations by domain, level, and topic. Webinar handouts and resources are easy to access, and the recording of any webinar you purchase is available in the LMS for one year for you to access at any time. Whether you’re an emerging professional who is new to the field, or an established professional who wants to stay sharp, our exciting webinar programming has something for you.

MONDAY, OCTOBER 14
A Call for Culture Change and Re-Prioritization of Our Most Vulnerable Patient: Establishing Neurodevelopmental Protection for the Neonate
This webinar is intended for emerging professionals with 0-7 years of experience.

MONDAY, OCTOBER 21
Ethical Concerns Regarding Diagnosis Disclosure: A Case Study Discussion
This webinar is intended for established professionals with 7+ years of experience.

MONDAY, NOVEMBER 4
Process Improvements: Applying “Elf” Teamwork to Manage Holiday Donations
This webinar is intended for emerging professionals with 0-7 years of experience.

MONDAY, DECEMBER 9
Supporting Patients, Families, and Staff at End of Life: A Framework for Success
This webinar is intended for emerging professionals with 0-7 years of experience.

WEDNESDAY, DECEMBER 11
Efficient Inquiry: Painless Research Methods for Busy Clinicians
This webinar is intended for established professionals with 7+ years of experience.

Your passion for professional development drives our programming. Please help us continue to provide high-quality, relevant programming by sharing your expertise and facilitating a webinar. If you have an idea for a webinar, please visit ACLP’s webinar proposals page to provide us with information about your presentation. In addition to the satisfaction that comes from sharing your passion, presenters earn 2 PDUs per hour of presenting. We look forward to partnering with you as a facilitator!
This new journal, with more robust research content, will be an outgrowth of Focus, which will no longer be a part of ACLP Bulletin in 2020. The editors of The Journal of Child Life: Psychosocial Theory and Practice are seeking the following types of articles:

- Quantitative research
- Qualitative research
- Program development, with pre- and post-implementation data
- Substantive, systemic literature reviews
- Analysis of theory as applied to child life

See Submission Guidelines & Instructions on the ACLP website.

Look for more exciting updates as we roll out The Journal of Child Life: Psychosocial Theory and Practice!

www.childlife.org