Susan Marchant Honored with 2015 Distinguished Service Award

Bindy Sweett, CCLS

Long before being selected by the Child Life Council Board of Directors as the 2015 Distinguished Service Award winner for her contributions during her 40 years in child life, Susan Marchant, MA, CCLS, began her career search. Her father was an ophthalmologist, exposing her to the world of medicine, where she felt she had an interest. However, tempered by a feeling that what she really wanted to do was to support the emotions of those who were receiving medical treatment, Susan did not commit to medicine. At the University of California at Berkeley, she double majored in psychology and child development, graduating with a BA in both subjects. More importantly, there Susan discovered the concepts of a new program of study. When she heard about child life, she knew it was what she had been searching for.

Entering a graduate program at Mills College, she took her first class and “was smitten,” but it was difficult to convince her parents that this unknown profession could be a viable career. Susan graduated from Mills College graduate school in 1980 with a degree in early childhood education with a concentration in child life. She feels fortunate to have been a part of the program’s first class of only seven students, and to have had the opportunity to learn under the tutelage of child life icon Evelyn “Evie” Oremland, who became one of Susan’s most important inspirations. At the time, Susan’s three pre-school children were all attending the children’s school at Mills, a lab attached to the college where her students today work as part of their training.

In the Fall 2008 issue of Bulletin, the first Child Life Alphabet column, “A is for Attitude of Science,” appeared. Since then, the series has covered everything from Kangaroo Care to Young Adults, exploring new topics in areas as diverse as direct services, research, child development, and administration. Child Life Alphabet has been a staple of the Bulletin’s front page and a popular column for readers and writers alike. We envision the next cycle through the alphabet, Alphabet 2.0, as an opportunity to reach higher and dig deeper into topics related to pediatric psychosocial care, with an emphasis on the theory and research behind each topic.

A is for AcclimAtion: Keys to relocAting for a Job and supporting those Who have

Marne Matysek, CCLS
Monroe Carell Jr. Children’s Hospital at Vanderbilt, Nashville, TN

“If you want a job, you have to be willing to move anywhere.” Variations of this phrase are uttered to students across the country, whether still in their undergraduate program or completing an internship. As we watch health care change and our field become more saturated, this phrase has been solidified as an essential truth for our job market. Once we have been confronted with this realization, how do we cope with this truth? As a new or seasoned professional who is job searching, how do you create the mindset of being willing to move across the country? And for established team members, how can you

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President’s Perspective

Strategic Planning to Shape the Future of Child Life
Carla Oliver, MSW, CCLS

With 2015 already flying by, the CLC board, volunteers, and staff have been hard at work advancing the ambitious agenda set forth for the organization in CLC’s 2012-2014 Strategic Plan, which was shared with members back in January of 2012. It seems like only yesterday that we were bringing together a dedicated and diverse group of academicians, clinicians, students, and leaders in our field, who all rolled up their sleeves to assist in the execution of a very courageous strategic plan. I feel inspired reflecting on how far we have come since those early strategic discussions in 2011.

The execution of the plan has required meticulous attention to detail and due diligence on the part of many. Over the past few years, our committees and task forces have dedicated countless hours to this collective undertaking, leaving no stone unturned as they engaged in research, benchmarking, and thoughtful discussion to develop the recommendations that have helped us to realize many of the goals outlined in the strategic plan. I revisited some of our major accomplishments in a recent blog in CLC Community, and while there is plenty of work left to be done, the progress we have made is truly staggering!

As I write this column, we are in the final stages of preparation for the development of the Child Life Council’s new strategic plan, with our first strategic planning session scheduled in late March, followed by a second session set to take place in May, right before CLC’s Annual Conference on Professional Issues in Cincinnati.

With the guidance of Jon Hockman, a certified facilitator from d3 Group who worked with CLC during our last Strategic Planning process, a group of child life leaders will come together for Phase 1 of building the strategic plan. The group will consist of the current board, several CLC staff members, and volunteers Janet Cross (chair, Health Care Task Force), Cathy Humphries (co-chair, Graduate Accreditation Task Force), and Nancy Ramhap (chair, Child Life Certifying Committee). Over the course of two days, we will discuss where we’ll continue the direction set forth for the organization in the 2012-2014 strategic plan, as well as potential new directions. High-level thoughts and themes that will help to steer that conversation will include:

• What do we want to be in 2025, as an organization and a profession?
• How will we stay highly relevant?
• What creative roles for child life specialists are out there that we haven’t tapped?
• How will we continue to gain credibility and be seen as the experts?
• What resources (financial, people) will be needed to carry out the goals?

Leading up to the first strategic planning meeting, we worked diligently to gather input to help inform the process. During last year’s Annual Child Life Directors Networking Retreat in Scottsdale, AZ, we held a session seeking feedback from program leaders, and earlier this year, each member of the board reached out with similar questions to three randomly-selected CLC members representing a diversity of experience, location, and program size. We’ve also sought feedback on these questions from CLC committee and task force chairs and members of the Canadian Association of Child Life Leaders, continued on next page
Your New Electronic Bulletin: A Prep Book

The Child Life Council and the Bulletin editorial team are proud to introduce the new electronic version of our CLC publications. In response to CLC member surveys, which have shown that a significant portion of our membership prefers the ability to access Bulletin and Focus digitally, we have partnered with Graphcom to make child life publications available in a new, enhanced way. This robust format allows for us to provide full color images, live web links, easy navigation, and additional space for stimulating and valuable articles. In addition to being able to read Bulletin on a computer, tablet, or phone, it’s easy to print the entire issue or selected articles for “hands on” reading or sharing, or download the full issue as a PDF to your computer.

If you haven’t found it yet, one of the first tools you may want to access is the slide bar on the very right side of the screen. Moving this up will magnify the page, making it easy to read on any size screen. We invite you to take a few minutes to explore the navigation buttons across the top of the screen. At the center, you’ll find a box that will show where you are in the issue (or allow you to quickly move to a new location), and on both sides of that, arrows that will move you through the issue. Left of that, you’ll find buttons that will take you to archived issues of Bulletin (new online issues; previous print issues can still be found on the CLC website), provide you with thumbnails of all pages, a table of contents or a list of advertisers, or change your view. To the right, you’ll find the tools that will allow you to zoom, search, share, print, add sticky notes to pages, or flag articles as favorites. And moving to the very right side, there are buttons to get help, change your settings, or access text copies of individual articles. A few of the more commonly used tools are repeated down the right side of the screen for easy access.

We hope you’ll enjoy reading and exploring Bulletin in the new format. As always, if you have any questions or suggestions, feel free to email the Bulletin editorial team at bulletin@childlife.org.

President’s Perspective continued from previous page

and have had many conversations with individual child life specialists at conferences, over email, and on the phone. I would like to thank each and every member who has given thought, time, and ideas to our process.

Once the initial discussions have concluded at the March planning session, the second and final phase of the process will take place in May in Cincinnati. This phase will include all of the representatives from Phase 1, as well as all of the newly-elected board members who will be helping to implement the plan once it is introduced later this year.

I feel so fortunate to have been a part of developing the plan in 2011, and to now participate in leading the plan for 2015. Simultaneous to this planning process, I am also a member of the Operational Excellence Committee at my own organization, working on the strategic planning process there. Through these experiences, I have learned what I consider to be the key ingredients to strategic thinking and the process of planning:

• **True open-mindedness.** This means leaving negativity and skepticism behind. There is no room for attitudes and thoughts such as “That won’t work,” or “We’ve tried that before.” If we enter into the planning process with a mindset that we are open to new things and others’ thoughts and ideas rather than coming in with an agenda, our potential for boundless creativity is infinite.

• **Honesty.** There is no room for groupthink when planning strategy. It is important that all members of the group feel safe speaking their minds, disagreeing with others’ ideas, and admitting when they make mistakes.

• **Having a 30,000-foot view.** In CLC’s strategic planning process, we have to look at options that will ultimately advance the profession as a whole, which means not bringing a “what’s best for me and/or my program” perspective into the process. Of course, this can be easier said than done, but I have witnessed a number of task force members demonstrating such selflessness as they work to implement elevated standards. While moving forward may ultimately change or end their current programs, they know it’s what is best to advance our field. It is this kind of complete commitment to the greater good that moves us to become better.

Put quite simply, the bottom line of any strategic plan is to “win.” We want to come out of this process with a bold plan that is focused on what is truly best for the child life profession. That said, while change and new initiatives can be exciting, they can also be challenging, scary, and many times they force us way beyond our comfort zones. Knowing this, we are committed to providing timely communications to members as the plan is introduced and the work begins.

I really look forward to seeing the next great leaps forward that we will be making as a result of the new strategic plan. I hope that you feel inspired as a member to assist us with seeing our strategic plan flourish. Please consider sharing your thoughts and ideas with us by contacting strategyplanning@childlife.org, or participating in the work of implementing the plan by volunteering to join a committee or task force. 🌟
Reflecting Forward

Jessika C. Boles, MEd, CCLS

This winter, my father finally retired from his thirty-year tenure with a large oil and gas company in west Texas. In true Morris family fashion, he and my mother decided to return to nature, renting an old farm in a rural valley in Montana and taking up new hobbies like organic sustenance gardening, making reclaimed-wood furniture, and preparing for rainbow trout season. Finally, they are living the life they had always dreamed for themselves – it’s just thousands of miles away from me (in Tennessee) and my brother (in Connecticut).

To prepare for this monumental psychological shift into retirement and physical relocation to the great cold north, my mom began cleaning out the home in which they had spent the past eighteen years. As a result, I received weekly deliveries of giant cardboard boxes filled with treasures and keepsakes from my youth. Some of these I remembered saving, others I knew my parents had chosen to hold on to for some sort of sentimental value.

For my mother, this pre-spring cleaning was a time of great joy; each package that left her house (whether destined for the mail or the dumpster) represented a cleansing of the soul, a severing of ties to the Texas town she had been waiting to leave for years. For me, each box that crossed my home’s threshold immediately went to an unused corner of the guest bedroom…where the pile grew, and waited for me to find the mental and physical energy to sort through my life’s worth of contents. I knew there were old books, handmade toys and dolls left to me by my grandmother, finger paintings I made in kindergarten, a comprehensive binder of my softball pitching and batting statistics (covering my career from T-ball through college – thanks Dad!), and handwritten notes from classmates I am no longer in touch with. What do you do with twenty-eight years of memories in a corner full of boxes? Needless to say, I have a very different outlook on spring cleaning than my mother!

Some of you may currently be reveling in the possibilities of spring, embracing new beginnings, thinking about the future, preparing for positive change. I, on the other hand, look at spring as a time of conscious reflection. My winter is usually full of things to do, and 
doing
d keeps me from really sitting down to process my thoughts and feelings on the previous year. As a result, I have stared at the boxes in my guest bedroom for weeks, and have just now slowly started to excavate the contents. Mostly I get distracted by the memories, and then disabled by the anxiety that comes with throwing any of them away.

Beyond my personal struggle with my inherited archive, clinically, my physical desk space is full of reminders from the past year. There are two paper cranes entangled in front of my keyboard that tell the story of a young man I recently worked with as his brother was dying in our hospital. Over the winter months, he spent many hours processing with me his thoughts on life, death, and everything between. These particular cranes were folded late one afternoon as his brother continued to decline, and he shared that “Twenty years from now, if I live that long, this is what I want to remember when I think of this place.” Those cranes and that moment made me better at what I do, and better at who I am.

Hanging on the bulletin board above my computer monitor is a large butterfly decorated with colored bits of balled up tissue paper; its blue wings remind me of a boy with hair just the same color, a boy who communicated in song. I still think of him every time I hear Death Cab for Cutie’s song, “I Will Follow You into the Dark,” and I see him as he played it on the guitar for me one of the first times I met him. All I did in that moment was sing along, breaking through my own stage fright, and crumbling down the protective walls he had built around his thoughts and feelings. That song and that moment...
made me better at what I do, and better at who I am.

Finally, there is a blue half-sheet sticky note on the bottom right corner of my computer monitor emblazoned with the number “149.” One hundred and forty-nine is the number of patients whose legacies I now carry with me in the work that I do every day. There are 149 stories I could tell, 149 sets of unique memories, but every once in a while, much like in this column, “some stories insist on being told” (Ellis, 2004; p. 32). Should this number continue to rise, I will still find that those stories and those memories make me better at what I do, and better at who I am.

As you can tell by this new, all-digital issue of Bulletin and Focus, some has changed, but much has remained the same. You may recognize some of the same logos, layouts, issue organization, and familiar recurring columns. Given the historical value of Bulletin, it was one of our primary goals to carry on the decades of work before us by paying homage to those who helped the publication get where it is today. As the child life profession and Bulletin move ever forward, we take a moment to acknowledge and appreciate the foundations of our past in a new feature, “Moments From the Past,” on the back cover. In addition, we have re-envisioned our previous Alphabet column to bring you a new Alphabet 2.0 – a series of articles that will dive deeper into the foundational, theoretical, professional, and ethical issues we all face as child life practitioners, administrators, educators, and students. Be on the lookout for new columns to debut in this issue and issues to come that will provide specialized resources for those working with particular patient populations or conditions, explore pathways to evidence-based practice for child life specialists, and highlight global perspectives on the provision of psychosocial care for children in hospitals. Our hope is to continue to provide thought-provoking, conversation-stimulating, and practice-enhancing articles that will promote professional growth and reflection for all involved in child life. We aim to offer a variety of avenues for authors and readers to explore these issues in a digital format that affords more connectivity, multimedia capability, and a more personalized delivery technique.

Fear not – the future is upon us! But it is here with a focus on the present, and a reverence for the past. We hope that you will enjoy learning and growing with us as we create a (digital) legacy for future generations of child life professionals!

References

Milestones
After nearly 35 years of teaching at Utica College, Melodee Moltman, MS Ed, CCLS, has recently retired. Melodee did her clinical work in rehabilitation at Carrie Tingley Hospital in New Mexico, and then was hired at Utica College as an assistant professor. During her years at Utica, Melodee’s roles have varied from that of internship coordinator to chair of the department. Melodee coordinated the “Wheelock Child Life in London” program three times. Melodee has been very involved in spreading the word on child life internationally. In 1990, she presented a paper on child life in Beijing, China, at the first Sino-American Women’s conference. In 1997 and 1998, she consulted in Kuwait, and during a sabbatical year in 2003, she taught child life at the Kuwait Association for Care of Children in Hospital and Kuwait University. In 2011, she was an invited speaker at a symposium for the support of children with childhood cancer and blood disorders in Riyadh, Kingdom of Saudi Arabia. Melodee intends to continue her advocacy for child life into retirement, both within CLC and in her community.
Bereavement Support in the Emergency Department: Learning From Our Psychosocial Disaster Plan

Katie Nees, CCLS, MSHS  
Sarah Braukman, BA, CCLS  
Emily Smith, MA, CCLS  
Cincinnati Children’s Hospital Medical Center,  
Cincinnati, OH

Time of death, 8:18pm.
Within 10 minutes, a security officer has been punched by a family member of the deceased, who was then escorted away from the trauma bay. The mother of the patient is on the floor, unable to physically stand or speak. As the next hour goes by, the number of family and friends arriving at our hospital’s emergency department grows to around 40. Later, the stained glass window in the chapel is broken by a grieving family member, and the crowd has spilled out into the main concourse of the hospital, making it difficult for staff and other patients to move through the halls. There are family members sobbing as they try to comfort one another. Children are sitting on the floor, some watching the commotion, and others coloring. Security is giving a final warning to the violent offenders that the police will force them to leave the premises if their unacceptable behavior continues.

Time of death is the moment when medical interventions stop, but the work of the child life specialist and psychosocial support team kick into higher gear. In the Emergency Department (ED) at Cincinnati Children’s Hospital Medical Center (CCHMC), we handle many traumatic and unexpected deaths. We have a solid psychosocial support team, but still struggle with post-death situations similar to the scenario depicted above. This is the type of situation where the needs of the family and the number of visitors start to outweigh the capabilities of our clinicians, and even the structural environment itself. We struggle as a team to maintain safety and comfort for all patients, families, and staff, while also sensitively supporting grieving family and friends. This situation is hardly unique to our ED, as Isaacs (2013) reports: “Family members may react to news of death in different ways, with calm or hysteria, shock, anger, disbelieving, numbness, crying, or even with violence” (para. 34).

As members of the CCHMC child life team within the ED and Level I Trauma Center, we initiated the formation of a disaster plan centered on our ED psychosocial team, which includes social work, pastoral care, and child life. The initial goal was to have a formalized process of role delineation and communication for mass casualty events in which our hospital might experience an influx of patients and their loved ones. However, through the course of these discussions, the ED child life team began to identify that a disaster plan of this type can and should apply to any situation that exceeds our capabilities. In other words, a single traumatic death may still lead to a situation where our ED psychosocial team disaster plan might come into play, and developing a formal policy about the roles of our team members in such a scenario could help prevent escalation of an out-of-control situation (Isaacs, 2013; Sacchetti, Paston, & Carraccio, 2005).

With all of this in mind, we expanded our goal to create a psychosocial disaster plan that would assist with the management of large crowds in the ED, regardless of whether it was a situation of mass casualty or the more commonly experienced single-patient death with a large influx of family members. We determined early in the process that in order for a true psychosocial disaster response plan to be effective, we would also need to include other disciplines such as counseling services, the Family Resource Center, interpreter services, and security. Building on the solid psychosocial support structure already in existence, we identified components in need of additional resources, including space allocation to accommodate large crowds and a greater understanding of how each individual discipline’s role could be maximized to promote safety for visitors and staff while allowing for necessary privacy and grief.

This psychosocial disaster plan details vital processes specific to large-scale disasters such as patient identification and parent reunification, but also includes processes for family support that can be utilized in both large scale disasters and situations
Involving one death. These processes are centered on communication as the key factor in psychosocial support during these events and a plan to sensitively address needs in a way that ensures the safety of staff and visitors. In the past, after a family learned of their child’s death in the trauma bay, they often filled spaces like the ED waiting area, displaying intense grief reactions in front of other patients and families. This was largely due to staff not putting a plan in place ahead of time to take family members other than those in the trauma bay to the designated private space immediately upon arrival.

Initial and ongoing communication was identified as a key component to sensitively supporting grieving family and friends while maintaining safety. This communication begins with a brief psychosocial team huddle to allocate roles and verbally set in motion specific action steps. The action steps include the following:

• Determine one or two primary caregivers within the family and, with their assistance, identify four additional family members as Group 1. Patient’s siblings are added to this group.
• Identify a private room for Group 1, and have a member of the psychosocial support team escort them to this room and remain with them as a consistent supportive presence.
• All other family and friends who arrive are considered to be a part of Group 2.
• Identify a space, such as a main concourse waiting area, for Group 2, and alert personnel at all entrances to direct additional Group 2 people who arrive to this location. An identified member of the psychosocial support team should communicate with this group early on that they will not be able to view the body and encourage them to find an alternative location to gather and support one another.

The psychosocial team members are split between Group 1 and Group 2, providing necessary support. More specifically, Group 1 is accompanied by a chaplain and a child life specialist who provide bereavement support, visits with the body, and an opportunity for memory making, if appropriate. Group 2 is assigned security personnel for safety and a social worker to provide empathic support, updates, and appropriate and clear information on boundaries and suitable behavior while within the hospital. Each member of the ED psychosocial team, including security, continue close communication via the hospital-based mobile phone system, updating each other on changes and/or additional needs.

For any plan to be successful, the entire team needs to be on the same page. With a psychosocial team comprised of rotating chaplains and social workers, it was initially difficult to ensure that everyone both understood and supported the new expectations regarding family presence following traumatic death. The huddle became even more crucial in establishing this continuity, with the ED-housed child life staff taking leadership in this initiative. Clear expectations for families as well as for support staff need to be laid out from the beginning so that there is no room left for individual interpretation.

Education on bereavement and disaster plans and the importance of unified psychosocial triage are proving to be an ongoing initiative to ensure the best chance of success for this new approach to care. We know that our institution can never be 100% prepared for what comes through the ED doors, but we have learned a lot through navigating this process of preparing for the unpredictable.

As we strive to create safety in bereavement situations, our practice and decisions are guided by the principles outlined in CCHMC’s “Mourner’s Rights.”

References
Writing the Child Life Diversity Statement

Sarah Beth Gray, CCLS
Monroe Carell Jr. Children’s Hospital at Vanderbilt, Nashville, TN
Nikki Orkoskey, MA, CCLS
Cincinnati Children’s Hospital Medical Center, Cincinnati, OH

“Diversity is the one true thing we all have in common. Celebrate it every day.”

— Author Unknown

Diversity can be defined as the condition of being composed of distinct elements or qualities (Merriam-Webster, 1998). A diverse organization is one that values differences in gender, age, race, sexual orientation, physical ability, and ethnicity. According to Simma Lieberman, a diversity and inclusion consultant, a diverse organization is one that recognizes that people with different points of view, backgrounds, and experiences contribute unique perspectives that benefit the organization as a whole and the people it serves (Lieberman, n.d.).

The Child Life Council recognizes the importance of creating an inclusive culture where people’s differences are appreciated and utilized towards a common goal. It is important for an organization such as the CLC that supports a profession whose workforce is primarily Caucasian females to make efforts to attract and promote the hiring of a more diverse group of professionals. A diverse child life workforce can enhance the quality of services provided to the diverse groups of people it serves and ensure that a variety of thoughts and skills are part of the profession’s decision-making.

The diversity task force, consisting of child life professionals and a student representing different races, genders, sexual orientations, ages, physical abilities, and ethnicities, was created in early 2012. The task force formed when the CLC Board of Directors aimed to improve membership services. The Board noticed a need to advance diversity initiatives which included developing and implementing a plan to be more proactive in recruiting underrepresented demographic groups into the child life profession. Developing guidelines and educational opportunities to enhance cultural sensitivity skills within the practice of Child Life was also a goal. It is within these initiatives that the Child Life Diversity Statement was born.

When creating the Diversity Statement, the task force reviewed the diversity statements of similar organizations, including the National Association of Social Workers, American Art Therapy Association, Association of Professional Chaplains, and the American Speech-Language-Hearing Association. In addition, the diversity statement from the National Soccer Coaches Association of America was used as a model.

The task force realized that it was crucial to represent all aspects of diversity and to include any and all aspects of diversity that affect child life students and professionals and the patients and families they work with. It is the hope of the task force that the Diversity Statement will put us in line with similar organizations and lead to a more diverse membership within the Child Life Council and the profession of child life.

References


Child Life Diversity Statement

The Child Life Council is committed to fostering diversity by offering a welcoming and supportive environment for its members, leadership, and the patients and families that we serve. We strive to maintain an environment that respects variations in culture, age, gender, race, ethnicity, physical ability, sexual orientation, gender identity/expression, religious affiliation, veteran status, and socioeconomic status.

Recognizing that diversity enriches the field of child life and enhances creativity and professional growth within the child life community, the Child Life Council encourages all aspects of diversity. This requires continued effort to attract and develop qualified persons of diverse backgrounds whose unique life experiences and ways of thinking foster a culture of inclusion and diverse perspective.

The Child Life Council affirms the need to attract individuals from diverse backgrounds and build on an organizational environment that values engagement, stimulates innovation, and inspires performance that leads to the advancement of its members.

Upcoming Events

September 12 - 13, 2015
Florida Association of Child Life Professionals 24th Annual FACLP Conference
Hyatt Regency, Jacksonville, FL
For information, visit: www.faclp.org
Addressing the Unique Needs of Pediatric Patients with Autism Spectrum Disorder in the Surgical Setting

Geri Sehnert, MS, CCLS
Golisano Children’s Hospital, Rochester, NY

Undergoing a surgical procedure is extremely challenging for pediatric patients with autism spectrum disorder (ASD). An unfamiliar environment, the potential for pain, and the experience of meeting countless new people in a short amount of time can all lead to psychological upset as the patient struggles to cope with a multitude of stressors. Cuvo (2011) explains that “children with autism might not comply because of the core features of autism (i.e., impairments in communication and social behavior, restricted repetitive behavior), as well as associated characteristics and comorbid disorders (e.g. intellectual disability, attention deficit-hyperactivity disorder)” (p. 382). Thus, bringing a child with ASD to the complicated hospital environment heightens the potential of behavioral challenges.

It is widely acknowledged that there are concrete and predictable ways that health care workers can address these behavioral issues so that patients with ASD can have the least stressful experience possible (e.g. Lai, Milano, Roberts, & Hooper, 2012; Seid, Sherman, & Seid, 1997; van der Walt & Moran, 2001). Courtman and Mummy (2008) found that lack of cooperation among children with special needs is usually predictable and should be addressed in advance of healthcare encounters. Therefore, this review of the research will address the most common and effective ways to help children with ASD and their families to best cope with the surgical experience, both prior to hospitalization as well as during health care delivery. Such modifications can help to reduce stress and minimize the trauma of the experience. Training pediatric health care workers on these interventions and techniques can increase knowledge and competence and offer specific strategies that will improve the level of care that pediatric patients with ASD receive in the surgical environment.

Pre-Hospitalization Modifications

Pre-Operative Tour and Teaching

A successful surgical experience begins before the child comes to the hospital on the day of the operation. Because the potential for the lack of cooperation in children with ASD is fairly predictable, early communication with families, by phone or in person, can be helpful in establishing the hospital’s commitment to meeting the challenging needs of these patients (Muskat et al., 2014). Most researchers agree that it is helpful to create an individualized and clear plan of care before the day of surgery (Hagglof, 1999; Muskat et al., 2014; Karam & Barakat, 2011; Lai et al., 2012; Seid et al., 1997; van der Walt & Moran, 2001). Courtman and Mummy (2008) agree that contact with caregivers prior to admission is beneficial. They state that the severity of the child’s autism and expected behaviors can be determined in advance in a discussion with caregivers. Creating a high risk profile helps doctors to document patients’ behavioral patterns, aggression and violence, sources of anxiety, and likes and dislikes. This profile can be shared with health care providers and become an action plan for use on the day of surgery.

Role Play

Hagglof (1999) found that providing opportunities for typically developing preschool age patients to role play and identify misconceptions pre-operatively helped lessen the psychological discomfort after surgery. In a study of typically developing children going to the hospital for surgery conducted by Fincher, Shaw, and Ramelet, (2012) participants viewed photos of what to expect during the surgical visit, role played with medical equipment, and were given a tour. Additionally, children were able to take home role play materials such as a doll, identification band, hair cap, and anesthesia mask. The authors found that pre-operative preparation reduced caregiver and patient anxiety by 20% compared with a control group who did not receive any pre-operative education.

Seid and colleagues (1997) found that children with severe autism may have varying degrees of success with pre-operative role play. If there is a high degree of impairment, the patient may become more anxious or frustrated. If it is determined by the parent and the health care worker that the child would benefit from role play with the anesthesia mask, increasing the time spent and frequency of repetitions is beneficial. Another way to potentially increase coping behavior in patients with ASD is to show a video of a child successfully undergoing a medical experience. Cuvo, Reagan, Ackerlund, Huckfeldt, and Kelly (2010) reported on a successful study in which DVDs were shown prior to a physical exam as a way of preparing the patient with ASD to perform a desired behavior.

There are many papers written on the topic of using role play as a modality in helping pediatric patients cope with the surgical process, especially in regards to the child life profession. There is a predictable contrast, though, between what is recommended for typically developing children versus those with ASD.

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Pre-Operative Contact with Families and Caregivers

One research study points to a systematic approach to pre-operative communication between caregivers and health care workers (van der Walt & Moran, 2001). Patients with ASD were identified in advance through the Autism Association of South Australia. These patients were then entered into a database that providers could access to inquire about past experiences in the hospital. Anesthesiologists were then automatically alerted that there was a patient with ASD coming in for a procedure.

A telephone interview with the caregivers elicited pertinent information such as severity of ASD, food phobias, special needs, special activities or objects, general health, social circumstances, and other information the caregivers considered important. Based on this information, the anesthesia plan was formulated and discussed with the caregivers. On the day of surgery, the operating room staff received this information so that they could minimize the families’ wait time and carry out the predetermined plan. These patients were given a private room with minimal distractions and were placed first in line on the surgical list. This practice resulted in higher satisfaction levels for caregivers and patients and the interventions in this study helped turn hospitalization into a manageable experience for these patients and families.

Children’s Medical Center at Winthrop-University Hospital in Mineola, NY, has developed Special Kids Treatment and Referral Center (the STAR program) which seeks to address the unique emotional and developmental needs of children and their families throughout an inpatient or outpatient visit, alleviating stress and providing tools to help get through the experience (Fischer, 2014). Patients and parents fill out two forms, one being an “All About Me” form, in advance of medical encounters. This information is used by child life to create a “detailed patient profile and visit experience log” (Fischer, 2014, p. 13). Parents call the STAR line in advance of a hospital visit and the child life specialist meets the family to provide the interventions indicated on the “All About Me” form. Then:

…the specialist remains with the child for the duration of the visit, employing demonstration, distraction and role playing techniques as necessary. Additionally, if the patient undergoes surgery, the specialist will stay with the child as he or she calmly falls asleep and is by the patient’s side when he or she wakes up (Fischer, 2014, p. 13).

The STAR program has received positive feedback from parents and physicians, and Fisher (2014) states that, “at its core, the STAR program is fairly simple. There is nothing revolutionary about asking a patient about his or her preferences. But these little details are sometimes overlooked, and they can be the tipping point between success and failure” (p. 13).

These programs demonstrate that pre-operative coordination for the pediatric patient with ASD and his/her family can be an important tool in meeting the child’s unique needs preoperatively, on the day of surgery, and in the post-operative period that follows.

Differential Reinforcement and Stimulus Fading

Differential reinforcement and stimulus fading involve gradually increasing exposure to a fear-evoking stimulus and then offering a reward for desirable behaviors (Shabani & Fisher, 2006). Although there is scant research on using differential reinforcement and stimulus fading for children with ASD in the surgical environment, it is worth noting one successful study as it offers insight into a methodology that can be suggested to parents and caregivers as a pre-operative method of, for instance, using a mask for anesthesia induction. Shabani and Fisher (2006) found that using stimulus fading and differential reinforcement for a patient with autism and diabetes was effective in increasing compliance with needle sticks for obtaining blood-glucose levels. Their study involved an 18-year-old boy with ASD, mental retardation, and Type 2 diabetes. Unable to obtain a blood sample for over two years, the staff successfully used differential reinforcement as a means of eliminating his typical avoidance responses (crying, screaming, elopement, self-injury, and aggression). An outline of his arm was drawn on a piece of paper. During the trial, his success was gauged by not moving his arm more than 3 centimeters from outside the outline. A favored food item was used as a reinforcement when he kept his arm still while being exposed to the lancet used for a blood draw. After completing 30 sessions of trials, he was able to successfully complete the task of a blood draw, and glucose levels were obtained. His mother reported that he was subsequently able to tolerate blood draws and measure his glucose levels with no further problems.

Differential reinforcement and stimulus fading can be another tool for use in treating needle and other phobias in children with ASD. Certainly, limitations to this approach are the availability of personnel trained in this approach as well as the potential expense incurred by the family when hiring a qualified therapist to administer the trials. Additionally, if not done in a school...
environment, the family of the child would need to make a significant time commitment to complete a successful program. One conclusion is that the benefits of this technique outweigh the limitations in certain cases. However, this approach provides a level of individualized instruction that can minimize the struggle for children with ASD who require blood draws or other medical interventions such as surgery.

**STAFF TRAINING**

A recurring theme in the literature revolves around staff training as a component in ensuring that pediatric patients with ASD receive the highest level of specialized care in the hospital (Courtman & Mumby, 2008; Muskat et al., 2014; Karam & Barkarat, 2011; Lai et al., 2012; Seid et al., 1997). Courtman and Mumby (2008) contend that hospital staff members are usually not trained in behavior management skills, which can greatly affect the frequency and severity of challenging behaviors. In a qualitative, interpretive descriptive study done by Muskat and colleagues (2014), one health care practitioner remarked that, “There’s expertise [at this hospital] for dealing with many, many conditions...[but not] for autism,” and that “There’s a real level of discomfort that we’re not equipped to offer the care that these children and their families need” (p. 6). Lack of staff training, knowledge, and confidence are all factors in this predicament.

Lai and colleagues (2011) agree, further stating that common techniques such as using behavior management and positive reinforcement, along with an awareness of ASD and its associated features, help to facilitate success in visits for sedated dental procedures. At present, they remark, medical staff training that includes specific techniques to help dental patients with ASD is very limited. This lack of training further limits the ability to tailor specific procedures to their patients’ individual needs. Seid and colleagues (1997) see the benefit of surgeons becoming more expert in managing the special needs of patients with ASD as a means of improving clinical outcomes, increasing patient/caregiver satisfaction, and containing costs. A physician fact sheet titled *Meeting the Needs of Children with Autism Spectrum Disorders During Medical Visits, Dental Visits, and other Challenging Procedures: Advice for Health Care Professionals* was created by American Academy of Pediatrics (2008) as one component of a comprehensive training program for physician to assess and treat children with ASD. The tip sheet offers specific advice for caregivers such as:

- Educate the staff about the effects of facial expression and voice.
- If necessary, train staff on how to make their voices more praising, relaxing, coaxing, and sympathizing.
- Remove unnecessary objects, instruments, and equipment from treatment rooms.
- Set up needed instruments and equipment before the child’s arrival and keep them out of view during the initial warming up (or calming down) stage (American Academy of Pediatrics, 2008).

The tip sheet also provides numerous ideas for ways to decrease stress by making the environment more calm and minimizing wait times.

Though physician training resources are available, it is evident that there is an overall lack of comprehensive medical staff training in managing children with ASD in the hospital environment. More studies are needed to identify best practice techniques for instructing staff. The reasons for demanding better understanding of the special needs of this population are well documented, but to better meet these needs, research clearly demonstrates that the staff who treat them need to be adequately trained.

### Table 1. Day of Surgery Modifications Supported by Each Author

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<tbody>
<tr>
<td>Minimizing wait times</td>
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<td>x</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Minimizing sensory input such as: low lighting, minimal noise, and movement</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
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<td>Soft music in OR</td>
<td>x</td>
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<td>Child-friendly operating and recovery rooms</td>
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<tr>
<td>Bringing familiar comfort items</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
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<tr>
<td>Keeping own clothing on instead of changing into hospital attire</td>
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**HEALTHCARE MODIFICATIONS**

**LOW SENSORY ENVIRONMENT**

Many researchers agree that providing a low-sensory hospital environment is beneficial to patients with ASD and that typical sensory experiences such as bright lights and loud noises may overwhelm pediatric patients’ ability to cope (Karam & Barakat, 2011; Lai et al., 2012; Loo, Graham, & Hughes, 2009; Marshall, Sheller, Mancl, & Williams, 2008; Nelson & Amplo, 2009). In fact, using modifications that are specific to the patient with ASD can help make the experience calmer for the patient, family, and caregivers. The waiting area provides a plethora of potentially over-stimulating experiences such as babies crying, television noise, and a crowd of people who are largely unknown to the patient. Decreasing wait time on the day of surgery is one effective modification that can help reduce these potentially overwhelming sensory experiences (Karam & Barakat, 2011; Lai et al., 2012; Loo et al., 2009; van der Walt & Morran, 2011). Minimizing sensory input such as light, noise, and movement is also helpful.

Karam and Barakat (2011) found that surgical patients benefit from wearing their own clothing and bringing personal comfort objects to the hospital. These are simple modifications that are beneficial in helping the patient maintain composure. In addition, they found that a waiting area

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*continued on page 12*
with toys and child-friendly operating and recovery rooms make the whole experience more welcoming.

In a study of how applied behavior analysis (also known as behavior modification) can be used with pediatric dental patients with autism, Hernandez and Ikkanda (2011) found that identifying a child’s preferences for items that can later be used as comfort items was valuable. These comfort items were used as positive reinforcement when undergoing dental treatments.

Overall, many researchers agree that greatly reducing environmental sensory stimuli and bringing comfort items from home can be essential in helping patients remain calm (Hernandez & Ikkanda, 2011; Karam & Barakat, 2011; Nelson & Amplo, 2009; Seid et al., 1997; van der Walt & Moran, 2011). Karam and Barakat (2011) offer the most comprehensive evidence that using a low-sensory environment is a way to provide comfort to a pediatric surgical patient with ASD. While other research shows promise in offering a variety of modifications, it is important to advocate for additional research that mimics this well-developed and inclusive approach. Table 1 provides a summary of possible modifications to the healthcare environment and routines, along with the research that supports the use of each particular modification.

**Caregiver Support and Input**

An overwhelming theme in a review of the literature on the topic of children with ASD in the hospital environment is the importance of caregiver input. Many parents are eager to discuss their child’s diagnosis and limitations. In describing her child’s anxiety, one caregiver said, “If you think about it, it’s like having exams every day of their lives and that can’t be nice for anybody, to live under that amount of stress all the time” (Ozsivadjian, Knott, & Magiati, 2012, p.115). Another mother described why change is so aversive to her child, assuming he/she does not understand.

<table>
<thead>
<tr>
<th>Author</th>
<th>Caregiver Concerns</th>
<th>Caregiver Suggestions</th>
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<tbody>
<tr>
<td>Bultas (2012)</td>
<td>Physicians do not have a holistic view of the impact ASD has on a family.</td>
<td>• Involve caregivers in all decision making.</td>
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<td></td>
<td>Health care workers need to appreciate the emotional toll that ASD has on the whole family.</td>
<td>• Create a caregiver profile to have on file.</td>
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<td></td>
<td></td>
<td>• Provide written instructions instead of relying on caregiver to remember details.</td>
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<tr>
<td>Seid, Sherman, &amp; Seid (1997)</td>
<td>Caregivers do not want to be separated from their child during their hospitalization.</td>
<td>• Respect caregiver as expert regarding child’s idiosyncrasies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Respect caregiver’s understanding, opinions, and wishes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Let caregiver help model the anesthesia mask for child.</td>
</tr>
<tr>
<td>Pratt, Baird, &amp; Gringas (2011)</td>
<td>Child with ASD needs a private room.</td>
<td>• Caregiver can provide information on child’s functional age.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provide a pre-admission checklist to state child’s likes and dislikes.</td>
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<tr>
<td></td>
<td></td>
<td>• Caregiver can describe antecedents to undesirable behaviors.</td>
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<tr>
<td></td>
<td></td>
<td>• Caregiver can provide relevant information about behaviors during prior health care experiences.</td>
</tr>
<tr>
<td>Haggloff (1999)</td>
<td>Caregivers need emotional support from health care staff.</td>
<td></td>
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<tr>
<td>Muskat et al. (2014)</td>
<td>Too many health care workers in the room at once.</td>
<td>• Decrease waiting times.</td>
</tr>
<tr>
<td></td>
<td>Health care workers not speaking to the child, assuming he/she does not understand.</td>
<td>• Have a resource for health care workers to refer to outlining some of the issues of patients with ASD.</td>
</tr>
<tr>
<td></td>
<td>Staff inflexibility.</td>
<td></td>
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<td></td>
<td>Long waiting times.</td>
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Table 2 provides a list of specific caregiver concerns and suggestions described in the research evaluated in this review of the literature.

**Pre-Operative Medications**

Non-pharmacological methods to relieve the intense anxiety that children with ASD experience in the surgical environment rarely work when not used in conjunction with an oral or injected premedicant (Courtman & Mumby, 2008; Karam & Barakat, 2011; Loo et al., 2009; van der Walt & Moran, 2001). Premedicating children refers to the practice of administering an oral, injected, or intravenous relaxation medication while the patient is at home or more frequently, in the pre-anesthesia area. This premedicant is not meant to make the child sleep, but rather to provide relaxation, reduce anxiety, and in some cases, cause an amnesiac effect (Karam & Barakat, 2011). In addition, the use of oral relaxants further serves to minimize the distress of receiving general anesthesia for a procedure (Courtman & Mumby, 2008; Karam & Barakat, 2011; Loo et al., 2009; van der Walt & Moran, 2001).

Using sedation may be the best tool anesthesiologists have for reducing stress and increasing compliance at the time of induction. Karam and Barak (2011) found that in children with behavior disorders...
where there was an anticipated difficult behavior, noncompliance at induction increased from 22% to 50% when a premedication was not given. They also reported that using intranasal and sub-mucosal (under the tongue) routes were options that should be considered when managing an agitated pediatric patient.

**Specialized Post-Operative Care**

The post-operative period of surgery is the time immediately following the completion of the surgical procedure. There are several noted interventions geared toward making the post-operative period tolerable for pediatric patients with ASD. Research is in agreement with most recommended methods of helping these patients cope. Seid and colleagues (1997), Courtman and Mumby (2008), van der Walt (2001), and Karam and Barakat (2011) each identify removal of the intravenous (IV) catheter and nasal cannula before the patient becomes distressed by its presence, having caregivers present as the patient emerges from anesthesia, and expedited discharge to home as ways to manage possible distress and assure that the surgical patient is returned to a familiar environment as soon as possible. Additionally, several researchers found that letting the patient recover in an isolation room provided a lower sensory, more soothing environment for recovery than an open room that contains many patients (Courtman & Mumby, 2008; Karam & Barakat, 2011; Seid et al., 1997). Three studies also found that anti-emetics administered before emergence from induction proved helpful in allowing the IV to be removed sooner, instead of the typical practice of waiting for the patient to show signs that they were nauseous (Courtman & Mumby, 2008; Karam & Barakat, 2011; van der Walt & Moran, 2001).

**Discussion**

There are a variety of effective measures that can be taken to reduce the stress and anxiety of surgery for children with autism spectrum disorder. Modifications to the surgical experience include aspects of care that occur pre-hospitalization, in the hospital environment, and on the day of surgery. Although the large majority of research regarding how pediatric patients with ASD cope with surgical procedures is qualitative in nature, academic papers that present evidence based on qualitative data from studies that are completed outside of the surgical environment are still valid and helpful in determining best practices for hospitals. However, there is a glaring need for research completed specifically with pediatric patients with ASD within the surgical environment. Bridging this gap in research would accomplish the task of providing categorical conclusions surrounding the best way to help children with ASD in the surgical environment.

Information on the presence and etiology of autism has burgeoned in the last decade, which is helpful in providing the basis for understanding complexities in the field of ASD. If hospitals are going to succeed in meeting the needs of pediatric patients with ASD, more surgery-specific research is needed. Additionally, quantitatively testing theories that support suggested tactics such as pre-operative preparation, using pre-medications, fostering a low-sensory environment, providing adequate staff training, and utilizing post-operative modifications can serve to encourage hospitals to make necessary changes.

This literature examined for this review shows the most commonly cited barriers to optimum surgical care of pediatric patients with ASD are in staff education and providing a low-sensory environment to decrease the amount of stress that hospitalization causes. Staff education is imperative and can include inviting experts on ASD in healthcare environments to speak at educational rounds, providing opportunities for staff to attend seminars and conferences related to health care and ASD, and creating online educational resources that can be easily accessed from work or home. When all members of the health care staff are adequately educated, the patient with ASD can benefit from a comprehensive plan of care that considers the individual’s special needs.

The literature also demonstrates that creating a low sensory environment is a valid and important tool for decreasing hospital anxiety. Another essential area of inquiry is to investigate ways to identify patients who require environmental modifications prior to hospitalization. How can parents and caregivers find out about hospital protocols that could make the surgical experience less stressful for their child with ASD? How can child life specialists build upon existing programs to broaden the exposure of preparatory programs so that the greatest number of identified patients will be reached? Child life specialists are leaders in executing psychosocial care for pediatric patients with ASD and striving to make the hospital experience as nurturing as possible. Available studies support the notion that a variety of health care workers are interested in co-managing the wide scope of needs for these patients. This collaboration is beneficial to the families of children with ASD and, indeed, to the patients who must endure medical experiences that stretch the limits of their coping.

**Putting Modifications into Action for Pediatric Patients with ASD**

Many hospitals are working to improve the hospital experience for pediatric patients with ASD. Based on sound research and developmental principles, programs such as the above-mentioned STAR program create an atmosphere where these patients can not only tolerate their medical care, but thrive. As the surgical child life specialist at Golisano Children’s Hospital at the University of Rochester Medical Center, I am constantly looking for ways to make the surgical experience less stressful for all patients. One way this is being accomplished is through a comprehensive training course for our anesthesia team. It consists of a pre-test, readings, videos, (which demonstrate an effective and an ineffective way to talk to parents and children about impending anesthesia), and a post-test. There is also commentary from attending pediatric anesthesiologists regarding best practices for engaging children and parents. The emphasis is on using developmentally appropriate language and recognizing that each child and family is unique and requires different language and levels of information. In addition, we are working to create a library of social stories and an event timeline of visual symbols that will be available online and in the hospital. These resources, coupled with the expertise of our child life team, are helping patients with ASD and their families navigate a complex and oftentimes overwhelming health care environment.

**References**


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**REGISTER NOW**

**33rd Annual Conference on Professional Issues**

May 21-24, 2015

Cincinnati, Ohio

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**IT’S NOT TOO LATE** to make plans to attend CLC’s 33rd Annual Conference of Professional Issues in Cincinnati May 21-24! This is the largest gathering of child life specialists in the world, and the perfect opportunity to meet kindred spirits, learn and grow, and have fun. The Conference Planning Committee has worked hard to plan educational sessions and events perfect for child life professionals at all points in their careers, from students to retirees. Some highlights of the three days include:

- A laughter-inducing opening session speaker, Loretta LaRoche
- An exhibit hall packed with vendors showcasing products and services that can help you in your work
- Educational sessions in many formats, on a variety of topics, interspersed with times for formal and informal networking
- Free time to explore Cincinnati and enjoy its restaurants, history, and scenery
- An inspiring closing session, featuring Alex Sheen, founder of [because I said I would](http://alexsheen.com)

You’ll be moved by the speakers, encouraged by colleagues in circumstances similar to yours, and motivated by the energy that comes from being surrounded by child life specialists. The opportunities to make connections with others in your field are unparalleled. You’ll be inspired, rejuvenated, and equipped to elevate your child life game!
Pathways to EBP

Providing Child Life Professionals at All Levels with Information, Tools, and Direction to Stimulate Evidence-Based Practice

Annette Bonjur, CCLS
Cincinnati Children’s Hospital Medical Center
Kristen Johnson, MS, CCLS
Children’s Health Children’s Medical Center (Dallas)
Emily Jones, MS, MEd, CCLS
Cincinnati Children’s Hospital Medical Center
Amanda Moatz, MEd, CCLS

One component of the mission of the Child Life Council’s Evidence-Based Practice (EBP) Committee is to “incorporate and promote evidence-based practice in the field of child life.” For some new committee members this seems like a lofty task as they, themselves, are far from experts on the topic. However, the mix of “experienced” and “novice” EBP contributors that comprise the EBP Committee more accurately reflects the range of skills and knowledge that exist across the child life community. To introduce “Pathways to EBP,” a new recurring column in CLC’s Bulletin, the EBP committee found it pertinent to share a few of the big questions or obstacles related to EBP that have been discussed by committee members over time and the suggestions that have been shared to help overcome these.

Q: The term “evidence-based practice” is everywhere. What does it mean?

A: Evidence-based practice (EBP) is an approach to clinical decision-making that combines the best available research findings with patient preferences and clinical expertise.

Q: Where do I begin if my department or institution does not currently have a strong EBP presence? What steps should I take to get started?

A: Many child life specialists have stated that they feel overwhelmed by EBP because they do not have experience working in research, they had a difficult time during their statistics and research course-work in college, or it has been several years since the last time they took a course in research. If you have these same feelings, you are not alone. The Evidence-Based Practice Committee is here to say that anyone can participate in EBP, regardless of having any formal training in EBP or research.

The first step is learning about EBP. Explore the training modules in the CLC Resource Library. This includes training for each step of the process, from assessing practice needs to implementing EBP into practice, and every step in between. These training modules follow the Child Life Council-endorsed EBP model, making them a good resource for everyone, including those who may have used an alternate EBP model in the past.

If your department is not currently engaging in the EBP process, you may also benefit from looking at the work of your multi-disciplinary team members. Generating and incorporating EBP into clinical practice is common among physicians and nurses, so you may be surrounded by EBP expertise and not even realize it. You could initially sit in on project meetings to familiarize yourself with the process and eventually you may be able to influence the next clinical question that will be addressed. Contributing to an existing project or collaborating with a team experienced in EBP will provide a hands-on learning experience and require the least amount of commitment (in knowledge and time) on your part.

Q: How do you generate interest and excitement regarding EBP in your department?

A: This is often challenging because so many people are intimidated by EBP. Begin with identifying just one person or a small group of people who already have knowledge and interest related to EBP. Team with these individuals to provide learning opportunities for staff in your division. A key to drawing in apprehensive team members is providing learning opportunities which are casual, easily accessible, and fit into daily workflow, such as an interactive “lunch and learn.” Another key element is to present the information in a manner which connects EBP to daily clinical practice in an easy and non-threatening way. Through these educational opportunities, additional staff can be identified who have an interest in EBP. Teaming less experienced staff members with others who have more experience with EBP is a great way to increase everyone’s knowledge.

Another way to create interest and excitement about EBP is to connect it directly to clinical work through the creation of evidence summaries. When staff have completed a literature search related to a topic they are passionate about, the information they have gathered can be broken down into simple recommendations and formatted into a brochure that can be made available to staff and families. Some examples include “Television and Toddlers,” “Helping Your Child Cope with Getting an Injection,” and “Pill Swallowing Ideas and Techniques.” This relatively quick translation of knowledge to practice (and observation of its impact) will increase staff’s confidence in several steps of the EBP process and motivate them to think critically about additional opportunities to incorporate EBP into their practice.

Q: In the busy daily practice of child life, how do you incorporate EBP on an individual level, as well as a departmental level? Additionally, how has it helped in your service provision as an individual or department?

A: Child life specialists are often pulled in several different directions with patient care and other departmental responsibilities. Taking on an EBP project may not seem feasible with one’s current workload, which is why it is so important to find easy and efficient ways to tie evidence into everyday clinical practice. A handful of statements already exist to support the daily practice of child life professionals. The CLC has commissioned EBP statements on assessment, preparation, and therapeutic play with the intention of continued on page 18
A Helpful Resource for Pediatric Mental Health Professionals, Especially Those in the United Kingdom:


As child life specialists, we consistently look for new and noteworthy resources to help us further our knowledge in promoting positive coping with pediatric patients. The book Promoting Psychological Well-Being in Children with Acute and Chronic Illness is an interesting read that appropriately increases the reader’s knowledge; however, it is most relevant for those interested in psychosocial care of pediatric patients in the United Kingdom (UK).

The authors, Melinda Edwards and Penny Titman, both have many years of experience working as consultant clinical psychologists at various hospitals in London. Titman is also the author of Understanding Childhood Eczema, which was published in 2003. Additionally, they are both members of the Paediatric Psychology Network Committee, a national special interest group for pediatric psychologists in the UK. The experience that they bring to the book comes from 20 years of working with children in mental health, general, and specialty medical settings. The book provides an overview of current research and techniques for both psychologists and clinicians working in a medical setting that serves children affected by chronic medical conditions. Within the first pages it becomes apparent that the book was written specifically for therapists; however, it presents information that is helpful to all members of the pediatric healthcare team, including child life specialists.

The content of this book is engaging; it addresses many topics related to coping, while providing just enough detail to make the reader curious about the minutia related to a specific topic. Overall, the book reads like a vast overview of techniques and policies developed to support the coping of children with a medical condition. It touches on many of the things for which child life specialists advocate, including patient- and family-centered care, reducing procedural stress, teaching relaxation and coping techniques, and empowering children to be involved in their healthcare journey. The book focuses more on children with chronic illness than those with acute illness, but because of this focus provides valuable information on how to increase children’s adherence to their treatment plan, as well as caring for the caregiver. One of the most appealing sections of this book is a list of resources that covers many topics from bereavement to bedwetting.

Multiple things make this book a thought-provoking read. The illustrations included are done by children and demonstrate how artwork can be an expressive tool for patients. The book also includes real stories that bring the audience into the child’s perspective. Additional passages highlight various organizations and the policies each has in place. For instance, the authors discuss the protocol developed by a support group to use when a member of the group passes away.

One of the key highlights of this book that is especially relevant to child life specialists is the section on patient- and family-centered care. Interestingly, patient- and family-centered care appears to be less commonplace in the UK than it is in US. According to the book, the UK practices patient-centered care yet has much less emphasis on including the entire family system in providing care. Although the nation has a different model, this book emphasizes the importance of including the entire family system. It also discusses ways to share news of a diagnosis or change in condition with families, and with patients when appropriate. This section would be especially helpful for physicians to read, as it talks about the importance of including psychosocial support during these conversations. The section on pain control is also helpful for child life specialists, as it includes information on muscle relaxation, guided imagery, deep breathing, and distraction. In many ways this section of the book validates the very important work that we do each day by expressing the importance of family support, preparation, distraction, and allowing the child to express his or her own opinions. Throughout the entire book, the importance of development is included and intertwined with the content, making it especially relevant to child life.

Although the book includes some information that is relevant and important to our role as child life specialists, it is not groundbreaking. Much of the material included is covered in some of the more well-known books written specifically for child life specialists, such as The Handbook of Child Life: A Guide for Pediatric Psychosocial Care by Richard Thompson. While this book provides a broad overview of some of the issues that concern children with chronic illness and their families, many of the themes in the content are connected to studies that were done in the UK and the policies that resulted from such studies. With a strong focus on policy in the UK, those interested in learning more about psychological support in a global policy sense would benefit from this book.

As it seems that there are some differences in the culture of medicine between the UK and US, some of the studies presented may not be as applicable or relevant in the US, specifically information presented about the legality of children giving consent. Additionally, as the title suggests by using the word psychological and not psychosocial, there are portions of the book that focus on things outside the scope of child life, such as cognitive behavioral therapy and diagnosing medically unexplained symptoms.

Overall, Promoting Psychological Well-Being in Children with Acute and Chronic Illness is a stimulating resource and an easy read but it does not share information that is groundbreaking to the field of child care.

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A is for Acclimation
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welcome and support new staff who have relocated for a job.

Child life specialists often toss around the word “reframing” when describing some of our interventions. Cognitive reframing “focuses on changing self-defeating or distressing cognitions into those cognitions that support adaptive behavior and reduce anxiety, depression and stress” (Vernooij-Dassen, Draskovic, McCleery, & Downs, 2011). Reframing thoughts regarding hospitalization is often the key to helping a child cope with a difficult part of their care. In the same way, this technique could be applied to those in our profession in powerful ways. Teaching students to survey their job options with a reframed mindset could prove invaluable. This could take many forms, but two of the strongest suggestions involve experiences with which most college students will be familiar.

First, some have suggested considering a first job as going away for college. According to the United States National Center for Education Statistics, for the fall 2012 semester, over 500,000 “first-time degree/certificate-seeking undergraduates in degree-granting postsecondary institutions” moved out of state (United States Department of Education, 2013). This statistic does not include intrastate moving, which most researchers consider to be much higher. Therefore, the experience of moving away from home and even across the country could be considered a relatively normative experience. Often, students consider universities far from home because of the fit for their needs. Relocation is not considered out of the ordinary or overwhelmingly obtrusive because it is “only” four years. Therefore, the same could be said of a first job – “you can do anything for four years!” In other words, considering the values of a department and needs of a position in order to find a good fit should be primary over the location of that position. When viewed in this light, the task of moving across the country does not seem as weighty.

The second idea for reframing a cross-country or international move is to think of it as studying abroad. While the majority of jobs most new professionals will be considering are in North America, each part of this continent is unique. There are a variety of cultures and demographics in each state, province, and city. Similar to studying abroad, relocating provides an opportunity to grow skills in considering culture. Meeting the needs of the area’s specific demographic can offer challenges which increase clinical skills in new ways. These incredible opportunities for growth may not be experienced if remaining in the same place. Relocation can also increase skills through the exposure to multiple child life departments and their distinct values. Changing perspectives can highlight many different styles of child life and amplify new professionals’ growth. Viewing the different strengths of a variety of team members allows new staff to incorporate favorite skills into their own practice and develop advanced competencies. Therefore, through relocation, professionals can gain a variety of cultural and career insights which encourage them to become well-rounded, and solidify the competency of family-centered care in a unique way.

Staff who will be team members of those who move far from home for a job are presented with a unique opportunity to provide support in ways that will lead to a successful transition. This can be done through departmental programming and personal support. Much research has been given to examining on-boarding programs, as they are linked to retention and satisfaction. On-boarding is considered differently than a basic orientation, as the goals are distinct. While orientation is the simple conveying of information, “onboarding involves a special, conscious effort to make a new employee quickly become a productive member of the organization, laying a solid foundation for a long-term relationship….Onboarding goes beyond orientation to provide an integration program that equips new hires with the resources to become fully engaged and culturally aware members of a productive workforce.” (Hillman, 2010, p. 1). This process is therefore very intentional and includes every member of the staff.

Not only does the on-boarding program need to be all-inclusive, but it also needs to happen quickly. Research demonstrates that the “first 30 days matter the most” for overall satisfaction and long-term retention (Hillman, 2010, p. 2). Beyond the information new employees need regarding their job description, departmental operational guidelines, and campus navigation, departments need to include time to connect with the individual on a personal level. This fosters a healthy work environment, another key to increasing commitment to an organization and long-term retention.

Beyond the information new employees need regarding their job description, departmental operational guidelines, and campus navigation, departments need to include time to connect with the individual on a personal level. This fosters a healthy work environment, another key to increasing commitment to an organization and long-term retention.

Life Council.

Helpful Resource
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life. Those practicing in the UK or interested in learning more about some of the international policies in place to support psychological well-being would find this book to be a useful resource, while those practicing exclusively in the US may not find it as beneficial. Despite that, it does a wonderful job of validating the very important and meaningful work that child life specialists do each day. ⭐️

Opinions about the books reviewed in Bulletin are those of the individual reviewer, and do not reflect endorsement by the Child Life Council.
Pathways to EBP  
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enhancing individuals’ clinical services and their ability to communicate the evidence behind their work. In addition to these statements, the CLC Evidence-Based Practice Committee has recently begun reviewing non-CLC commissioned EBP statements that support child life services. All of these statements, including their recommendations for practice, can be found in the CLC Resource Library.

Regardless of the size of your department or institution, you can still incorporate EBP into your practice and thus elevate your service provision as a child life specialist. Facilitating journal clubs is a great way to review and discuss current articles related to child life practice. This can familiarize staff with searching and critically appraising the literature in an informal and interactive way. In addition, EBP goals can be included in the criteria for annual performance evaluations or clinical ladder systems. Personal projects by staff who are already knowledgeable and passionate about EBP can always be encouraged and supported. These projects can be shared at staff meetings to generate interest and enhance familiarity with EBP and its direct relation to clinical practice.

As previously mentioned in the section about evidence summaries, one concrete example of such a project was titled “Reducing Pain for Children and Adolescents Receiving Injections.” This EBP project was completed by a small group of child life specialists at Cincinnati Children’s Hospital Medical Center. After writing a best practice care recommendation and developing brochures summarizing these recommendations, the information was shared with staff as well as patients and families. The brochures were strategically placed in clinical areas that see a high volume of procedures involving injections. The content from the best practice care recommendation was then added to the TVs in the medical center that stream education and information for patients and families. This sharing of information helped to empower patients and families to advocate for themselves when receiving injections.

Generating EBP guidelines and incorporating them into clinical practice are keys to providing high-quality child life services, but it can be challenging to take those first steps. The EBP Committee hopes that these answers, suggestions, and examples will help you or your department over some of the most common hurdles that keep child life professionals from exploring EBP.

Acclimation  
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increasing commitment to an organization and long-term retention. An HWE is defined as having standards including “skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership” and leads to increased patient and staff satisfaction (Hickey & Kritek, 2011, p. 32). An essential part of creating an HWE is creating positive relationships between staff members. “Social support within a team from a supervisor or colleague increased satisfaction levels of staff” (Pearson et al., 2006, p. 135). Therefore, as professionals in a teamwork-minded field, we should consider practical ways to build social support into our onboarding programs, especially for those who have relocated to join our specific team. This will not only affect their satisfaction, but also our own over the long term.

First, departments could consider hosting a “welcome lunch” for the new staff member. Planning the lunch during a pre-set staff meeting time allows the majority of the team to be present together. This time can also be used for a get-to-know-you time where everyone shares a fun fact about themselves to foster team-building through laughter and fellowship. For the staff member’s first day, staff could fill a distraction bag with common tools in order to ease the anxiety of finding and gathering needed resources. Also, an individualized welcome sign waiting on the staff member’s desk communicates the team’s anticipation and excitement of having a new member join the team. For larger programs, all of these departmental programming ideas could be organized under a “Recognition Committee” whose role is to celebrate staff in different ways.

Secondly, staff members can also support the new professional outside of work to aid in transitioning to a new city. Going to the movies or another favorite local entertainment venue, shopping at the best mall to find any needed work clothes, and having dinner as an introduction to some of the great local restaurants are all ways to help a new staff member navigate the best parts of a new city. This provides a sense of belonging and support as the new staff member is transitioning, before they are able to explore their own hobbies and interests and create a new community for work-life balance.

While a long-distance move can be daunting if viewed from the macro level, reframing mindsets and a supportive staff can create a more positive outcome than expected. As a profession, we must ensure the appropriate support systems are in place to provide the environment and context for success as we promote the idea of “you have to be willing to move anywhere.” Only then will we see the joys and benefits of relocation and acclimation.

References


Distinguished Service Award

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When asked about the mentors or role models that have fueled her passion, Susan says with great respect that Evie Oremland was her primary, initial role model, and Susan still uses her writings with students today. Aside from Evie Oremland, there were many other child life pioneers who served as important mentors and sources of inspiration, among them former Distinguished Service Award recipients Emma Plank and BJ Seabury. Susan referred to the new book The Pips of Child Life, which she reviewed for the CLC Bulletin, as she recalled her mentors.

In 1980, Susan began five years of clinical practice, and then moved into the director position at Children’s Hospital and Research Center Oakland, where she served until 2006. Among her proudest accomplishments during her time at Children’s is the development of a fully accredited on-site school program serving children from kindergarten through grade 12. Prior to the school program’s inception, an occasional drop-in by a teacher was the extent of schooling for patients. Additionally, she worked with the Chief of Psychiatry to develop a Family Resource Center at a time when such things were still rare.

At Mills College, where she has worked as an instructor since 2004, Susan redeveloped a course entitled Topics in Children’s Health and the Exceptional Child, contributing current perspectives to new graduates’ knowledge base on a range of topics including childhood diabetes, asthma, trauma, pediatric cancer, child abuse, and gender identity and reassignment. Susan acknowledges Katherine Schultz, Dean of the School of Education, whose commitment to social justice and dedication to bringing relevant and current topics into curriculum have been invaluable in allowing Susan to follow her passion.

An invitation to join Richard Thompson and Rebecca Reid in a program review of the Child Life Program at Utica College was a standout moment in Susan’s career. She is proud to have served on the CLC Executive Board with many talented and committed colleagues. Recent highlights include an invitation to Tokyo where she and her Mills College colleague, role model, and admired mentor, Dr. Linda Perez, spoke with a network of Japanese child life specialists and students, as well as pediatricians interested in understanding the development of the child life profession and associated education. Over several days, they gave sessions detailing how the child life program developed at both Mills College and at UCSF Benioff Children’s Hospital Oakland and educated the participants on the work of child life specialists in the U.S. Susan recalls this experience as “one of the most exciting moments in my career, speaking to a large Japanese academic audience interested in child life.” Susan is proud to know that more than 20 child life specialists working in Japan today are graduates of Mills College.

Susan believes that there are significant challenges that face the profession in the future, citing first that of “building a more diverse base...[and] training and hiring practitioners who mirror the communities within which they work.” The second challenge she identified is that of creating and preparing the research in the field. Susan is adamant that this will provide us with “more credibility, and align us with more established professions such as social work. Without solid research, credibility is hard to build.”

Susan believes that accreditation of academic programs is essential for our profession to continue its growth and recognition; however, she is concerned about the impact both financially and personally to many current academic child life programs across the country. Her involvement with the Graduate Accreditation Task Force, looking at the implementation of very complex changes to our education systems, led her to reflect on a third challenge for the future: that of assuring that there are enough internships sites to accommodate the growing number of prospective students.

When asked about advice Susan would share with future leaders, she was quick to respond, “Become very active with the [Child Life] Council. Involvement, networking, and relationship building will augment the work of our profession. We have the tools, strategies, and expertise to support children and families in multiple high-risk environments. We need to spread our wings.”

Susan has been continuously active with CLC. She was selected as a delegate for the Vision-to-Action strategic planning conferences that set a course for the future of the profession in the 1990s, and she worked for the Certification Committee as an item writer for the new examination process. Over the years, she has also served as chair of the By-Laws, Nominating, and Education and Training Committees. CLC staff member liaison Ame Enright describes Susan’s committee work as, “intelligent, thoughtful, highly analytical, and very diplomatic.” More recently, her knowledge and experience as an instructor have contributed to the work of the Academic Preparation Task Force, as well as her current role as a member of the Graduate Accreditation Task Force. According to fellow task force member Rose Resler, “Susan is the barometer for ‘doing what is right,’ reassuring members that we can work through change and advance the profession of child life.”

Susan is also back to working on the Nominating Committee, where decisions are crucial to the growth of our profession.

Susan is more than the kind, respectful child life specialist familiar to many of us. She has always loved animals, too. “We have a therapy dog, our golden retriever Ellie. I take her to PAWS to read to children. Libraries are set up after school so that local children who struggle with reading can come and read to the dogs.”

Susan and Ellie also volunteer at George Mark Children’s House, a pediatric hospice in the Bay area, and a retirement community. “I have had a horse for many years and found that riding the trails and mucking the stalls offered great personal therapy.” Once she retires, Susan would like to work with an organization like Guide Dogs for the Blind and assist with training.

Susan loves to spend any spare time with her partner of 36 years, her children and their spouses, and her six grandchildren. That is not surprising, given what Susan has loved about her work with children, families, students, and colleagues for many decades. Other interests include long hikes, lots of exercise, and the beach. She adds, “I plan to remain fully engaged with the CLC when I retire, doing whatever I can to keep the profession moving forward.” We look forward to doing it with you, Susan!
**POINT/COUNTERPOINT**

**POINT: The Privilege of Play: Can Child Life Bridge Play Deprivation?**

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

Play is universal is a common phrase within the field of child life—so common that I refer to it frequently in my own writing and advocacy, taking it for granted. However, the further away I get from my previous clinical experiences, the more I question the statement and the weight that we as specialists place on it. I am aware of how controversial this might be. I am relatively new to the field and many of the specialists whom I admire believe in the power of play and use it as the foundation of their entire clinical orientation. However, I currently view it as our status quo—one that might result in a field designed only for the privileged.

Previously, I have been vocal about the awe I experienced when noticing that the patient population I served were deprived of play. I recall school-aged children inquiring what a crayon was, asking what they should do with a doll, and tilting their head in puzzlement when handed a board game. For the population I served—wrought with poverty, social stigmatization, and nonexistent community support—play was simply a privilege they were not afforded. And because of this, the affordances my field offered were not a priority for the families. When I entered my position eager and full of naïve hope, I felt like a saleswoman trying to convince families that play was important. It took me too long to realize how colonialist this was of me, coming into their inner-city neighborhood and trying to sell the power of play to families with transient housing, chronic financial stress, and violent histories of discrimination, racism, and health inequity. Realizing my advantaged perspective, I adapted my practice and started designing interventions to meet the needs of the families with whom I worked. Behavioral adherence programming, social justice counseling, and LGBT support groups replaced the play I had been trained to provide. My work was clearly not that of a child life specialist; it was something different, something I was not trained for.

Play deprivation can impact a child’s social, emotional, cognitive, and physical well-being in early childhood (Milteer, Ginsburg, Council on Communications and Media, & Committee on Psychosocial Aspects of Child and Family Health, 2012). It is important. But are there other needs that must be addressed first that can open the door for play? And if so, are we instilling this flexibility in our trainees? Milteer et al. (2012) report that access to creative and physical outlets surrounding the impact of marginalization on development, conversations that are largely absent from child life conference schedules or textbooks. By including content on social justice advocacy in our training, our child life specialists will develop stronger skills in meeting families where they are and honoring the life experiences that have resulted in play deprivation.

In sum, the benefits of play contend that we advocate for the inclusion of play in all children’s lives. But if social obstacles are hindering the growth of play, we should also be addressing these limits by extending our conversations to broader social issues. If there is a hierarchy of needs and play does fall below social, cultural, and financial stressors, we need to consider how to bridge our skills to meet our families where they are. I beg my colleagues to engage in conversations regarding our training and how to ensure it is inclusive, socially just, and guided by the values of our field. And if play is not yet appropriate for some families, what tools should we be sharpening in the meantime?

**References**


COUNTERPOINT: Assessing Play Needs of Children Within the Scope of Child Life Practice

Katherine Bennett, M.Ed., CCLS
Monroe Carell Jr. Children’s Hospital at Vanderbilt, Nashville, TN
Laura Gaynard, Ph.D., CCLS
University of Utah, Salt Lake City, UT

Play is not only a universal phenomenon, but is an essential element of healthy human development. Regardless of culture, situation, lifestyle, race, or gender, play is the vehicle driving the development of cognitive, social, physical, and emotional competence (Crenshaw, 2008; Hewes, 2006). In fact, “research has repeatedly shown that the benefits associated with play are profound and wide-ranging” (Koller, 2008, p. 3). The critical aspect of play is emphasized in a recent report by the American Academy of Pediatrics in which the authors report that play is essential to the physical welfare of children beginning very early in life (Milteer & Ginsburg, 2012).

When children play, skills are honed, relationships are strengthened, and discoveries are made. Play is where children experiment with concepts for the future. Play is so critical to healthy development that the United Nations recognizes its significance as a specific element of healthy human development. Regardless of culture, children have a natural biological tendency to engage in play behaviors once basic needs are met (Brown, 2009; Gaynard, in press; National Institute for Play, 2014; Sutton-Smith, 2008). Some scholars maintain that humans have a natural biological tendency to engage in play behaviors once basic needs are met (Brown, 2009; Gaynard, in press; National Institute for Play, 2014; Sutton-Smith, 2008).

Children’s cultural background and socioeconomic status (SES) can impact their level of play, as explained by Jesse and Gaynard (2009). “Not all young children are able to play at the developmental level one might expect...Children from cultures that are less technologically advanced, and from lower socioeconomic classes, tend to engage in less complex and less sophisticated pretend play” (p.141). The authors suggest that the parents and helping professionals can support children to engage in increasingly complex play and symbolic play. The ability to play in this more sophisticated manner is critical in developing skills needed to adapt to changing environments. Playfulness also “allows us to psychologically cope with the past and present concerns, and prepares us for our future roles” and events (Jessee & Gaynard, 2009, p. 136).

In the absence of play, human development is hindered. This fact is reinforced by studies of individuals who have experienced a marked absence of play early in life. Research indicates that a lack of childhood play yields a decrease in social skills, emotional learning, problem solving, negotiation abilities, and school performance. Studies further show that individuals whose histories reflect a lack of play experience an increase in physical challenges that can have a life-long negative impact on health (Isenberg & Quisenberry, n.d.; Lifer, Foster-Sanda, Arzamarski, Briesch, & McClure, 2011; Milteer & Ginsburg 2012).

A variety of obstacles can prevent children from early play opportunities, according to researchers. These obstacles include: cultural or social restrictions in contexts where gender roles are rigidly defined and influence the types of play appropriate for boys and girls; absence of physical and psychological safety that is essential for play to occur; and a lack of income among children living in lower socioeconomic areas that leads to less time spent in play and recess. This, in turn, has a negative effect on children’s development. Additional obstacles that can stand between children and play opportunities include a lack of available playmates; a lack of space, time, and adequate or appropriate play materials; a lack of adult role models who support and provide an environment of play; and increased safety concerns, held by parents in many lower SES areas of today’s urban cities, leading to fears about injuries on the playground. The result is that these parents want to keep their children safely at home, thus significantly limiting their play (Bolig, 2005; Brown, 2009; Gosso & Carvalho, 2013; National Institute for Play, 2014).

There also exist idiosyncratic factors that create barriers to early childhood play opportunities. For example, detailed analyses of violent criminals reveal that a lack of play opportunities deprived these individuals of the ability to: 1) view life with optimism; 2) test socially appropriate alternatives; 3) learn social skills; and 4) cope effectively with life stress. Profiles of these violent criminals led researchers to conclude that play acts as a catalyst for positive socialization and is a powerful deterrent to violence (Brown, 2009; National Institute for Play, 2014).

In spite of the plethora of research reflecting the essential nature of play in the course of development, adults often question whether play is appropriate or necessary for children in traumatic or stressful situations. Hence, it is crucial that child life professionals not only serve as play advocates for all children, in all contexts, in all environments, but also confidently articulate to parents and other professionals the reasons play is so critical to healthy growth and development (Jessee & Gaynard, 2009; Milteer & Ginsburg, 2012; Isenberg & Quisenberry, n.d.).

Child life specialists possess unique abilities to educate parents and caregivers about the need for play in children's lives. In fact, education for families and advocacy for play opportunities are both core competencies of child life professionals (Child Life Council, 2010). Adults are often able to utilize play as an important tool to connect with children and support typical development. Child life specialists are able to understand play not only as a vehicle for development, but also as a process for creative self-expression and playful communication (Jesse & Gaynard, 2009). It is precisely during times of stress and trauma that children most often turn to play as a safe “place” to release and contain feelings of fear, distress, sadness, etc. (Clark, 2006; Schaeffer & Kaduson, 2006). Child life specialists understand this and have the knowledge and skills to facilitate the forms of play that best support children in healing via these play avenues. Child life specialists are also able to recognize the

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constraints on play by the surrounding circumstances of a stressful or traumatic environment and promote a healing context for both children and families. Family members and fellow professionals need child life specialists to educate them regarding the forms of play that will optimize development, facilitate the expression of feelings and thoughts, and lead to maximum healing for children during times of stress and trauma (Jessee & Gaynard, 2009).

ASSESSMENT & SCOPE OF PRACTICE

Having established the essential nature of play for all children for healthy development, our attention turns to the core issue in this discussion: The issue is not whether child life specialists should facilitate play when working with all populations; the issues central to this discussion include 1) the essential nature of play for effective assessment of children and families and 2) child life professionals’ knowledge of the child life scope of practice and their ability to work effectively within the boundaries of this role. Child life specialists may have a strong working knowledge of child development and a thorough understanding of the value of play; however, without effective and continual assessment of children and families, all care will be ineffective (Hollon & Skinner, 2009). Child life professionals will be equally ineffective if not confident about, and secure in working within, their scope of practice.

ASSESSMENT

According to Hollon & Skinner (2009), “The success of child life work is dependent on accurate and ongoing assessment of a child and his or her family” (p. 116). Thus, the cornerstone of child life care, regardless of where it is provided or with whom it is facilitated, is assessment. Central goals involved in performing assessments include determining where, and for whom, child life care is most needed within the context of each child life professional’s work environment. The credibility of our work is based upon a clear system of ongoing assessment out of which a rationale for child life care, tailored to the unique needs of each child and family, is formed and implemented (Child Life Council, 2006).

Effective child life professionals will quickly develop initial rapport with available family members and learn as much as possible about family factors such as support systems, cultural beliefs, SES, and current stressors (including factors such as transient housing, chronic financial stress, issues related to racism, or other “social injustice” challenges affecting the family). The family is often the only source for this information and a critical resource for ongoing assessment throughout a child’s care (Hollon & Skinner, 2009).

Assessment of child variables includes learning about the distress level of the child, the ability of the child to communicate, the child’s current stressors, his or her response to current and previous separation from home, etc. Play tends to be the best assessment method to use with children regardless of age, gender, and other individual characteristics (Gaynard, Wolfer, Goldberger, Thompson, Redburn, & Laidley, 1998; Hollon & Skinner, 2009). “Through play, children can relax and are more likely to ask [and respond to] questions, express concerns, and reveal misconceptions about what is happening” (Hollon & Skinner, p. 118). Thus, in the absence of play with a child it is unlikely that a professional will be able to facilitate an accurate assessment with a child or the child’s siblings. In addition, a child’s (and siblings’) ability and willingness to play, and parents’ understanding of the value of play, are significant aspects of a child life specialist’s assessment process in regard to the current status of the child, parents, and siblings (Bolig, 2005; Gaynard, et al., 1998).

SCOPE OF PRACTICE

A collaborative approach to practice is included as one of the ten child life “Standards of Clinical Practice.” This is the document where our professional scope of practice is most clearly defined (Child Life Council, 2002b). As stated in the child life “Code of Ethical Responsibility” (Child Life Council, 2002a) practicing within one’s scope of practice refers to engaging “only in those areas in which they are qualified and… to make referrals with due regard for the professional competencies of the other members of the health team or the community within which they work” (p. 10). Of course, child life specialists will benefit from broad knowledge about topics such as social justice counseling and issues of intersectionality or marginality gained from diverse, yet relevant coursework as well as from clinical experiences outside the child life scope of practice. However, knowledge of, or familiarity with, these topics and interventions by a child life professional does not necessarily place them within the defined boundaries of the child life scope of practice or replace the core competencies of a child life specialist. This knowledge by child life specialists may, however, certainly enhance their ability to refer more specifically and efficiently to other members of the team with which they work.

The tools of play, the frequency of play, and the themes in play often reflect the environment of the children playing. Unfortunately, too many children live in situations that hinder play, especially free play. These children continue to have a need to play, but the opportunity for and the value of play is perceived as lower. This reinforces, not removes, the need for child life professionals to facilitate play with this higher risk population and educate others about the essential nature of play for all. The work of the child life specialist is to continually assess within a defined scope of practice to better clarify the needs of children and families.

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Understanding, using, and conducting research is a valued competency for the child life profession. Developing child life students’ interest and skills in understanding and conducting research is essential to promoting more long-term utilization of evidence-based practices during their careers. As a child life academician, I have realized the importance of learning pedagogical principles to become more effective in engaging students in understanding research and producing scholarly or creative products consistent with child life professional standards.

I teach in the Child Development and Family Relations Department at East Carolina University (ECU). At this time, the Introduction to Child and Family Research course is an elective for our undergraduate child life students. Our graduate child life students are required to successfully complete the Research Methods in Child and Family Studies course during their first semester, and the Statistics in Child and Family Studies course during their second semester. While I do not teach the research methods courses, I include discussion of research in my courses and I have engaged with both undergraduate and graduate child life students in their research skills training. In this article, I provide examples of strategies I have used to engage child life students in learning research skills, in the hopes that as future child life practitioners they will continue to stay abreast of current research and be mindful of integrating evidence-based practices in their work.

The pedagogical principles of teaching research courses provided by Epstein (1987) resonate with my training practices with students. These principles include: starting where the students are, letting them set the pace, linking assignments to students’ objectives and concerns, respecting students and their innate desire to learn, demystifying research concepts without trivializing them, and reassuring students about the use of statistical techniques from a consumer’s point of view. Having a sense of humor and other coping skills are helpful because the research skills training process can be challenging both for the student and the instructor. As with clinical work where we first assess the child’s perception of need, when engaging students in the research process, I begin by assessing where the student is; for example, I consider their prior research experiences, research interests, and career aspirations. This also includes acknowledging student resistance to research, feelings of inadequacy, or personal fears regarding the research process. While empathizing with their concerns, I try to reassure and scaffold them along by letting them set the pace, making myself available during and outside of classroom hours, connecting research concepts/assignments to child life practice implications, and coaching them to be realistic in their expectations of perfection while completing their assigned research task. Some students have anxiety regarding the use of statistical computations and their inferences, and therefore worry that this would limit their ability to engage in a meaningful research process. I help them understand...
that while many study designs will require the application of statistical techniques for analyzing data, the research inquiry itself includes a sequence of procedures starting from the identification of a problem to the production of the final report of its findings (Creswell, 2008). When feasible, I facilitate student involvement in field work in areas specific to their research interests and jobs they aspire to have, to also help them become more sensitized to experiences of children, families, and professionals in those settings. In addition, I continue to maintain my own research agenda in the scholarship of application and community engagement and thus serve as a professional role model for students.

Research Training at the Undergraduate Level

I understand that for many undergraduate students their research experience with any mentor is likely to be their first venture into research with children and families. As a result, I recognize that they may need more ‘hand-holding’ initially, and more oversight throughout the process. I recognize that they are juggling a variety of other commitments (e.g., classes, part-time jobs, social obligations), and may have limited time for research work. I also make it my responsibility to fully explain expectations regarding research ethics, including respect for human subjects, accuracy in data management, and time management skills.

Below are four examples of how undergraduate-level students in our program are engaged to experience the research process beyond taking a traditional research methods course. These include independent study, honors thesis, special topics research-focused course, and research related assignments in child life courses.

Example 1: Independent Study

I occasionally recruit undergraduate students to work on research projects through an independent study opportunity. In one case, I engaged and guided a student to conduct a systematic literature review on the topic of Hispanic families coping with their child’s chronic illness and to design a mock study for collecting pilot data. This exercise resulted in meaningful research collaboration with the child life director at the hospital where she completed her internship. After receiving institutional review board (IRB) approval, she completed data collection for an integrative case study regarding Hispanic fathers coping with their child’s chronic illnesses. The current goal is now to publish both of these efforts.

This student reflected about her research experience: “I never thought that I would be part of an actual study, even less become the primary investigator. At first I was hesitant about taking up the task of doing the study and questioned myself if I was ready for it. With guidance received at each step, it was fascinating to put all aspects of research together, from the IRB process to finding potential participants to gathering and transcribing the interview data. The most rewarding and touching aspect of it all was to sit down with the fathers and listen to their personal story” (A. Torres Rivera, 2014, personal communication).

Example 2: Honors Thesis

In this instance, the student approached me to mentor her for her undergraduate honors thesis project. After eliciting her broad area of interest to explore “resiliency of youth” and taking stock of resources (limited research experience, timeline, lack of budget, population to explore), I encouraged her to first gain experience as a counselor with adolescents participating in a medical specialty camp. This was followed by our discussions regarding the idea to explore resiliency factors contributing to a successful transition from pediatric to adult care. After completing a literature review, and given her recent camping experience we agreed that she could research the question: “Can a medical specialty camp become a venue of providing reinforcement education regarding transfer from pediatric to adult healthcare?” I involved my graduate assistant to provide her with guidance as well; and the student successfully completed a small study with young adults with congenital heart defects to answer the overarching question, and submitted a written thesis to the honors program.

While guiding undergraduate students in the research endeavor takes considerable time and effort on the instructor’s part, it is rewarding to celebrate successes with students when they overcome the “what have I gotten myself into” stage of anxiety through the excitement of IRB approval and on to “I am so excited I have my first interview with the subject.” The growth evident in students from learning that one needs to make compromises (e.g. achieving an ideal sample size), to the persistence and rigor required in data analysis and writing the final report is well worth the time and effort.

Example 3: Elective Research Course

I have offered an elective course to provide a hands-on experience for our undergraduate child life students in the process of conducting social science research. All students completed training modules regarding ethical practices in conducting behavioral and social science research provided through the university’s office of research integrity. Students also had the option to volunteer as participants in a research study pertaining to student learning experiences designed to develop a specific competency required for child life practice. One student who took this course stated, “I was able to expand my knowledge by completing the IRB modules; something I may not have done otherwise… If I did not take this class, I may not have learned this information at this point in my life” (C. Sanders, 2014, personal communication).

Example 4: Research-related Course Assignments

While teaching the child life practicum course, I discuss steps in conducting research and assign a literature review paper assignment on child life practice topics to help students learn to read and evaluate research studies regarding psychosocial care in children’s health. When organizing their paper, students are taught to identify a broad problem area, specify why it is important by citing relevant evidence, or start their literature review with a conceptual definition of the key variable they have decided to explore (Fatten, 2007). The next steps are to identify and categorize relevant research, then integrate and present the information through critical analysis rather than to simply compile different abstract summaries; this proves to be a challenging but important learning experience for the students. I plan this assignment in the practicum course, with the hopes to instill in students the mindset to look for the research supporting best practices.

Research Education at the Graduate Level

Graduate students are generally expected to have better research skills and a more comprehensive understanding about
Mentoring
continued from page 25

the research process than undergraduate students. At the undergraduate level, the instructor guides students to think more analytically regarding various topics; at the graduate level the instructor serves more as a mentor for the student’s research project/thesis. For some, even, the research project could be more student-driven than faculty-driven.

Our master’s program is committed to promoting high standards of academic, professional, and scholarship preparation. We recognize that graduate students have goals to either i) gain advanced competencies for working directly with infants, children, youth, and families; ii) work in supervisory positions within child life departments and health related organizations; or iii) prepare for doctoral studies and careers in academia, research, and other university or clinical settings. After taking other foundational coursework, as well as the research methods and statistics courses, students are encouraged to select a faculty mentor whose area of practice and research is of interest to them. This mentor, along with two other committee members, guides the student to complete the required research project, especially the thesis at levels suitable to submit for publication.

continued on next page

Gaining Research Knowledge and Experience as Child Life Students

Kristin Kirby, BA
East Carolina University, Greenville, NC
Samantha Flick, MS
MUSC Children’s Hospital, Charleston, SC

Table 1 details our experiences gaining research skills as graduate students in the program described in the article “Mentoring Child Life Students: Strategies to Develop Research Skills” on page 18.

| Table 1. Gaining Research Knowledge and Experience as Child Life Students |
|---|---|---|
| **Steps in the Research Process** | **Identifying a Research Problem** | **Reviewing the Literature, Specifying the Purpose and Creating Research Questions or Hypotheses** |
| Samantha Flick | I had a longstanding interest in understanding children’s perception of a parent’s illness and child life’s role with children of adult patients. I identified the following problem for my own master’s thesis: “The Perceptions and Practices of Nurses Working in Adult ICUs Regarding Child Visitation and the Role of a Child Life Specialist in this Setting.” | I used the knowledge gained from undergraduate and graduate research methods courses to investigate the current literature surrounding my thesis research problem; this allowed me to identify gaps and ask pertinent questions to generate new knowledge. |
| Kristin Kirby | Through my practicum placement in a pediatric cardiology clinic, and a recent medical mission to Trinidad with a pediatric cardiologist, I began to notice parents’ gap in knowledge relating to their child’s congenital heart defects. This observation inspired and confirmed my thesis topic: “Exploring the Effectiveness of an Educational Booklet on Parental Knowledge of Congenital Heart Defects (CHD), Common Healthcare Needs and Parenting Confidence.” | The hospitalized child course in graduate school required an in-depth literature review on a topic in the field of child life, which necessitated reviewing a large body of research, addressing implications for future research and practice. I examined the topic of quality of life of children with CHD and their families. |
| **Steps in the Research Process** | **Data Management and Analysis** | **Interpreting the Data and Synthesizing the Findings (Reporting and Evaluating the Research)** |
| Samantha Flick | I have completed two statistics classes (one each at undergraduate and graduate levels). Learning how to use SPSS software in these classes, along with my thesis experiences, has provided me with further knowledge regarding organization of data and statistical analysis. I actively sought input from the statistician faculty member on my committee regarding appropriate analyses and management of data. | Connecting the findings of my study to existing literature and deriving practice, educational policy, and research implications was a challenging process for me. Also, I underestimated the number of drafts it would take to make my work ready for thesis submission. |
| Kristin Kirby | Prior to graduate school, I completed two statistical methods courses and have completed one at the graduate level. These methods can be applied to my thesis and also in the future while conducting research as a child life specialist. In addition, I have included a professor with extensive knowledge in statistical analysis on my thesis committee. | Working as a graduate assistant with a faculty mentor to conduct extensive literature reviews and data analysis has given me the tools in synthesizing findings and understanding what is most relevant to the current study. Further, I have begun to see research findings in a new light and am able to more clearly and accurately identify how empirical findings connect to practice in child life. |
As an example, the companion piece below, “Gaining Research Knowledge and Experience as Child Life Students,” details two graduate students’ perspectives on their training to gain research skills while using the steps in the research process as cited in Creswell (2008). I served as the thesis committee chair for both students, thereby providing mentoring throughout the research project.

Through the mentoring model, I collaborate with colleagues whose expertise in research and statistics enhances the research learning process and additionally serve on research committees as a project/thesis chair or member. Admittedly, we face hurdles while navigating the research process, when we all need to exercise patience with the process of needing to be focused in thinking and conceptualizing the research questions, in the use of succinct language, and with unanticipated delays. I listen to students’ concerns and just like we work in our clinical practice with children, I provide modeling, scaffolding, pacing, reframing, and reinforcement to remove myself out of their “copying” process, and to empower them to feel successful along the various mileposts of their research project. I also continue to work with alumni to present their scholarly work at professional conferences and to submit for publication in peer-reviewed journals. I continue my own professional development when I respectfully engage in research inquiry with students. It has helped me tremendously to develop trusting relationships with my students with whom I strive to develop enduring professional relationships, since as future child life specialists and leaders they will be instrumental in moving the child life profession forward.

**References**


### Designing a Study and Ethics in Research

A mock research project was required for the research methods class during graduate school. My group developed research questions and mock surveys for analysis. This experience proved valuable when designing my own thesis research study. I also completed the IRB training for ethical research conduct for social/behavioral studies.

My graduate research methods course provided opportunity to work in a group and develop a hypothetical research proposal. I have completed the IRB modules required in my program to serve as a research assistant and to understand how to protect human subjects used in research. These experiences have been applied and strengthened recently through my thesis work.

### Collecting Data

Before collecting data for my master’s thesis, I attended a survey design training to learn nuances of the online survey platform I used. I worked with my advisor and statistician to modify my study tool with permission of the original author, piloted it, and finalized it for online data collection. After successfully defending my research proposal, I submitted and received IRB approval. I obtained permission from a professional organization for critical care nurses to access my research proposal, I submitted and received IRB approval. I obtained permission from a professional organization for critical care nurses to access members on their listserv for data collection.

In my undergraduate research experiences, I collected quantitative data investigating body image perception as well as stress and coping in college students. Through these experiences, I learned firsthand the benefits and downsides to quantitative data. Recently, I have defended my thesis proposal and plan to collect data to measure parental knowledge of congenital heart defects and parental confidence when raising a child with a heart condition.

### Dissemination of Results (Journal, Conference, etc.)

I have not yet presented my research at a professional conference or published in a journal. However, I plan to work with my mentor to do both. I have attended conferences and I am getting familiar with the process of making scholarly presentations.

I have presented my work from my undergraduate thesis at regional conferences. In addition, I assisted an undergraduate honors student at ECU with her senior thesis and mentored her to develop her research poster for a student conference presentation.

### How Are You Learning to Apply/Connect Research and Child Life Roles?

Given my research interests, my mentor had facilitated a unique practicum experience for me with the support of child life colleagues in our local hospital to work with children of adult patients. This provided a perspective surrounding the need and relevance of my thesis research.

Two field based experiences in graduate school:

1. Assisting a pediatric cardiologist during a parent education based medical mission in Trinidad and
2. A practicum in a pediatric cardiology clinic have broadened my understanding of working with families and children with congenital heart defects, and how more research about child life roles with this population could benefit them.

### Future Research and Career Plans

I will work with my mentor to publish and present my thesis results in relevant outlets and further that knowledge. I believe my clinical work experience will present me with future topics that are worthy of researching in collaboration with my health care colleagues.

I hope to add to the body of literature that supports the importance of child life specialists’ role with children who have chronic illnesses and their families. My career plans include obtaining an internship and then job as a child life specialist.
CLC Calendar

**APRIL**

1-30  Evidence-Based Practice Statement submission window
8    CLC Webinar – Relationship Building and Collaboration with Nursing: The Key Ingredients for Teamwork and Job Satisfaction
15   CLC Leadership Development Institute Webinar – Basics of Evidence-Based Research
22   CLC Webinar – Better Prepared: Creating Care Environments for Patients with Autism Spectrum Disorder
29   CLC Webinar – More Than Just a Hand Mold: Re-envisioning Legacy Building with Chronic Populations

**MAY**

1    Standard Registration deadline for 33rd Annual Conference on Professional Issues
6    CLC Webinar – Group Clinical Supervision
18-21 CLC Board of Directors Meeting, Cincinnati, OH
21-24 CLC 33rd Annual Conference on Professional Issues, Cincinnati, OH

**JUNE**

30   Deadline for applications for the August 2015 computer-based Certification Exam administration (June 15 for those educated outside of the U.S. or Canada)

**JULY**

1    Deadline for Bulletin and Focus articles for consideration for the Fall 2015 issue
1-19 Abstract submissions for the CLC 34th Annual Conference accepted through the CLC website

Moments from the past...

**CHILD LIFE COUNCIL BULLETIN**

May 1984 Vol. 1, No. 5

Board Profile

Just now completing her term as a member-at-large on the executive board of the Child Life Council, Evelyn Oremland is the Director of the Child Life Program at Mills College in Oakland, California. Having been recommended for the position by Emma Plank (whose Master’s Degree in Child Development came from Mills in 1947), Evie initiated the program in 1976, first with a grant from the Rosenberg Foundation, and then officially adopted by the College three years later.

Evie has a Master’s degree in Social Welfare from the University of California at Berkeley. One of her first social work jobs was to direct a play program for 2 to 5 year olds at Moffitt Hospital (UCSF) in 1959. The position was categorized as “social group work,” but in that 2 to 5’s aren’t a conventional group, Evie, a social caseworker, but with child-related skills, was appointed. She recalls that she did a series of observations of well children in nursery schools in order to prepare for this work.

Evie and her husband, Jerome Oremland, (Chief of Psychiatry at Children’s Hospital, San Francisco), edited The Effects of Hospitalization on Children following a successful conference with that name, and they have since edited The Sexual and Gender Development of Young Children—The Role of the Educator.

Evie has taught continuing education courses for nurses, and has presented numerous papers related to her work.

Activity in the Northern California Affiliate of ACC has been built into Evie’s schedule, since the inception of the organization. She has held numerous board and committee positions, is on the Editorial Board of Children’s Health Care, and has also served as secretary of ACC.

Moments from the past...