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ACLP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

SPRING 2019 | VOL. 37 NO. 2

In Focus:

**Celebrating Difference: Improving
Psychological Well-Being in Children
and Young People Living with
Chronic Illness**

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from the **Executive Editor**
Kathryn Cantrell, PhD, CCLS

Helpers and Heroes

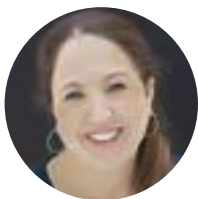
“Let’s do it again and again, it’s the best thing ever!” Jayden made this statement at least a dozen times each play session. In our weekly, hour-long meetings, we developed a well-oiled routine of building a party scene in the sand tray and then dramatically destroying it with a “storm of the century.” At the beginning of our time together, Jayden, a seven-year-old with a history of trauma and developmental delays, ended the storm scene with a resigned, “Well that’s it, they’re all dead,” referring to the myriad of dolls and plastic animals that were left stranded in the sand. The more we worked together, Jayden began incorporating a variety of characters that were there to help after the storm. Each week characters from police officers to doctors to teachers to “play people like Kathryn” would materialize and sweep up the debris, comfort the animals, and most importantly, restart the party. In our last month of working together, before we said goodbye, Jayden’s narrative switched when he introduced himself into the storyline. “Jayden the Magnificent” was able to turn the storm off-course and even though the party “was more boring,” Jayden emerged as a hero who saved all of his fellow revelers.

I said goodbye to Jayden around this time last year, but mention him often while teaching. The evolution of his play themes reminds me of children’s natural drive to achieve strength and courage, to be heroes and helpers. Likely, many of you have a long list of similar examples. I return to the idea of resilient play in this Spring 2019 issue of *ACLP Bulletin* for a few reasons. First, the lineup of articles in this issue is varied, yet well-connected to the foundational work of child life specialists as helpers who make room for play. The articles in this issue illustrate the lengths to which we will go to ensure that children and youth have access to play. From a children’s museum to a cardiac wellness program to a child life disaster relief team, we are skilled



at finding places and spaces for play, even in the midst of chaos. Second, this issue’s *Focus* article, “Celebrating Differences: Improving Psychological Well-Being in Children and Young People Living with Chronic Physical Illness,” describes and evaluates a group intervention that facilitates youth’s stories focused on the “superpowers” they use to manage their health. The project is a vibrant combination of therapeutic play and narrative theory, and the authors’ methods for evaluating the program might inspire your own future research projects. Finally, this issue celebrates one of our profession’s great players by honoring Deb Vilas, MS, CCLS, LMSW, for the Distinguished Service Award.

By the end of our time working together, Jayden became more accepting of others’ help, while also emerging as the hero of his own story. All along, his superpower was play. So dust off your capes and prepare your playrooms—I imagine this issue will fuel a new wave of energy and ideas to spark your practice. I look forward to hearing your stories about all of the courageous heroes you help in the meantime. I even know of a place where those stories would make great articles: <https://www.childlife.org/membership/aclp-bulletin/bulletin-submission-guidelines-instructions>. ✨



President's Perspective

Stephanie Hopkinson, MA, CCLS

Strategic Plan and Movement Forward

What comes next? To answer such a question, we turn to our new [strategic plan](#) to keep us focused on priorities and potentials over the next three years. We have entered into 2019 with a new comprehensive framework that will guide ACLP through the next three years. The plan includes a new vision and mission statement that align with the current landscape of ACLP and supports a strong movement forward. The goals of the new plan acknowledge the diverse experiences, roles, and needs of our membership. The four pillars upon which the strategic plan is based—1) membership, 2) education, 3) partnerships and non-dues revenue, and 4) certification—provide us with the opportunity to focus on important areas that will carry us into the future.

An exciting highlight of the work that is taking place is the progress of the Academic Review Committee, which builds upon the dynamic work of previous task forces for both undergraduate and graduate academic programs.

ACLP staff and volunteers across committees and task forces continue to work hard to support the vision, mission, strategic direction, and plan of the association. I want to take this moment to give you a peek into some of the thinking and approaches that guide daily operations and the visionary decisions undertaken by the board. Critical to any decision is the consideration of ACLP's strategic direction, the financial impact of any options weighed, and the resources needed to carry forth a plan, including human capacity and overall

sustainability of ACLP. The board, along with the ACLP staff, is diligent in their approach and work hard to make thoughtful and informed decisions.

An exciting highlight of the work that is taking place is the progress of the Academic Review Committee, which builds upon the dynamic work of previous task forces for both undergraduate and graduate academic programs. The focus of this committee is managing the undergraduate and graduate academic endorsement process. I would like to express my gratitude on behalf of the board of directors and ACLP community to the leadership and members of this committee who have worked hard to get us to this point. Congratulations to the academic programs that have earned ACLP endorsement!

2019 also brings the launch of a new high-quality [online education platform](#), which allows us to provide more learning experiences for each of you. As the healthcare environment continues to evolve and change, we are keenly aware that the needs of the membership follow this pattern as well. Specific content over the next three years will be focused on students, academic professionals, internship supervisors and coordinators, and those in community-based and non-traditional roles. Educational options will focus on the diverse learning needs of the membership, from child life specialists who are just entering the field to those who are seeking advanced level educational experiences. Please take the opportunity to explore our learning platform to learn more about live webinars and new packages and specials, in addition to our free member pop-up webinars.

It has been a very busy start to the year, and we are looking forward to all that will continue as the year progresses.

We are ACLP! Community, Vision, and Action Together! ✨



CEO Shares

Jennifer Lipsey, MA

Who is the Association of Child Life Professionals?

We are a community of child life professionals spanning a wide range of ages, experience, and expertise. We are led by our board of directors, all Certified Child Life Specialists, selected through our nominations process managed by Certified Child Life Specialists. We are supported by a dedicated staff, whose leadership positions are filled by the board. We produce educational content for the professional development of specialists at varying levels of child life practice and have a Certifying Commission (comprised of Certified Child Life Specialists) responsible for upholding and maintaining standards for minimal competency.

While we are not a formal advocacy agency or lobbying entity that can create jobs, nor a national legislation office that can immediately affect healthcare policies or licensure for practice, we can identify and engage those entities who *are* able to institute change and we can provide education around the value and challenges inherent to the work of our members.

We exist to educate, connect, and provide child life professionals with content necessary for their ongoing development throughout their career trajectory. Learning opportunities identified by child life specialists as relevant and needed are developed and presented by their child life colleagues and offered live and on demand for lifelong learning. We produce materials designed to arm child life professionals with recommendations and guidelines for the continued evolution of their practice and program infrastructure, as well as general resources identified by their child life peers to inform practice.

We are . . . you. This organization was created by child life pioneers who persevered through rigor-

ous pathways to create a non-profit group because they believed in the power of a collective voice, in the meaningful connections that child life creates, and in the impact it makes. Those who led us to this point carved challenging trails to establish academic curricula, internship programs, and FTE positions, both inside and now outside of the hospital. We continue in reverence to the beautiful, artistic balance between clinical competency and therapeutic presence that child life requires of its practitioners. We are pursued by those who have identified child life as central to the pediatric experience and who wish to subsidize our activities through sponsorship and advertising that allow us to keep our members' fees as low as possible.

This organization was created by child life pioneers who persevered through rigorous pathways to create a non-profit group because they believed in the power of a collective voice, in the meaningful connections that child life creates, and in the impact it makes.

We connect, educate, set standards of practice, build the child life community, and offer resources to equip child life professionals with the foundation upon which to create, sustain, and grow their practices. We were born from the work of child life pioneers and thrive because of the contributions in time, insight, and wisdom of our child life volunteers. We are leaders, makers, caregivers, mentors, and learners.

We are ACLP. ✨



ALPHABET 2.0



Q is for Quiet Leadership

Jennifer Fieten, MA, CCLS

CONCORDIA UNIVERSITY ANN ARBOR, ANN ARBOR, MI

When I consider the leaders I have encountered over the course of my child life journey, the individuals that have left the strongest impressions have been those who were not just leaders by title or words, but those leaders who consistently treated people well and took the time to cultivate and encourage those under their leadership and guidance. Such leaders were not necessarily the ones who were in the forefront or most vocal, but those who chose to remain in the background, quietly demonstrating their leadership by providing opportunities for their staff members to expand professionally and to receive due recognition. As a result, these quiet leaders led teams that were dedicated, hardworking, and productive.

Consistent with the adage “There is a time and a place for everything,” we, as child life specialists, know that there are circumstances that require differences in approach: times to be assertive, and times to pick our battles. Just as there are instances when extroverted leadership is beneficial, there are also situations in which introverted leadership can be most effective. Quiet leaders are incredibly powerful; they focus on actions instead of words and are able to generate excitement, encourage ownership, and develop loyalty in those under their guidance (Gregory, 2010). Recent research acknowledges the need for differences in leadership approaches and encourages an expansion of the way successful leadership is defined, transitioning from a dominant focus on extroversion to a fuller recognition of the importance of introversion and a quiet leadership approach (Kahnweiler, 2018).

What are extroversion and introversion, and what influence does personality type have on leadership approach? According to psychoanalyst Carl Jung, an extrovert is one who finds meaning outside of the self, preferring the external world of objects, activities, and interactions with people; while an introvert is one who is introspective and focused on thoughts, feelings, and ideas (New World Encyclopedia, 2014). The extrovert is replenished by engaging in activities and by interacting with people, while the introvert is replenished by solitude and reflection. Jung believed that both existed



in each person, with one type being dominant over the other (New World Encyclopedia, 2014). How does personality type then influence leadership approach? Extroverted individuals tend to exude energy, enthusiasm, and assertiveness, and are known to be action oriented and talkative. These characteristics are then manifested in the individual’s leadership approach. In comparison, introverts tend to be quiet, low key, deliberate, and have an advantage in long-term memory and problem solving (New World Encyclopedia, 2014). The introverted individual then exhibits these characteristics when leading. Quiet, introverted leaders are not motivated by the need for dominance, nor are they threatened by their proactive employees; therefore they are more willing to listen to others and accept their suggestions (Atamanik, 2013).

Historically, research has characterized successful leadership as including extroverted qualities; however, this emphasis is now changing to encompass both leadership styles and the contexts in which success occurs (Atamanik, 2013). Many child life specialists feel pressured to exhibit extroverted qualities, yet the research recognizes the value of the introvert and the advantages of introversion. The success of a leader is greatly affected by the leadership context. Research indicates that proactive employees are more productive when led by an introverted leader, whereas passive employees report greater workplace satisfaction when led by an extroverted individual (Atamanik, 2013).

There are times and places for both the extroverted and introverted, quiet leadership approaches, and the child life profession has leaders with extrovert dominant personality traits, as well as those with introvert dominant personality traits. In addition, we as pioneers in the field of child life recognize the importance of various types of personalities and leadership approaches, and understand that varying circumstances require different approaches. Given our recognition of strength in diversity, we must explore and acknowledge the importance of quiet leadership.

Quiet Leadership and the ACLP Strategic Plan

As we continue to move forward as a profession and develop as a discipline, our evolution is greatly influenced by our strategic plan and goals. The Association of Child Life Professionals' (ACLP) Strategic Plan clearly states that it will advance the field of child life by enhancing the professional growth and development of members with a goal of increasing leadership capacity (ACLP, 2018). ACLP engages in the cultivation of leaders by providing opportunities to participate in leadership roles within ACLP committees, work groups, and task forces. As a participant on a committee, work group, or task force, professionals are encouraged to attend leadership related training. Additionally, ACLP-provided webinars, conference sessions, and networking opportunities further explore the multiple facets of leadership and promote the individual's development of leadership-specific skills; this includes the cultivation of the introverted, quiet leader. The skills of the introverted, quiet leader can be cultivated by providing space for development of ideas, creating opportunities to prepare prior to meetings, providing space after meetings for the leader to consider thoughts and responses, respecting the need for solitude, and creating opportunities to work independently (Everwise, 2015). The cultivation of future leaders is an essential component of the ACLP Strategic Plan and is a fundamental function of our ACLP leadership. One of the duties of leadership is to produce more leaders (Nader, n. d.). To be in a position of leadership is to also be in a position to influence.

Characteristics of Quiet Leadership

According to Robin Sharma (n.d.), leadership is about "impact, influence, and inspiration" (para. 1). "The truth is that everyone in a professional role needs

to influence others" (Kahnweiler, 2013, p. 1). Quiet leaders influence those they guide with great care and consideration. Introverts are intentional in the way in which they influence, focusing on careful thought and depth (Kahnweiler, 2013). They understand that to be effective and efficient, one must consider all aspects and potential outcomes of a scenario. Quiet leaders also value the unique strengths of each member of the team. Quiet leaders know that influence is not about forcing people to come to see things a certain way, but about learning from others and negotiating a compromised solution (Kahnweiler, 2013). Quiet leaders understand the importance of listening, letting go of the ego, and keeping their cool in stressful situations; they are realists who move carefully, put together contingency plans, and highly value trust (Gregory, 2010; Badaracco, 2002).

Quiet leaders understand the importance of listening, letting go of the ego, and keeping their cool in stressful situations; they are realists who move carefully, put together contingency plans, and highly value trust.

What factors underlie quiet leadership? Quiet leaders have earned the respect of their team; they display the appropriate level of confidence, are understanding, compassionate, and open-minded. They think laterally rather than hierarchically, are likeable, relatable, and approachable (Gregory, 2010). Quiet leaders recognize the importance of relationship. There is power in being a quiet leader. "The power of a quiet leader is that once one has earned the respect of his or her team, one does not have to speak loudly to be heard" (Gregory, 2010, para. 12). Quiet leaders also understand the responsibility of being an influencer. "... Influencers make a difference by challenging the status quo, provoking new ways of thinking, effecting change, or inspiring others to move forward" (Kahnweiler, 2013, p. 15). Quiet leaders are quiet influencers, exhibiting many strengths, including intentional preparation, engaged listening, and focused conversations (Kahnweiler, 2013).

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Q is for Quiet Leadership

Quiet Leadership and the Child Life Profession: Implications for the Field

The implications of quiet leadership for the field of child life lie in the context of its use and in the advancement of the profession through the cultivation of new leaders. As professionals working in healthcare, the situations we encounter are oftentimes complex and unexpected. The majority of challenging problems encountered within the healthcare setting are not resolved quickly (Badaracco, 2002). These problems require great thought and contemplation, as well as deliberate action—skills that are frequently attributed to the quiet, introverted leader (New World Encyclopedia, 2014). The settings within which we function are diverse in working styles, requiring leadership approaches specific to each organization's needs. Additionally, as the child life teams amongst which we work become more diverse, there will be increased value in cultivating leaders that personify variances in leadership style.

Conclusion

Both introverts and extroverts make effective leaders (Atamanik, 2013). Historically, the focus has predominantly been on the success of the extrovert leader. However, we are now seeing a shift in this view to

encompass the introverted, quiet leader. Quiet leaders are incredibly powerful, focusing on actions instead of words, and are able to generate excitement, encourage ownership, and develop loyalty in those under their guidance (Gregory, 2010). As a field, we must value these differences among our own professional body by identifying the strengths of our diverse population, fostering these strengths, promoting growth, and cultivating new leaders with different leadership approaches. We must create a professional culture in which both extroverted and introverted leadership is valued and accepted. Individually, we must reflect on our own tendencies and challenge any personal biases that we may associate with extroversion or introversion and examine ways to work effectively and comfortably in collaborative efforts, communicate and understand one another, and work together as members of the same professional family. For the introvert, this also includes engaging in self-reflection to find his or her “voice” to take steps towards identifying and sharing unique gifts in a way that is authentic to the individual (Ancowitz, 2009). We can celebrate both leadership approaches by fostering strengths, providing professional development opportunities, and educating one another on working effectively with our counterparts. By doing this, we propel our field forward, advancing to achieve our strategic plan, our mission, our goals, and our vision. ✨

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Deb Vilas (right) celebrates with a graduating student.

Back to our Roots: A Career Dedicated to the Power of Play

Deborah Vilas to Receive 2019 Distinguished Service Award

Allison Sohanlal, MSc, CCLS

MCMaster UNIVERSITY, HAMILTON, ON, CANADA

The Distinguished Service Award honours those who have demonstrated strong leadership and outstanding contributions to the field of child life. This year's recipient, Deborah (Deb) Vilas, MS, CCLS,

LMSW, represents these attributes with a common thread throughout her life: the act of service.

The word "service" comes immediately to mind when describing Deb's passion for her diverse and varied career. Starting at an early age, the concept of service was modeled by Deb's parents, especially her father (a minister), and was a core part of her upbringing. Deb's life experiences have also had a heavy influence on the feeling that child life was not a career choice, but that she was called to this profession. She endured many hospitalizations throughout her childhood that provided her with a certain comfort level for being in

the hospital environment, and also an awareness of the services and supports that she and her parents did not receive. These early life influences are the cornerstone of Deb's focus to serve others. With one glance at Deb's [professional website](#), you begin to peel back the layers of her core beliefs, values, and passion for all things play.

Deb "found" child life after a period of soul searching, as she left a career that sparked little joy for her and deliberated about what career path she next wanted to pursue.

Deb's jump into the world of child life developed through a series of forks in the road, with each decision

[*continued on page 8*](#)

Distinguished Service Award

creating a unique path. Deb describes her career in child life as always developing, changing, and expanding; a career filled with joy and passion for connecting with others, demonstrating the power and benefits of play for everyone, and advocating for the child life profession as a non-negotiable, vital part of any psychosocial team. Deb “found” child life after a period of soul searching, as she left a career that sparked little joy for her and deliberated about what career path she next wanted to pursue. A volunteer role led to a position as volunteer administrator at Memorial Sloan-Kettering Cancer Center, where she met a child life specialist. Deb describes her introduction to the role of a child life specialist as a light bulb going off that inspired her almost immediately to enroll at the Bank Street College of Education to obtain a degree in early childhood special education with a concentration in child life.

Deb has spread the philosophy of child life far and wide through multiple avenues and isn't slowing down anytime soon! In the last three years alone, she has presented 15 times across seven countries, including being invited to speak at the United Nations Headquarters in New York City.

A New Yorker through and through, Deb has amassed a diverse career in child life over the past 25 years that has included hospital-based services, community agencies, private consulting, and a faculty position at the Bank Street College of Education consisting of teaching, advising, and field supervision. She has made several contributions to ACLP committees as a member of the Research and Scholarship Committee, taskforces for research and technology, and the Mentor Program.

Deb's footprint in the field of child life will undoubtedly involve her many scholarly contributions to the profession. She is the author of

countless publications through articles, book chapters, blogs, and educational videos. She was instrumental in the development and production of the widely used [“That's Child Life”](#) video to showcase the impact of child life services and the ways that play can transform the hospital experience. In 2013 she received the Disney Scholarship for Innovations in Play, which led to the development of the [Report on Findings of Play Practices and Innovations Survey: The State of Play in North American Hospitals \(2014\)](#). This report provides data that helps healthcare professionals advocate for family-centered services and sparks a conversation for child life students and professionals alike to consider what areas need continued focus to ensure play is fully accessible and available to children and their families in hospital. The report on play practices also led to the creation of the [Vilas Playroom Assessment Rubric \(VIPAR\)](#) tool, of which Deb is particularly proud. These projects have led to Deb's expertise being utilized by organizations such as Disney through their Team of Heroes project. Deb says she is energized when “work feels like play,” and has been able to serve on a panel of medical experts to identify how hospitals can create a more personalized and comforting experience for patients and families.

Last year, Deb received the Fred Thomases Faculty Excellence Award through Bank Street College. She has helped nurture the careers of countless child life specialists, both through her faculty position at Bank Street and through her outreach globally. Her nomination package includes support from a number of past students who describe her as “the ultimate child life mentor,” “the one person who will give you the right words at the right time,” and who feel strongly that “her lessons and voice are the backbone for so many specialists' practice.” With respect to her global support of child life, she is described by one of her contacts abroad as a “child life influencer” who is humble, respectful of other cultures, and able to approach challenging situations through creative thinking and a hands-on approach to assist people who want to bring child life practices to their organization but have few resources available to support them.

Deb has spread the philosophy of child life far and wide through multiple avenues and isn't slowing down anytime soon! In the last three years alone, she has presented 15 times across seven countries, including being invited to speak at the United Nations Headquarters in New York City. Her expertise in child development and play is renowned in the United States where she is frequently invited to present at conferences focused on child life, healthcare, and teaching. Her global reach has allowed her to share her knowledge through conferences and hands-on, play-focused workshops in the Czech Republic, Japan, Mexico, New Zealand, and the Palestinian Territories. The opportunity to travel has come about in only the last five years for Deb (a self-described homebody), showing once again her openness to trying new things, saying yes to experiences outside of her comfort zone, and welcoming personal and professional growth.

Meeting Deb for the first time, she immediately makes one feel at ease, like an old friend. She is honest and forthright in speaking to the challenges and successes along her career path and what she has learned from each one. When asked where she would like to see the child life profession in 10 years, her answer is quick and direct: "Out in the community." Asked to expand on her vision, she is strong and steadfast in speaking to a child life specialists' ability to foster resilience in children and youth both in hospital and when they return to their communities and schools. Deb is inspired by the many child life specialists who continue to forge their own paths in private practice, working in the community to meet a seemingly never-ending need for psychosocial care and support. At present, Deb's career involves consulting with schools and daycare

Distinguished Service Award

Since 1988, the child life profession's outstanding leaders and pioneers have been honored with ACLP's most prestigious award, the Distinguished Service Award. This award recognizes exceptional ACLP members, not only for their outstanding contributions to the field of child life, but also for their professional experience, leadership, integrity, and vision. All ACLP members are encouraged to consider nominating a deserving colleague, peer, or mentor. All *[nomination materials](#)* and guidelines are available on the ACLP website. The nomination and review process takes place in late summer/early fall each year. Questions about DSA criteria or the nomination process can be emailed to awards@childlife.org. To learn more about the lives, careers, and contributions to child life made by previous recipients of the Distinguished Service Award, please visit the [ACLP website](#).

centres seeking to meet the needs of chronically ill children, providing remote supervision to child life specialists in private practice, public speaking engagements, and her faculty position at Bank Street. When asked how she balances it all, she credits "loving what I do, the constant support of my life partner, and yoga and meditation to keep me grounded." Deb is an inspiring example of how to use your own voice to reach out into the world, support what you believe in, and fight for the needs of children, youth, and families by connecting with others and saying yes to the paths that are presented to you. Please join us at the opening session of the 2019 Annual Child Life Conference in Chicago, IL, to celebrate Deb's Distinguished Service Award achievement. ✨

REFERENCE

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IN THE NEWS

Connections to Child Life

A NOTE FROM THE EDITORS:

Welcome to the newest column in *ACLP Bulletin*, titled "In the News: Connections to Child Life." Below you will find two examples of the kinds of articles we hope to publish in future editions. First, we have reprinted a position statement which you probably already received in June 2018, as a direct email from ACLP. The first two paragraphs include a description of the impact of the policy on the separation of immigrant children from their parents at the United States/Mexico border from the perspective of child life. This clear discussion illustrates how professionals in child life perceive a major national event and its effect on children and families. The second article addresses a more local but still significant event, and adds a description of intervention by child life professionals. Both formats are valid for this column and are welcome by the editorial staff.

If you see something in your community, in your country, or in the world that affects the well-being of children and families, whether or not you have provided any direct intervention related to the event, please consider writing about it. Guidelines for this column are available on the [ACLP website](#). Your submissions have the potential to reach out and change both policy and action, and contribute to the voice of child life!


ACLP Position Statement, June 2018

The Association of Child Life Professionals joins other professional organizations whose members have

expertise in child development, health, and welfare in opposing the traumatic separation of children from their families by Immigration and Customs Enforcement. Children who experience separation from family members and relocation to Department of Homeland Security facilities will face serious, potentially long-term psychological trauma.

ACLP shares the concerns outlined in the [American Academy of Pediatrics \(AAP\) Policy Statement on the Detention of Immigrant Children](#) and urges that all children housed in government facilities receive evidence-based, developmentally-appropriate care in order to minimize the negative psychological impact of family separation. Any facility housing children should be staffed with professionals trained in child development and the emotional and psychosocial care of children. ACLP urges the Department of Homeland Security and the Department of Justice to limit family separation and encourages U.S. policymakers to advocate for the emotional and physical safety needs of all children.

We thank the many ACLP members who have contacted us about this issue and ask that you consider adding your voice to the debate by contacting your political representatives and sharing your views using the #protectfamilies and #keepfamilies together hashtags.

ACLP is committed to representing your views on issues affecting the children and families in our global community. Please continue to share your opinions with us at action@childlife.org. 

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Disaster Relief in Our Communities

Katie Nees, MSHS, CCLS

CHILD LIFE DISASTER RELIEF

Texas Border Crisis. Hurricanes Florence and Michael. Thousand Oaks and Pittsburgh shootings. California Camp Fire. The weight of these tragic situations is impossible to miss. Regardless of your knowledge of the details, you likely feel the urgency that these disasters create and are concerned about how these situations will forever shape the lives of the children they touch.

The reality is, these disasters have been increasing. The United States as well as the world has seen a rise in both natural and man-made disasters. Child life specialists around the country are utilizing their skills to help the children impacted by these life-altering events to mitigate the negative impact on the youngest survivors. The child life specialists' stories after these deployments are stunning and inspiring.

But let's take a closer look at smaller, less publicized events that are even more frequent. There are small-scale shootings, fires, and other disaster events happening within our communities that are not widely covered by the media but that still have a significant impact on the children directly involved and those who witness these incidents. What if the children impacted by these events had an adult responding to the scene who is tuned into their needs and fears and whose primary focus is to help meet their coping needs? In other words, what if the first responders in your community included psychosocial personnel? Slowly, this new territory is being successfully navigated by child life specialists around the country.

One [*Child Life Disaster Relief \(CLDR\)*](#) team was called in by their city's emergency management organization after a local shooting. The shooting was drug-related and involved a SWAT team stake-out where the only fatality was the SWAT team's main person of interest. However, this stake-out and shooting event occurred at a local motel, where multiple families were evacuated in a flurry of chaos by armed and masked police officers. These families were all low-income families who had been using this motel for temporary housing. They were taken by police to a local church where they spent the next 30 hours sleeping on cots, being interviewed by police, and trying to figure out their next steps. The

local child life team was contacted within an hour of the shooting and two child life specialists, trained by CLDR for just this kind of situation, responded immediately. They walked in to the church to find a tense environment. Several families and individuals were moving about slowly and quietly talking while nervously watching each other. Heavily uniformed police officers were spread out throughout the building and disaster relief personnel were scurrying about setting up tables, cots, and other supplies.

The two child life specialists were greeted by the disaster relief staff with enthusiasm. "We just don't know what to do with the kids," they said. They led the two child life specialists down a hall to a classroom to use as a play space, but the child life specialists asked if they could create a small space within the main large room instead. They explained that it may be important for both the parents and the kids to be able to see each other for a sense of safety after such an event. The staff immediately agreed and stated, "I didn't even think of that. Yes of course!" Together they created a small play space within the main room. The families watched quietly as the two child life specialists started

Gradually, the children began to come into the space and engage in play. The atmosphere of the whole room changed as adults watching the play began to smile and look more relaxed. A few adults asked for a pack of cards and soon a group of adults were playing, laughing, and talking together. The play space completely transformed the whole room.

pulling out various toys and art items intentionally chosen for free-play and processing. Gradually, the children began to come into the space and engage in play. The atmosphere of the whole room changed as

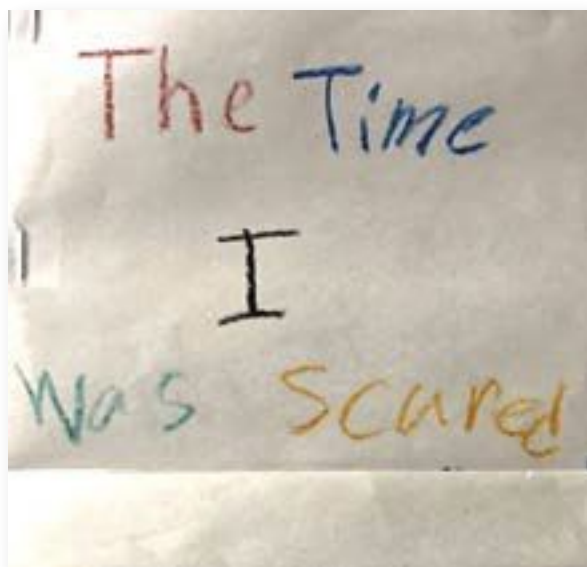
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Disaster Relief in Our Communities

adults watching the play began to smile and look more relaxed. A few adults asked for a pack of cards and soon a group of adults were playing, laughing, and talking together. The play space completely transformed the whole room.

While the children played, they frequently looked up timidly at the police officers standing in the room. They gradually communicated through their play the scary scene of having men dressed in black with large black masks and guns drawn kicking down their doors and yelling, “EVERYONE OUT NOW!” Through their play, the children were able to communicate their fears and concerns about the items they left behind and also a sense of confusion about whether cops are “good guys or bad guys.” The two child life specialists that night and two others who came the following day were able to help the kids process through these thoughts, feelings, and fears. They encouraged one of the police officers to join the play for a while to build trust. They also allowed the kids to write notes and draw pictures to pass out to the police officers around the room. When it was announced that the adults would be able to go back and retrieve more of their belongings from the motel, which was still considered a crime scene, the child life specialists spent time supporting the children with their questions and fears brought on by this new announcement.

The police and disaster relief workers repeatedly expressed their gratitude for the work of these child life specialists. “We don’t know how we have done this so long without you. This is amazing.”



The police and disaster relief workers repeatedly expressed their gratitude for the work of these child life specialists. “We don’t know how we have done this so long without you. This is amazing.” However, as you can probably imagine, the child life specialists were equally grateful. They were grateful first and foremost that the needs of children were being recognized, and that the need for psychosocial first responders was slowly becoming a reality.

Children affected by large-scale disasters demonstrate a clear need for support; children affected by small-scale events in our own communities need the same support. Together, we can continue to build bridges and navigate uncharted waters to make sure all children have the tools and resources needed to build resilience after disasters. ✨



Heart Institute patients tour the helipad at Children's Hospital Colorado

GETTING TO THE HEART OF THE MATTER: Creating a Heart Institute Wellness Program

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The Heart Institute Wellness Program at Children's Hospital Colorado is a support system for pediatric cardiac patients and their families, designed and facilitated by a multidisciplinary care team with members represented from medicine, spiritual care, social work, psychology, and child life. The program developed through the work of a team of practitioners who collaborate to care for children and families across the care continuum. Diagnosis and treatment of a heart condition can be very difficult for children and families (Bellinger & Newburger, 2010). Despite the obstacles they face, most families remain strong and resilient, finding healthy ways to cope and adjust to a child's disease. The Heart Institute Wellness Program focuses on the strengths of families, and each member of our multidisciplinary team offers families different ideas on how to thrive.

The Need for a Wellness Program

According to the National Child Traumatic Stress Network (2014), traumatic stress reactions occur among children and parents related to serious illness and invasive or frightening treatment experiences. Creating an interdisciplinary team to approach the unique needs of this population is paramount. Hicks and Davitt (2009) reference the importance of a team-based approach with representatives focusing on each area of mind, body, and spirit when treating children with chronic conditions. Compassion fatigue for the providers can also be common when working with a chronic population. Participation in a multidisciplinary care team can help normalize these feelings and offer necessary support for the child life specialist, as well as the other members of the team. A few hospitals have developed such multidisciplinary teams but have failed to include both psychologists and medical staff or maintain coordinated services across the continuum of care (Desai, Ng, & Bryant, 2002). A group of pediatric psychosocial professionals working in oncology developed the "Standards for the Psychosocial Care of Children with Can-

[continued on page 14](#)

Creating a Heart Institute Wellness Program

cer and their Families” after a need was observed to establish specific, evidence- and consensus-based standards of care (Wiener, Kazak, Noll, Patenaude, & Kupst, 2015). Prior to their work, there was significant variability in psychosocial services offered to patients in different pediatric oncology settings. No similar standards were found for cardiac care. Thus, this multidisciplinary team was initiated due to the observed need for enhanced and streamlined psychosocial services for patients treated with heart conditions and their families.

The medical director of the Heart Institute Wellness Program, Dr. Jeff Darst, often shares these two stories as the impetus for the creation of the Wellness Program:

As I began to talk more with children before and after their catheterization procedures and in the clinic, I learned more about how they perceived what was happening to them. And, in most cases, it was different than I would have expected. As a cardiologist, I knew that a child who had a VSD had a hole between the lower chambers of the heart which permitted recirculation of blood through the lungs, an inefficient circulation. To the child, he had a “hole in his heart” which allowed blood to “leak out with every beat,” the same way water might leak out of a bucket with a hole in it. I had no idea that’s how he understood his condition.

I met another teenager with an unusual ECG, but no definable cardiac risk. Because he had a rare ECG, I asked him to return in six months, but placed no restrictions upon him, and reassured him his heart was fine. When he returned six months later, his father reported that he “could no longer play baseball,” though he was previously the best player on his team. After further testing showed his heart to be fine, the patient revealed that he was “afraid he was going to die because of his heart.” When I asked him if he remembered our previous visit, and how reassuring I had thought I had been, he responded: “If you’re so sure I’m okay, then why did you make me come back?”

Medical care for these children is not enough. Children with heart problems or perceived heart problems must make sense of what they hear in the way they perceive the world. For that reason, care of children from multiple perspectives can help providers understand how best to help children.

Components of the Heart Institute Wellness Program

The Heart Institute Wellness Program has begun initiatives that enhance the psychosocial care of patients and families.

Table 1 is a comprehensive representation of the various programming that is available to staff, patients, and families.

These events help promote a sense of universality for cardiac families, which has been shown to be important when adjusting to and coping with a chronic diagnosis (Hicks & Davitt, 2009). Child life’s participation has led to increased rapport with families and opportunities for parents to share about their family unit. These initiatives also help to counteract compassion fatigue that can be a result from working with a chronic patient population, allowing child life specialists to interact with patients and families in a community setting, instead of a hospital setting.

Funding for these events was proposed and granted from the cardiology department’s operating budget. However, through collaboration with the hospital’s foundation, a donor was recently identified and a fund was created to provide future funding for the Heart Institute Wellness Program. Further ideas for programming include developing a “comfort cart” for end-of-life situations, stocking bookshelves in the inpatient units with both educational and therapeutic materials, and continuing to expand upon community events.

Outcomes and Implications

While our evidence at this point is anecdotal, we believe that child life’s involvement in this program has led to many positive outcomes. Not only has it resulted in stronger relationships between child life specialists and providers, physicians have also observed increased engagement from patients. Parents have reported the benefit of connecting with families who have had similar experiences, leading to higher levels of patient and family satisfaction. A mother of one heart transplant patient says, “For our family, it means support when we most need it, a warm smile... a friend when you feel so alone, and hope that there is more to life than just pain and suffering.” Child life specialists have observed an increase in appropriate child life referrals, with heightened team cohesion and a better understanding of each role. The wellness program supports ongoing child life interventions and assists with newly integrated programs such as Beads of Courage, which has added therapeutic value for patients and families. Child life’s participation in the wellness program has also led to increased job satisfaction. Intentional relationships allow space for processing and acknowledging the need for self-care. One child life specialist reports experiencing burnout prior to initiation of this team, stating, “I’m grateful for a group of colleagues who understand and respect each other’s roles. Working

HEART INSTITUTE WELLNESS PROGRAM				
ACTIVITIES	PARTICIPANTS	FACILITATOR	FREQUENCY	DETAILS
Rounds and Planning Meeting	Multidisciplinary Team	Co-Directors	Weekly	Discuss complex and ongoing patient cases
Therapeutic patient support group	Patients attending single ventricle clinic	Child life specialist	Bi-monthly (coincides with therapeutic parent support group)	Normalization and socialization opportunities (e.g., hospital scavenger hunt and self-expressive activities about living with a congenital heart defect)
Therapeutic parent support group	Parents whose child is a patient in single ventricle clinic	Social work	Bi-monthly (coincides with therapeutic patient support group)	Open-ended discussion time for parents to share similar experiences and challenges of raising a child with a single ventricle
Cardiology Coffee Time	Parents of inpatients	All members of the Heart Institute Wellness Program rotate	Weekly	Normalization and socialization opportunity for families facing similar cardiac diagnoses
Remembrance Event	Cardiology staff	All members of the Heart Institute Wellness Program	Yearly	Opportunity for staff to honor the patients who have died within the last year
ICD Day	Any patient who has an ICD implant	Child life specialist and various conference speakers	Yearly	Patients participate in therapeutic activities (making stress balls, Bingo led by physicians, medical play) while parents attend conference sessions
Single Ventricle Summit	Any patient who has a single ventricle	Child life specialist and various conference speakers	Yearly	Patients participate in therapeutic activities (making stress balls, Bingo led by physicians, medical play) while parents attend conference sessions
Community events (i.e. Zoo Lights, Pumpkin Patch, arcade event)	Diagnosis-specific invites	All members of Heart Institute Wellness Program	Yearly	Opportunity to promote connection between families facing similar cardiac conditions

Table 1. Components of the Heart Institute Wellness Program

together seamlessly to accomplish goals or brainstorm tough cases rejuvenated me and made me feel valued.” While these quotes speak to the success of this wellness program, further research is needed to quantify the benefits. One thought is to study the outcome of the therapeutic clinic group, specifically looking at patients’ perceptions of having a cardiac diagnosis before participating and after participating in the therapeutic activities.

Final Thoughts

Through the creation of a wellness program, child life specialists are given opportunities to work alongside other disciplines, gaining insight that will better enable them to meet the individual needs of patients and families. Working with children and families facing chronic conditions presents unique professional challenges (Hicks and Davitt, 2009). The idea of a wellness program was based on an alliance between existing providers to utilize individual training, experience, and talent. Hospital budgets are usually tight, so efficient use of expertise is essential in the care of children. Furthermore, specialists are already working at full capacity, so adding workload or responsibility may not be possible. Therefore, a wellness program should be designed to promote the work being done by specialists, to increase visibility and change the culture to include child life and other provid-

ers in all aspects of children’s care. Finally, efficiency can be increased by the collaboration between child life, social work, spiritual care, psychology, and medical teams via regular meetings and communication. This can ensure the right providers meet the right patients, and can help maximize specialized care. ✨

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PLAY AND HEALTH AS EVERYDAY EXPERIENCE: Being a Child Life Specialist in the Children's Museum

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BOSTON CHILDREN'S MUSEUM, BOSTON, MA

What does it mean to be a child life specialist working in a museum? How do the child life skills we are trained to use in medical settings apply within an informal learning environment? As the health and wellness educator at Boston Children's Museum, I get asked these questions frequently. Being part of families' everyday activities offers child life specialists the opportunity to go beyond their traditional roles. Recognizing how most children and their families spend their time outside hospitals and therapy appointments, the medical and developmental perspectives of child life are valuable in places, such as museums, where healthcare needs are not the main focus.

In a recent publication, the American Academy of Pediatrics has strengthened their position on the importance of play by urging pediatricians to prescribe play, emphasizing how play fosters children's healthy development, mitigates toxic stress, and promotes well-being (Yogman, Garner, Hutchinson, Hirsh-Pasek, & Golinkoff, 2018). Yogman and colleagues describe developmentally appropriate play as "a singular

opportunity to promote the social-emotional, cognitive, language, and self-regulation skills that build executive function and a prosocial brain" (p. 1). Yet, children's increased media consumption and a public fear of children freely playing outside have all contributed to the decline of play opportunities (Gray, 2011; Lukianoff & Haidt, 2018), which is also associated with the rise of mental health issues in children (Gray, 2011).

Children's museums are responding to this downward trend in playtime by offering exhibits, programs, and community outreach initiatives that promote opportunities for play. The following outlines how I, as a child life specialist in a children's museum, support this effort by ensuring that the Museum's playful experiences are developmentally appropriate for all children, specifically engaging the medical community and medically involved families.

Raising awareness of health and medical experience.

With a focus on developing foundational skills and a lifelong love of learning, Boston Children's Museum welcomes over 550,000 children ages 0 to 10 and their caregivers every year. A significant portion of my work involves using play to help those visitors develop healthy habits, prepare them for

healthcare experiences, and raise awareness of how illnesses affect people. I create programs with a range of topics such as safety, hygiene, and mental health, partnering with a variety of local organizations that support children's health. For example, each year local hospitals' child life programs join the Museum in the Healthy Kids Festival, in which visitors participate in various forms of medical play, including a teddy bear clinic, finger casts, rehabilitation games, and syringe painting.

Advocating for developmentally appropriate practices.

Museum staff come with various backgrounds ranging from performing arts to sciences to fundraising, but few have expertise in child development. As such, one of my roles is to serve as an internal consultant, ensuring that what happens in the Museum is developmentally appropriate, supports different types of families, and optimizes healthy growth and well-being. I advise colleagues in designing new exhibits, modifying programs to reach a wider age range, and communicating with caregivers.

This work includes taking children's mental health and emotional coping seriously and incorporating the social-emotional aspects into Museum practice. For example, in 2013 the Museum had to carefully evaluate how to best support families after the Boston Marathon bombing. My child life expertise enabled me to consider age-appropriate understanding of the event, coping styles, and families' backgrounds and previous experiences that affected their responses. I advocated for the Museum to remain a safe, normalized, playful environment, encouraging children's self-expression and creativity. I wrote a blog post to help caregivers support their children in processing the event, as the Museum welcomed conversations without bringing such discussions to the forefront of the Museum activities.

Supporting children with special healthcare needs within the Museum.

Although play opportunities are equally important to all children, those with special healthcare needs are often restricted from participating in normal childhood experiences. To them, even a playful environment such as the Museum can be a tough place to visit. The crowds may pose some health risks, unruly movements of people may be overwhelming to navigate, and the busy environment may be too high-paced for children who need extra time to approach a new experience. When a child has special healthcare needs, the entire family is affected. Many of these families report interpersonal stress and awkward moments with strangers, which impede appropriate social engagements that promote children's healthy development (Seligman & Darling, 2009). In order to address these concerns, I work closely with families and community groups to optimize the Museum experience and train all staff on inclusion and accessibility so that the Museum is welcoming.

While the Museum aims to be accessible at all times, there are also options for those families to visit the Museum without the stress of crowds. In 2012, I started *Morning-star Access*, a monthly program during which the Museum opens early for children and families who have various types of needs, including autism, blindness, ambulatory difficulties, and weak immune systems. This program can be a stepping stone for many families to gain familiarity with the Museum, building confidence to visit the Museum during the regular hours for a more inclusive experience. To encourage use of the Museum by social and health service organizations, I created the *Providing Opportunities for Play* (POP) initiative. Through POP, the Museum provides training, resources, and discounted passes to participating organizations that incorporate the Museum visits as part of their intervention with their clients. Additionally, I created various written resources that families can use to gain appropriate expectations of their upcoming visits. On a daily basis, I prepare families and field trip groups for their visits and support them throughout their Museum experience. With these accessibility efforts, the Museum has seen an increased number of visits by families and school/community groups with children who have special healthcare needs.

Despite the recognized importance of child-directed play, in our current society, adults decide the time, place, and types of activities for children, threatening children's right to play. However, playful experience can still emerge from the everyday routines and societal expectations (Lester & Russell, 2010). Child life specialists can reach more children and families by applying our unique expertise to families' everyday experiences beyond the medical or therapeutic environment. With the proven benefits of play for healthy development and well-being, the decline in play opportunities is a public health issue, which makes it even more meaningful for child life specialists to work in places like children's museums. ✨

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THE OPIOID CRISIS: An Interprofessional Response

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Young poet and peace activist Mattie J.T. Stepanek once said, “Unity is strength . . . when there is teamwork and collaboration, wonderful things can be achieved.” As Certified Child

Life Specialists, we all know the benefits of teamwork and collaboration in the hospital setting. However, although we know how vital it is to optimal patient- and family-centered care, we also know how hard it can be to get everyone on the same page, working together collaboratively.

This past October the graduate students and faculty at Azusa Pacific University (APU) were able to facilitate and participate in an Interprofessional Education (IPE) event that included 172 graduate students from seven different disciplines: child life, social work, psychology, athletic training, physical therapy, and nursing. The vision statement of Azusa Pacific University’s Interprofessional Education is as follows, “APU IPE encompasses a community of collaboration by increasing knowledge of other disciplines, incorporating the IPE competencies of values and ethics, roles and responsibilities, interprofessional communication, and teams and teamwork that

“APU IPE encompasses a community of collaboration by increasing knowledge of other disciplines, incorporating the IPE competencies of values and ethics, roles and responsibilities, interprofessional communication, and teams and teamwork that will ultimately improve education and consumer satisfaction, safety, and outcomes.”

will ultimately improve education and consumer satisfaction, safety, and outcomes.” Upon check in, students and faculty were assigned to a specific table with the goal of having a representative from each discipline at each table.

The topic of this year’s IPE event was “Opioid Crisis: An Interprofessional Response.” Our world today is changing and opioids are more accessible than ever. In 2017 more than 70,200 people died from a drug overdose (National Institute on Drug Abuse, 2019). While many of those who are dying from drug overdoses may be adults, they are leaving behind children who are affected first-hand by the rise in opioid use. As healthcare professionals, we must collaborate together to not only put a stop to this epidemic but also to increase education and support available for our communities.

After hearing from a law enforcement officer about the opioid crisis and learning about ways to combat and treat the problem, students and faculty were given a case study to dissect. Each discipline was asked to share what their role would be in the given case and how they would provide services to a patient and his family (wife and 2 school-age boys). As each discipline shared and those at the table understood their role, collaboration came naturally. Conversations began and commonalities were found as students understood the involvement of each discipline. Many of our attendees had never heard of child life and our students were so excited to share their role of working with the children of the patient, providing education and support as their dad received care.

In just over an hour, what started as seven separate disciplines quickly became one unified team, working together and collaborating to come up with a treatment plan to provide seamless family-centered care for our patient. When we asked our child life students to share what stood out most,



one of them shared, “I really enjoyed how there were individuals from various multidisciplinary teams and we were able to share with one another about our scope of practice. It was eye-opening how many disciplines did not know what child life was, or how we practiced in our field.” Another student shared, “The care outcomes of a patient and family are not based solely on one discipline. It requires a collaborative effort amongst these disciplines to ensure holistic care for the family.” One of our first year students shared, “My biggest takeaway from the IEP event was how each specialty could help contribute to the treatment and prevention of opioid addiction through non-pharmaceutical pain management (nursing and physical therapy), connecting to resources and community support (social work), and providing emotional/psychological support (child life and marriage/family therapy).” Not only did other disciplines learn the role and value of child life, but our child life students were also able to learn the role and value of others on the team and how their efforts could

be combined to achieve maximum effectiveness for patients and their families.

The feedback from our child life students was reflective of the feedback from all disciplines involved. Data gathered from our Readiness for Interprofessional Learning Scale revealed that 84.9% of attendees strongly agreed with the statement, “Learning with other students/professionals will make me a more effective member of a health and social care team.” Each of the nearly 200 students involved now have the opportunity to take the knowledge they learned about the other disciplines and apply it in their practice as a professional. When we collaborate and work together as a team we are able to provide superior care for our patients and their families. One of our students summarized this very idea and shared, “Every discipline has their own perspective of the situation and we need to work together to come up with a treatment plan that works best for the patient and family.” 🌟

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Child Life Focus



ABSTRACT

This project sought to improve psychological well-being of children and young people (CYP) with chronic physical illness, and their carers, through an innovative group intervention based on narrative therapy, therapeutic play, and theatrical performance. The project encouraged the development of CYPs' stories focused on the strategies or "superpowers" they use to manage their health. The groups were attended by 42 CYP with a mix of health conditions and 46 carers. Participants overwhelmingly reported that it was helpful to meet others who understood their experiences. All CYP, carers, and referring clinicians recommended the group. CYP and carers self-reported improved psychological well-being after the groups. However, there may be a need for sustained therapeutic support of CYP and their families.

Celebrating Difference: Improving Psychological Well-Being in Children and Young People Living with Chronic Physical Illness

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Introduction

Children and young people living with chronic illness are at increased risk of developing psychological problems when compared to the well population (Glazebrook, Hollis, Heussler, Goodman, & Coates, 2003; Meltzer, Gatward, Goodman, & Ford, 2000). Psycho-

logical difficulties in the context of chronic physical illness can have negative implications for patients' prognoses, quality of life, treatment adherence, and outcomes, leading to repeated procedures and increased use of pharmacology (Edwards & Titman, 2010). In addition, there may be a care-giving burden

associated with looking after a child with physical illness; for example, there may be a cost to a carer's psychological health through a deteriorated self-concept or decline in emotional well-being, and a negative impact on her/his physical health as a result of stress (Raina et al., 2004). There is growing

recognition of the importance of addressing the psychological well-being of paediatric patients (e.g. National Service Frameworks for Children and Young People, Department of Health, 2003). For example, the United Kingdom (UK) government strategy, *No Health Without Mental Health* (Her Majesty's Government/Department of Health, 2011) sets out objectives to ensure that the psychological well-being of paediatric patients is addressed alongside their physical health needs. These objectives include enhancing the physical health of those with mental health issues through fitness, well-being, and access to care tailored to patients' lifestyles (Her Majesty's Government/Department of Health, 2011). However, despite guidance and appeals for psychological support from patients and their parents, evidence-based psychological interventions for patients are scarce (Glazebrook et al., 2003), and provision is inconsistent (Care Quality Commission, 2015).

Setting the Context

The National Health Service (NHS) is the publicly funded national healthcare system for the UK. The Royal London Hospital (RLH) is part of Barts Health NHS Trust and provides psychosocial support to its paediatric patients (aged 0-17 years) and their families through its play department and Paediatric Liaison Team (PLT). The play department comprises Health Play Specialists and play workers (United Kingdom equivalent to Certified Child Life Specialists and child life assistants, respectively). Health Play Specialists are qualified registered health professionals who provide therapeutic care and emotional, medical, and procedural support. They are assisted by play workers who provide normalisation of the hospital environment, as well as general and therapeutic play. The PLT provides psychological and psychiatric assessment and intervention to paediatric patients and is made up of professionals from social work, clinical psychology, and psychiatry. Both teams work with inpatients and outpatients. In response to demand for these services outweighing staffing and resources, an innovative intervention for children (ages 6 – 11) and young people (ages 12 – 17) living with chronic physical illness (for brevity, referred to as 'CYP' throughout this article) and their parents or carers (for brevity, referred to as 'carers' throughout this article) was developed. The intervention was a joint undertak-

ing between the hospital's play department and PLT that sought to promote psychological well-being in CYP living with chronic health conditions, and their carers.

Background Information

Therapeutic Play

Play and playfulness are related to social, emotional, and cognitive development (Fisher, 1992). On the topic of play, Erikson wrote, "to play out is the most natural auto-therapeutic measure childhood affords. Whatever other roles play may have in the child's development...the child uses it to make up for defeats, sufferings, and frustrations" (1940, p. 561).

Brown (2009) reported that play is particularly helpful for children struggling with anxiety or stressful circumstances. It is now accepted that therapeutic play is a valuable intervention with hospitalised children (Clatworthy, 1981) and has a positive impact on children's psychosocial welfare and physical recovery (Wolfer, Gaynard, Goldberger, Laidley, & Thompson, 1998). It can also contribute to a reduction in children's anxiety while they are inpatient (Johnson & Stockdale, 1975) and reduced self-reported hospital fears (Rae, Worchel, Upchurch, Sanner, & Daniel, 1989), as well as less expression of emotional distress, better coping during hospitalisation, and a clearer understanding of procedures (Wolfer et al., 1998).

Therapeutic play is defined as purposeful and directive play to assist in communicating perceptions and gaining mastery (Koller, 2008). Therapeutic play focuses on the process of play as a mechanism for mastering developmental milestones and critical events such as hospitalisation. During therapeutic play, children are encouraged to ask questions to clarify misconceptions and express feelings related to their fears and concerns. It acts as a vehicle for eliciting information from children while also sharing information about what to expect from medical procedures and what sensation may be experienced. Therapeutic play typically consists of at least one of the following:

- The encouragement of emotional expression;
- Instructional play to educate children about medical experiences; or
- Physiologically enhancing play.

Narrative Therapy

Narrative therapy is a therapeutic approach which regards people as experts in their own lives and aims to help them identify their skills and values in a respectful, non-accusatory approach (Denborough, 2008; White, 2003). It approaches problems as separate from people and therefore allows the development of an identity which is separate from the problem faced (White, 2003, 2005, 2007; White & Epston, 1990). Narrative therapy asserts that people can hold unhelpful stories about themselves, known as thin stories or descriptions which allow little space for the complexities and contradictions of life (White & Epston, 1990). These thin stories often focus on weaknesses and disabilities and are generated by those in positions of power such as health professionals in the lives of patients, or parents and teachers in the lives of children

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(Morgan, 2000). These stories have been described as 'problem-saturated'.

Narrative therapy proceeds on the basis that people will have skills, competencies, beliefs, values, commitments, and abilities that will help them reduce the extent and impact of problems in their lives. By focussing on these aspects, individuals are encouraged to re-tell their stories in an alternative and preferred manner involving richly described or thickened stories. These new stories do not

support or sustain problems (Freedman & Combs, 1996) and are based on strengths and abilities. The alternative stories hold potential to change people's relationships to the problems they face. The current work supposed that this approach may be particularly relevant for children and young people living with a chronic physical illness, who may adopt a dominant 'sick role' narrative of their lives focussing on dysfunction. That is, narrative therapy may enable a focus on the person's response to difficulty (e.g. illness) rather than only on how they have been

affected by the difficulty (Yuen, 2009).

There is a dearth of evidence on psychology-based groups for CYP living with chronic illness using a narrative therapy approach, and all research so far has focussed on interventions for single conditions. Casdagli, Christie, Girling, Ali, & Fredman (2017) discussed the use of the Tree of Life, a narrative therapeutic approach, to engage CYP living with type 1 diabetes at University College London Hospital (UCLH). This approach uses trees as a metaphor to reflect on the child's experiences (roots), strengths, abilities, and

Table 1. Narrative Therapy Techniques Utilised in the Intervention

TECHNIQUE	APPLICATION TO INTERVENTION
De-centring	In interactions with CYP and families, the project team sought to step away from prioritising their own interpretations and assumptions in a process known as de-centring (White, 1997). The team gave priority to CYP's and their families' stories, knowledge, and skills, and gave them primary authorship of their stories. The team aimed to enable patients to more richly describe the alternative stories of their lives; to step into and explore some of the neglected territories of their lives; and to become more acquainted with the knowledge and skills in their lives relevant to addressing the problems faced.
Externalising	The project team focussed on the health condition as the problem, rather than the individual (White & Epston, 1990), and on helping CYP distance and separate themselves from the problem and the problem-focussed identity.
Statement of Position (SOP) Map 1	The team aimed to assist CYP to give a name and identity to the problems they faced, to map the effects of the problem on their lives, to consider their own position in relation to the problem, and to identify the values that they felt were important to them.
Statement of Position (SOP) Map 2.	The team focussed on guiding CYP to identify times when they had taken a new and positive initiative, to map the effects of this initiative, to consider their own position in relation to the initiative, and to identify the values that they held in relation to the initiative.
Documentation	The intervention used the development of superhero characters (for children aged 6 -11 years) and identity boards (for young people aged 12 - 17 years, see Figure 1); the presentation of certificates for children, and key chains for young people; and the writing of therapeutic letters (discussed in item 6, below) containing a summary of the main ideas and thoughts that developed for the CYP during the intervention (White & Epston, 1990). These aspects recorded the work done in the group, marked the end of the work, and recognised the skills, knowledge, and preferred stories of the CYP in permanent form. The characters, certificates, key chains and letters were developed to contribute to a richer development of CYP's preferred stories.
Definitional ceremony	Definitional ceremonies are "rituals that acknowledge and regrade people's lives" (White, 2007, p.165), and provide people with "the option of telling or performing the stories of their lives before an audience of carefully chosen outside witnesses" (White, 2007, p. 165). Music, song, art, and video can be utilised in the process, which can become more of a ritual or performance to a carefully chosen audience in this process (White, 2007). An audience of "outsider witnesses" (Myerhoff, 1982) was carefully selected by the CYP and invited to the afternoon session of this project where CYP gave a theatrical performance (facilitated by Chickenshed Theatre) of their hero characters and identities. The audience included family members and staff (such as nurses, paediatricians, and speech therapists) who had worked with the CYP.
Outsider witnessing	Within narrative practice, an outsider witness is an invited audience to a therapy conversation, a third party who is invited to listen to and acknowledge the preferred stories and identity claims of the person consulting the therapist. Outsider witnesses may be part of a person's existing community or they may be invited from outside these networks, in which case they may be professionals. The project team observed the CYP's afternoon performances and then used therapeutic letters (White & Epston, 1990) to acknowledge and authenticate CYP's preferred stories as a form of outsider witnessing. This was done by either reflecting on any expressions or images used by CYP that struck a chord with the team, or by noting how the team may have been moved or changed as a result of witnessing patients' stories (Carey & Russell, 2003). The letters used the language and words spoken by CYP during the session and continued the language of separating the problem from the person, such as by referring to 'the health condition'. The letters also contained questions that the team had wondered about since the intervention, such as: <i>We also saw how you got really involved... and were a key part of the performance despite being nervous about speaking in front of others. We wondered where you found this courage, and if courage helps you to do things that are difficult in other areas of your life? We also noticed that you were very talkative in one to one situations and wondered if it feels easier to talk in smaller groups?</i>

interests (trunk), hopes and dreams (branches), and the important people in their life (leaves). It also discusses the challenges they face (storms) and how they manage these (as a forest; Denborough, 2008; Ncube, 2006). The aim of this project was to reduce the negative emotional impact of the diabetes on CYP through enabling participants to share their experience and knowledge of diabetes with each other during a one-day group session. Watt (2012) has also utilised a narrative therapy group approach for adolescents with type 1 diabetes through employing outsider witnessing practices (discussed in greater detail below). Another study discussed the use of a group intervention informed by narrative therapy with CYP at UCLH; Portnoy, Girling, and Fredman (2016) reported on the use of the 'Just Bead It' program with oncology paediatric patients. This intervention uses a narrative therapeutic approach with five aspects to enable CYP to understand their cancer journey in new ways through beading. Christie, McFarlane, Casdagli, and Fredman (2016) have also reported on the use of outsider witnessing to support young people living with chronic pain and fatigue, and have implemented regular workshops that employ current patients as 'expert consultants' as part of their support to other young people receiving treatment for chronic pain and fatigue at UCLH. To our knowledge, this current project is the first to use narrative therapy within a mixed health condition paediatric population.

The Clinical Intervention

This intervention was designed for CYP living with different chronic illnesses. The aim of the intervention was to promote psychological well-being. The project consisted of a one-day group for CYP that consisted of both therapeutic play and narrative therapy elements. Each group had a morning and afternoon session.

Connection to Theory

In the morning sessions, therapeutic play techniques were used through the use of superhero-based ice-breaker activities, which encouraged children to create their own superhero characters; meanwhile, young people are encouraged to create their own mood boards (see Figure 1) after a period of discussion about both the challenges of living with a chronic illness and the ways in which CYP cope with these challenges. In the



Figure 1. Sample mood boards.

afternoon sessions, the groups also utilised therapeutic play in drama-based activities such as acting, movement, mime, and singing as a means of bringing to life the characters and stories which the CYP had created.

A number of aspects of narrative therapy were utilised in this intervention, summarised in Table 1.

The Project Team

The project team consisted of the hospital's clinical lead of the play department who is a Certified Child Life Specialist; a Clinical

Psychologist; a research consultant; and a part-time project assistant. Other hospital staff members were involved as group leaders and group facilitators. Group leaders were either Health Play Specialists from the play department or professionals from the PLT. Group facilitators assisted with the group and were healthcare professionals working at RLH who had attended a training session dealing with facilitating the intervention. Chicken-shed Theatre facilitated the afternoon drama activities.

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Table 2. Schedule of the Intervention

ACTIVITY				
TIME	CHILD	YOUNG PERSON	CARERS	FACILITATOR
10-10:30am	Registration			Project Assistant
10:45-11:30am	Ice breakers			Group Leads and Facilitators
	What is a superhero? What challenges do superheroes face? How are we like superheroes? Development of superhero characters	What is a hero? What challenges do heroes face? How are we like heroes? Development of identity boards	Free time, (optional sheets to complete to stimulate thought about challenges faced as carer of CYP with a chronic illness)	
11:30-12:30	What are the challenges you face? What are the initiatives you use to manage these challenges?	What are the challenges you face? What are the initiatives you use to manage these challenges?		
12:30-13:30	Lunch			
1:30-3:15	“Bringing to life” of superhero characters for a performance	Development of preferred identities for a performance	Facilitated group discussion about challenges faced as carer of CYP with chronic illness and coping strategies	Chickenshed Theatre/ Group Leads and Facilitators
3:15-4:30	Performance and certification ceremony			All

Methods

This project aimed to promote psychological well-being in CYP living with chronic health conditions by focussing on the strategies or 'superpowers' they use to manage their health. It was evaluated using measures of psychological well-being and satisfaction.

Table 3. Breakdown of Participant Numbers by Intervention and Gender

SESSION		MALE	FEMALE	TOTAL
1	Child	5	4	9
	Carer	2	7	9
2	Child	4	3	7
	Carer	2	6	8
3	YP	1	3	4
	Carer	0	4	4
4	Child	2	4	6
	Carer	1	6	7
5	YP	0	4	4
	Carer	0	5	5
6	Child	2	4	6
	Carer	2	5	7
7	YP	2	4	6
	Carer	1	5	6

Working with CYP

The intervention was open to all CYP aged six to 17 years of age with a chronic illness accessing RLH's paediatric services, and their carers. Each group catered for a maximum of ten CYP. The intervention took the form of a one-day group from 10am-4:30pm at RLH. The group was repeated on seven Fridays during school holidays spread over a 15-month period. Four groups were held for children aged six to 11 years, and three for young people aged 12 to 17 years. CYP were referred by their medical teams or could self-refer. Carers attended a session concurrently.

The intervention utilised both therapeutic play and narrative therapy, using the concept of heroes as a metaphor for considering how the children and young people use individual strategies ('superpowers' for the purpose of the intervention) to address the challenges they face. The child intervention adopted a superhero metaphor whilst the young person intervention used a modern-day hero theme. The inter-

vention was adapted to meet the differential needs of children and young people but each day followed a similar structure. Carers had an optional homework assignment for the morning session and attended a group



Figure 2. Participants in superhero capes preparing for the graduation ceremony.

intervention in the afternoon. The structure of the day is set out below (see Table 2).

Working with Carers

Promoting the psychological well-being of CYP is supported through working with the systems around them. In light of this, carers of CYP were required to attend a concurrent group session (unless in extenuating circumstances, e.g. mental or physical incapacity). While CYP were working with the project team in the morning, carers were invited to reflect on firstly, the challenges their CYP faced and how these were managed, and secondly, the challenges they faced as carers of a child with a chronic illness and how these were managed. Carers were given a list of questions to consider and reflect on, and were invited to share these later in a group session with other carers. This group session included time spent exploring the challenges carers face and the initiatives and strategies used for managing.

Celebrating Alternative Stories

At the end of the afternoon, the CYP delivered a performance that they had developed with Chickenshed Theatre where their ideas, narratives, and characters were brought to life (see Figure 2). This was witnessed by their families and hospital staff (where possible, the referring clinicians such as consultants, nurses, and therapists attended). The performances included various skits, songs, a rap, group improvisation, and group movements. At the conclusion of the performance, CYP were presented with certificates to mark their participation in the day. The certificates recorded the unique ways in which they were a superhero (for children) or a health hero (for young people). In addition, children received superhero capes to wear while young people were given silver key-rings engraved with the logo of the group. In order to recognise each carer's individual strengths and abilities, certificates were also prepared for the CYP to present to their parent or carer at the end of the performance. The certificates described ways in which the CYP had told us their parents or carers were good at looking after them and meeting their needs.

Participants

88 participants attended: 28 children, 14 YP, and 46 carers (see Table 3).

Table 4. CYP Participant Demographics

VARIABLE	CHILD (N = 28)	YOUNG PERSON (N = 19)
Age (M, range)	9 (7-13*)	14 (12-18*)
Sex (N, % of group total)		
Males	13 (46%)	3 (16%)
Females	15 (54%)	16 (84%)
Ethnicity (N, % of group total)		
White - British	9 (33%)	5 (27%)
White - any other background	2 (7%)	0 (0%)
Black or Black British - African	2 (7%)	3 (16%)
Black or Black British - Caribbean	3 (10%)	0 (0%)
Black - any other	3 (10%)	4 (21%)
Asian or Asian British - Bangladeshi	3 (10%)	4 (21%)
Asian or Asian British - Indian	1 (4%)	0 (0%)
Asian or Asian British - Pakistani	0 (0%)	1 (5%)
Asian - any other background	1 (4%)	0 (0%)
Mixed - White & Black Caribbean	2 (7%)	0 (0%)
Mixed - White and Black African	0 (0%)	1 (5%)
Other	1 (4%)	1 (5%)
Refused	1 (4%)	0 (0%)
Religion (N, % of group total)		
Roman Catholic	2 (7%)	1 (5%)
Christian Church	1 (4%)	1 (5%)
Islam	3 (10%)	5 (27%)
Church of England	0 (%)	2 (11%)
Other	2 (7%)	1 (5%)
Unknown	20 (72%)	9 (47%)
Medical speciality (N, % of group total)		
Gastroenterology	3 (11%)	2 (11%)
Haematology	7 (25%)	7 (36%)
Retinoblastoma	4 (14%)	3 (16%)
Surgery	3 (11%)	0 (0%)
Diabetes	2 (7%)	2 (11%)
Oncology	4 (14%)	0 (0%)
Neurology	2 (7%)	1 (5%)
Respiratory	3 (11%)	2 (11%)
Dermatology	0 (0%)	1 (5%)
Endocrinology	0 (0%)	1 (5%)
Referrer type (N, % of group total)		
Clinical Nurse Specialist	9 (32%)	5 (26%)
Consultant	4 (14%)	0 (0%)
Psychologist	10 (36%)	9 (47%)
Play Specialist/Play Worker	3 (10%)	4 (21%)
Teacher	0 (0%)	1 (6%)
Physiotherapist	1 (4%)	0 (0%)
Speech and Language Therapist	1 (4%)	0 (0%)

*A 12-year-old and a 13-year-old attended child groups and an 18-year-old attended the young person group as it was felt that their developmental needs would be better met by these interventions.

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Measures

CYP psychological well-being was measured using the Paediatric Index of Emotional Distress (PI-ED; O'Connor, Carney, House, Ferguson, & O'Connor, 2010). It was completed by CYP and carers. Carer psychological well-being was measured using the Hospital Anxiety and Depression Scale (HADS, Zigmond & Snaith, 1983). The HADS is a self-assessment scale developed to detect states of depression, anxiety, and emotional distress in adults. Both measures were given prior to the intervention, within two weeks post-intervention, and at three months' follow-up. Satisfaction with the intervention was

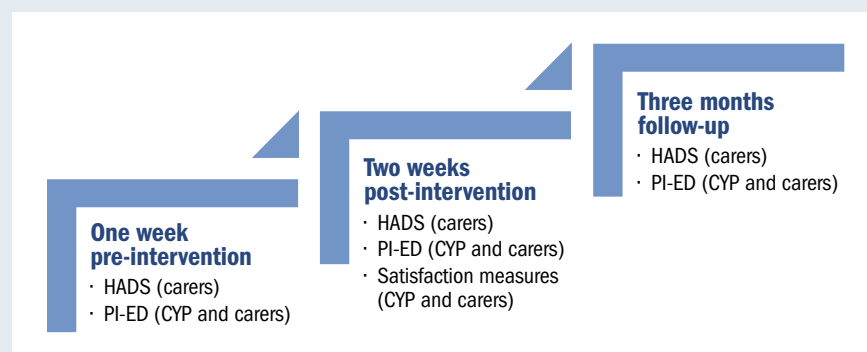


Figure 3. Outcome measures by times of administration.

measured within two weeks post-intervention using qualitative questions and Likert scales (see Figure 3). These were answered by CYP, carers, and referring clinicians.

Results

Participant Information

Along with 66 CYP, 66 carers agreed to attend the intervention, giving a total of 132 invitees. Of the 132 invitees, 28 children, 14 young people and 46 carers attended (see Table 4 for demographic information). Of the CYP who attended, 46% children and 84% young people were female. The lower number of young men than young women who attended the intervention might reflect referring clinicians' thinking about psychological well-being in relation to gender, or may be connected with how young men felt about the group intervention or about being part of it; data was not specifically collected on this point, meaning that it is not possible to draw any firm conclusions. Participants were ethnically diverse. Referrals came from a range of professionals (e.g. consultants, clinical nurse specialists, play specialists, and clinical psychologists) within a variety of medical specialities, including haematology, oncology, respiratory, diabetes, dermatology and endocrinology. The rates of referral may have been influenced by referrer interest in the intervention and in particular there were a high number of haematology patients. The data suggest that the intervention was acceptable to a range of ethnicities and medical specialities, as well as males and females.

Reasons for non-attendance included: conflicting family commitments on the day; difficulties with carers getting time off work; difficulties arranging child-care for siblings; anxiety around participation; and illness. In addition, some children (particularly those who had exams coming up) did not want to miss school. Although the groups were scheduled for days which were mostly during school holidays, some London boroughs operate on a different calendar and for a few children

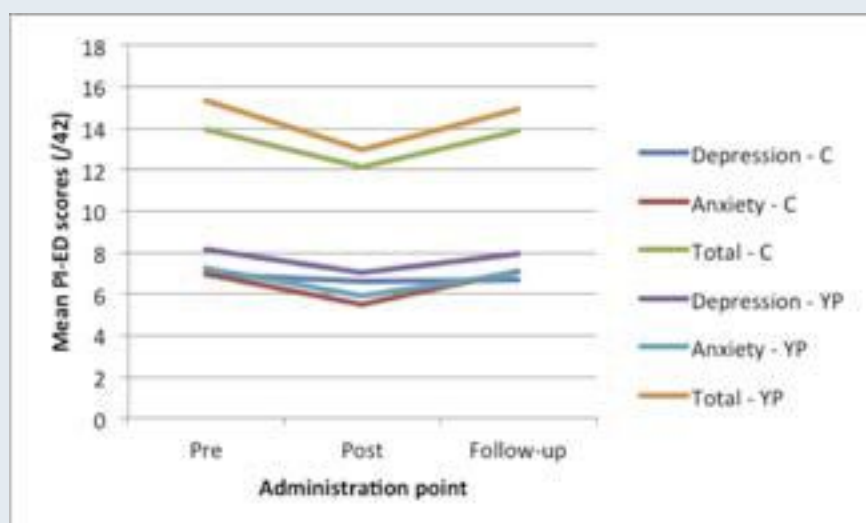


Figure 4. Children (referred to as C) and young people (referred to as YP) self-reported depression and anxiety mean scores (PI-ED).

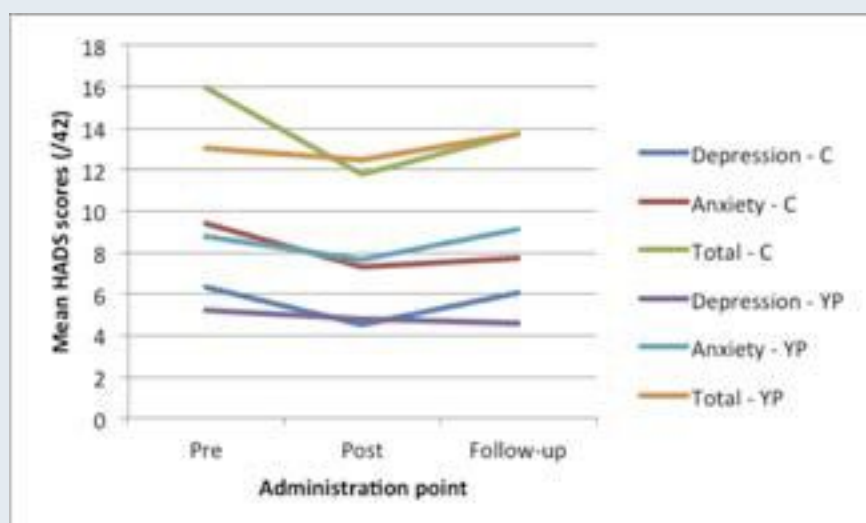


Figure 5. Carers of children (referred to as C) and young people (referred to as YP) self-reported depression and anxiety (HADS).

Table 5. Average scores on Depression and Anxiety Measures (PI-ED for CYP, HADS for Carers) at Pre-Intervention, Post-Intervention, and Follow-Up.

	PRE-INTERVENTION	POST-INTERVENTION	FOLLOW-UP
Child (PI-ED)	13.9	12.1	13.8
Carer of child (HADS)	16.0	11.8	13.7
Young person (PI-ED)	15.3	12.9	14.9
Carer of young person (HADS)	13.0	12.5	13.7

the groups were held on a school day, making it difficult for them to attend. The carers who attended were overwhelmingly parents, with a small number of other family members (such as adult sisters) attending where the parent was unavailable.

Outcome Data

A descriptive analysis of the quantitative data was performed and themes were extracted from the qualitative feedback given by participants and clinicians. Due to the small sample size, no measures of statistical significance were conducted.

Psychological well-being. Across measures, psychological well-being improved post-intervention for CYP and carers. Figures 4 and 5 show how participants' self-reported depression and anxiety mean scores decreased two weeks post-intervention. There was some deterioration at follow-up for CYP and carers but most scores remained below pre-intervention levels (see Table 5).

Satisfaction with the intervention. As aforementioned, satisfaction with the intervention was measured within two weeks post-inter-

vention using qualitative questions and Likert scales, provided to CYP, carers, and referring clinicians. All CYP and carers, and referring clinicians, indicated that they would recommend the group intervention. The majority of children (83%) and YP (80%) found the group helpful. This was echoed by the carers who reported the group to be helpful (carers of children 92%; carers of YP 100%) with all reporting that the intervention was tailored to the CYPs' needs. The majority of carers also reported that the carer intervention was tailored to their needs (carers of children 85%; carers of YP 100%). All clinicians reported that the group had been helpful to YP, with 85% seeing benefit for children.

CYP and their carers were also invited to provide feedback to open-ended questions about their experiences of the group intervention. This was designed to obtain richer responses from the CYP and carers about the intervention which could be used to further refine and improve the service.

The project team received overwhelmingly positive feedback on the group from CYP, families, and their clinicians. CYP reported

hearing about others' experiences and learning new coping strategies as helpful. A young person commented, "I feel less alone with my feelings," and a child said, "My favourite part was meeting new people and knowing how they cope with conditions." Carers reported that the group helped CYP to feel less alone and to talk about their condition and feelings, and that this boosted their confidence. A carer of a child said, "It helped my daughter be less shy," and a carer of a young person said, "It helped my daughter talk about her prosthetic eye." All carers commented that the group had helped them to feel less alone, and had given them an opportunity to talk. One carer said that the group "...was inspirational and removed a sense of isolation." Clinicians commented that many CYP showed improved confidence post-intervention with regards to both their own self-esteem and medical procedures. Three months later, CYP reported continuing to feel less isolated, more confident in being themselves, and more confident in their ability to cope with challenges. The group helped some CYP and carers recognise that they needed more support, which they are now accessing through the project team. Carers reported being more appreciative of how CYP managed their illness.

Unanticipated outcomes. Staff who assisted in the delivery of the group reported having increased skills and confidence in addressing psychosocial aspects of patient care. Working across disciplines may therefore not only have promoted the work of play and psychology within hospital settings but also benefitted patients and staff. Although we were not able to reliably measure impact, there may have been additional benefits to RLH in the areas noted in Table 6.

Discussion

Findings and Conclusions

While not statistically significant due to the small sample size, results suggest a reduction in symptoms of depression and anxiety following the intervention. There was initial reduction in symptoms of depression and anxiety at post-intervention for CYP and their carers and a smaller improvement was observed three months' follow-up with most scores remaining below pre-intervention level. It may be that to bring about lasting improve-

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Table 6. Potential Benefits to RLH Staff

ADDITIONAL POTENTIAL BENEFITS	QUOTES FROM RLH CLINICIANS
Reduced hospital admissions	"Parental and child anxiety had reduced dramatically. There have been no unrequired hospital admissions since X attended the group. Both she and her parents seem happier and more relaxed. This was a turning point of this family."
Improved adherence with medical procedures	"He successfully completed the clinic test, which he failed previously and wasn't even willing to attempt." "We have managed to have cannulas done with virtually no intervention."
Improved engagement with services.	"Since the group she has started attending and been much more vocal during the Youth Empowerment Squad (hospital youth forum) meetings." "I saw him recently for a clinical test and he came down to find me to ensure he would have support during the examination, was able to say what he needed and was comfortable talking to me and the doctor, which was very different from his last clinic appointment."

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ments, an on-going intervention is required to integrate resilience strategies into daily life. Peer support and a sense of reduced isolation may have been integral to these developments, as evidenced by qualitative feedback from participants.

Strengths of the project

This intervention incorporated a number of innovative features:

- It used narrative therapeutic skills within a superhero and modern day hero context which is currently engaging, both in popular culture and to CYP populations;
- The intervention was delivered to both CYP and their carers;
- The intervention was creative in that it utilised both narrative therapy and therapeutic play and involved the use of a theatre company to develop and strengthen the positive alternative narratives of CYP;
- The intervention promoted working across

two teams within the hospital, while also promoting working with agencies outside of the NHS;

- The intervention was not restricted to paediatric patients with one specific health condition; and
- Two separate interventions were individually tailored to the developmental needs of children and YP.

The intervention supports existing literature suggesting that psychosocial interventions are helpful to paediatric patients and their families, and shows that this also applies to mixed health condition groups. The group demonstrated improvements in psychological well-being of carers of CYP and of CYP themselves. A majority of participants reported that it was helpful to meet others who understood their experiences. Additionally, nearly all CYP, carers, and referring clinicians would recommend the group to others. This suggests that group interventions are

valuable in providing a sense of community and shared experience that perhaps cannot be gained through individual input alone. The group also provided anecdotal evidence for the importance of addressing the psychological needs of carers, and of considering the systems around CYP when thinking about their psychological well-being.

Although this was a small-scale evaluation of a new way of delivering psychosocial input to CYP with chronic physical illnesses and their families, the results suggest there is much to be positive about regarding the possibilities inherent in using narrative therapy and therapeutic play in this way. For example, some carers reported having a better understanding of the challenges their CYP experienced in having a chronic illness, and the various strategies that were being used to manage these. This may have helped to move away from “problem-saturated” or “thin” accounts of living with chronic illness that existed pre-intervention.

Limitations

There were some limitations to this intervention. Firstly, there may have been challenges in accessing the intervention for certain populations; for example, those living far away from the hospital, those for whom English is not their first language, those living with infectious conditions, those with significant cognitive impairment, and those who were unable to obtain childcare for siblings in order to attend the group. The project team attempted to ameliorate these difficulties through the provision of financial reimbursement of travel to and from the group, the use of interpreters, and the careful consideration of patient distribution within the groups to ensure fairness and risk management. Notwithstanding this, it may still have been difficult for certain clinical populations to access the group.

Secondly, as a pilot intervention, the project was relatively small-scale and therefore care must be taken in thinking about whether the results can be generalised to other paediatric populations. The skew in the number of participants from particular medical specialties as a result of referrer interest in or knowledge of the intervention may also reduce the generalisability of the results. In addition, given the period of time over which the data was collected, there is always the possibility that factors other than, or in addition to, the intervention might account for the improvements seen in the post-intervention measures.

There were also limitations to the methodology used to measure outcome. For example,

the team received a significant amount of positive feedback about improvements in coping by the patients and their families who attended the group but there was no measure of improved coping as an outcome; it may be that the study missed capturing a benefit of the group in this regard. The timing of the completion of the measures was not always evenly spaced. There was also some initial confusion with CYP and carers not knowing which measures were to be completed by which individual (CYP, or parent/carer), and different carers completing measures at post-intervention versus follow-up. The team attempted to address these difficulties by amending the instructions for completion of the measures and printing the measures on differently coloured paper, but there may still have been some impact. In addition, data sets were often incomplete, which may have skewed the results obtained.

Recommendations for Clinical Practice

This project was funded by a grant from the Health Foundation and the grant has now largely come to an end. At a time where the NHS is under financial constraints, there are challenges in accessing funding for new services and having enough staff support or time in which to train staff. At present, the project team are delivering a shorter version of the intervention which they are seeking to embed across Play and PLT services and deliver across other sites where Barts Health NHS Trust services are provided.

Key features of the shorter group include:

- Being strengths-based (but not necessarily using a hero metaphor) and using narrative therapy and therapeutic play techniques;
- Being less time-intensive;
- Being open to “repeat participants” including carers;
- Being provided by a wider range of professionals within the Play Team and PLT;
- Being held regularly with the potential for YP to act as Group Facilitators for children;
- And having an identified Project Assistant to manage the project, as well as back-fill staff for clinicians running or facilitating the group.

This project highlighted the importance of considering the psychological well-being of CYP living with chronic illness, as well as the psychological well-being of their carers. It also reinforced the important role psychosocial support services can play in improving care in paediatric services, with benefits for both the psychological and physical health of patients. ✨

Acknowledgements

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SPECIALIZED RESOURCES



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

Recommended Resources for Working with Children of Adult Patients

Natalie Chango, MS, CCLS

PENN STATE CHILDREN'S HOSPITAL, HERSHEY, PA

Working with children of adult patients can involve a vast array of diagnoses and situations, ranging from a life-altering injury to a chronic illness to the death of a loved one. A review of books and resources was conducted to explore what is currently available to meet the varying needs of this complex population. Because death and grief are all too common outcomes when working with children of adult patients, many of the resources focus on those topics. While there are many resources available, those on this list were selected because they fill a gap, are more current, and in some cases incorporate technology.

BOOKS

- Levis, Caron. (2016). *Ida, always*. New York, NY: Simon & Schuster, Inc. Two polar bears, Gus and Ida, live in a city zoo. When Ida becomes sick, the zookeeper gently explains to Gus that Ida won't get better and will die. The book explores anticipatory grief and reminds us that the memory of a loved one can remain with us forever. This book is recommended for ages 4 to 8 years.
- Zucker, Bonnie. (2016). *Something very sad happened: A toddler's guide to understanding death*. Washington, DC: American Psychological Association. This book was written for two- and three-year-olds to introduce the concept of death. The reader is encouraged to adapt the text to personalize the story for the child. The book explains death in simple terms and identifies feelings. Notes for caregivers are provided.
- Rowland, Joanna. (2017). *The memory box: A book about grief*. Minneapolis, MN: Sparkhouse Family. In the story, a young girl grieving the loss of a loved one worries that she will forget her loved one and decides to make a memory box. As she looks back at memories and ahead to new experiences, she finds reassurance that she will not forget. This book is recommended for ages 4 to 8 years but may be best suited for the higher end of the age range.

WEBSITES/ONLINE RESOURCES

- Caron Levis: Scribbling for kids, teens, and grown-ups. (2017). *Ida, Always* Activity & Discussion Guide [PDF file]. Retrieved from http://docs.wixstatic.com/ugd/c0e481_5a6e02f05a7746d697e3fca5b7f5af43.pdf At the author's website, there is a free activity guide that goes along with *Ida, Always*. The packet includes discussion tips for talking to children about death as well as activity ideas and activity sheets that accompany the book.

- The Shared Grief Project www.sharedgrief.org The aim of the Shared Grief Project is to let children and teens who have experienced the death of a loved one know they are not alone. Athletes, celebrities, and other well-known figures share their personal stories of loss from a young age and offer words of encouragement. This website would be appropriate for older school-age children and teens.
- Telling Kids About Cancer. (2012). *Telling Your Child About Cancer: Age-Appropriate Advice*. Retrieved from <http://www.tellingkidsaboutcancer.com> This website is a helpful resource for preparing parents to talk to children and teens about a cancer diagnosis. There is a conversation guide to help parents plan the logistics of having the discussion as well as information about developmentally appropriate reactions and language to use.
- Stroke Foundation. (2018). *Supporting Children After a Family Member's Stroke*. Retrieved from <https://strokefoundation.org.au/en/About-Stroke/Help-after-stroke/Stroke-resources-and-fact-sheets> This handout is a helpful resource addressing common concerns parents and caregivers may have regarding their children after a family member has a stroke. Tips covered on the handout include the importance of talking to children and teens about what has happened, preparing children to visit the hospital, and maintaining their normal routines.
- The National Multiple Sclerosis Society. (n.d.). *Someone You Know Has MS: A Book for Families* [PDF file]. Retrieved from <https://www.nationalmssociety.org/NationalMSSociety/media/MSNationalFiles/Brochures/Brochure-Someone-You-Know-has-MS-A-Book-for-Families.pdf> In this story Michael explains his mom's MS diagnosis, her symptoms, and how to deal with emotions that all the family members experience. This is recommended for ages 5 to 12 years. Other free resources you can download from this website include *When a Parent has MS: A Teenager's Guide* and *Keep S'myelin* activity book and newsletters. ✨

Natalie Chango has been a child life specialist at Penn State Children's Hospital for 17 years in a pediatric acute care setting. Recently Natalie has transitioned to a brand new position working with children of adult patients at Penn State Health. Natalie can be contacted at nchango@pennstatehealth.psu.edu for questions or more information about the resources mentioned. The author verifies that there are no financial affiliations with any of the above mentioned organizations or entities.

Whether working in a traditional child life role or an alternative role (for example, with children of adult patients), all child life specialists rely on their knowledge of child development in order to provide effective interventions for children and teens in stressful healthcare situations. A key responsibility for child life specialists is educating caregivers on the importance of providing honest, age appropriate information to children and teens. While child life specialists understand the implications of lying or withholding information, caregivers need guidance and reassurance about how to best support children and teens as their family copes with a serious illness or injury. Families often think they are doing the right thing in trying to protect children and teens from the harsh realities of life; however, by keeping information hidden, children and teens are in essence being told that they can't handle what is happening and then are being forced to draw their own conclusions, which are often far worse than reality. Child development theory reminds us that younger children in particular are susceptible to egocentrism, magical thinking, and literal thinking which can all lead to misconceptions and misunderstandings (Turner, 2009). In regard to children of adult patients, families must be aware that not only do children

and teens have a right to know what is occurring with their loved one, but they also have an essential need to know (McCue, 2011). Though families may try to shield them from these difficult situations, children and teens still feel the effects of what is happening and are especially vulnerable when their world is turned upside down by changes in their normal routines and separation from a caregiver. To help children and teens learn to cope with the stress these changes bring, they need truthful information about their loved one and reassurance that their needs will be met. Child life specialists can help families navigate these challenging conversations. While the knowledge and skills child life specialists use to work with families are tried and true, the resources listed here may offer new ways to support and engage with families.

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BOOK REVIEW

Tessa L. Randolph, CCLS

ST. LUKE'S CHILDREN'S HOSPITAL, BOISE, ID

The Whole-Brain Child: 12 Revolutionary Strategies to Nurture your Child's Developing Mind

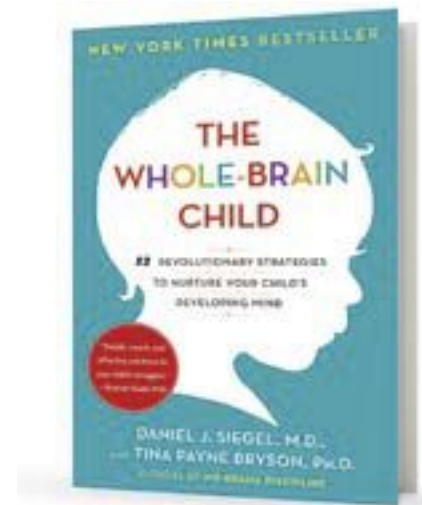
Daniel J. Siegel, MD
Tina Payne Bryson, PhD

A New York Times Best-seller, *The Whole-Brain Child* is a practical, pioneering book that shares neuroscience-based tools to effectively work with children, especially when challenges arise. Geared toward parents, this book can also be a useful teaching tool for child development professionals who wish to enhance children's and caregivers' understanding of how the brain operates under stress. The authors, a pediatric neuropsychiatrist and a psychotherapist, describe a new perspective on how the brain functions and matures, and they provide suggestions to promote healthy emotional and intellectual development. The book offers 12 strategies for intervening during day-to-day events and demystifying aggravations to raise calmer, happier, and healthier children. It includes clear explanations, examples, age-appropriate approaches, and illustrations for real-life application. *The Whole Brain Child's* content aligns with the child life skill set when working with a child and family in a long-term, supportive relationship. Its concepts can be applied over time to help foster growth for children dealing with the stress and uncertainty of illness, injury, trauma, disability, loss, and bereavement.

The informative introduction focuses on explaining the links between brain, behavior, thought, and emotion. Exploring these connections demonstrate how one can turn diffi-

cult moments into opportunities for thriving, as opposed to simply surviving. Brains perform best when their multiple parts work together, as an integrated whole, in a coordinated and balanced way. Beginning with insight into fundamental brain concepts, the text shows readers how to integrate both sides of the brain, memory, and self. The authors describe brain integration as a river, with chaos on one bank and rigidity on the other. The goal is to help the child remain in the middle of the river in order to avoid emotional turmoil.

The book's six chapters detail the 12 strategies and offer "What You Can Do" sections that provide practical recommendations for application. Children facing hospitalization and other challenging life events experience big emotions like anger and fear that lead to emotional outbursts and arguments. Aligned with child life goals, the key strategies emphasize how to seize these moments as opportunities to integrate developing brains and foster healthy development. Also aligned with child life practice is the book's promotion of child-friendly language to support understanding of difficult concepts. For example, strong emotions are characteristic of what the authors refer to as the "downstairs brain," intact at birth and responsible for primitive functions, basic needs, and instincts. This part of the brain tends to dominate in children. The "upstairs brain," or prefrontal



cortex, is responsible for logic, making decisions, and balancing emotions, and is under construction until the mid-twenties.

The authors use a "hand model" to represent the brain and its functions, which provides a concrete way to share these concepts with children. This model uses a closed fist to represent the relationship between brain parts and show how the neocortex develops to maintain control over the limbic brain. This hand model can help children understand the brain activity that causes them to "flip their lid" and "lose their mind." The intent of these strategies is to benefit adults working with children by providing tools to help them build the staircase between the "upstairs" and "downstairs" brains so they are able to integrate disparate functions and develop healthy social and emotional skills. However, these strategies may work best when a child life specialist is able to work with a child over a period of time so that the child benefits from repetition, practice, and mastery of newly learned concepts and skills. Alternatively, this book could be offered as a resource to caregivers who will be able to work on these skills within the context of an ongoing relationship with the child.

Child life assessments and interventions can employ the 12 strategies to help children pay attention to sensations, images, feelings, and the

thoughts and experiences of others. The strategies encourage identifying emotions, telling stories, thinking and listening, and replaying memories to enable emotional intelligence and integration. While the examples and visuals describe parenting situations in daily life, each strategy can easily be applied to child life practice to help children manage their emotions, thoughts, and interactions through stressful or potentially traumatic experiences. The science-based methods included in the book support the philosophy of child life practitioners: that children's experiences—and traumatizing events in particular—should not be overlooked, but should instead be addressed using age appropriate strategies.

Each chapter and strategy is followed by a conclusion, which includes a summary of age-appropriate ways to utilize each strategy and identifies additional resources supporting the most important points in the chapter. In congruence with child life practice, the focus is on optimal development and well-being while promoting coping and minimizing adverse effects. While the text is repetitious at times, the detailed dissection of each strategy is what makes the tools obtainable and useful for anyone with an interest in understanding children's developing brains. The authors are thorough in explaining these concepts, although they do utilize some explanations that might be too elementary for those professionals with a more detailed background of anatomy and physiology. For those without such a background, the authors do well to teach this science and research in easy to understand terms. This is what gives the book strength as a parental resource.

While *The Whole-Brain Child* is not a substitute text to gain professional knowledge, it may give child life specialists suggestions for child-friendly

language to teach these strategies over the long term. In addition, while there are an abundance of successful examples, there seems to be a lack of guidance for what to do when these proposed strategies fail and when it would be appropriate to consult a professional. However, the examples discussed in this review point to the techniques that are applicable far beyond the hospital walls, which makes this a great tool for child development professionals, educators, clinicians, and caregivers, especially when working with children and families over a longer period of time.

Use of the 12 strategies can directly and positively impact social and emotional development by providing caregivers, child life specialists, and

other professionals with the necessary tools to shift and shape children's brains. These teaching tools increase comprehension of the many brain parts and can be added to child life professionals' toolboxes as skills that are taught to both the patient and the caregiver, to promote healthy emotional and intellectual development during and after hospitalization. ✨

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

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LOOSE PARTS

Creating and Constructing

How to Repair an Inguinal Hernia

Molly Farrell

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When we think of hernias, we often think of an adult who overextended during exercise or lifted too much the wrong way. Would it surprise you to hear that hernias are relatively common in children (Figueroa, 2016)? As adults, we understand the pain and toll a hernia can inflict on our bodies; a child, however, may not understand what is causing the pain. This activity illustrating an inguinal hernia and demonstrating its repair is directed towards school-age children. Sensory-oriented tasks offer an increased understanding of the condition and provide opportunity for self-expression. This activity takes roughly an hour to complete and would be best suited for school-age patients before surgery or during recovery. For younger patients, it is recommended to complete steps 1 through 4, as well as steps 6 and 7, prior to starting this activity.

Materials Needed:

- A clean plastic juice bottle (for the “body”)
- Newspaper/paper, cut into 1” strips (used to papier mache the body and muscle tissue)
- Glue/modge podge (used with the newspaper for papier mache)
- Paint (for coloring any part of the body to the child’s liking)
- Foam Sheets (used for the “skin”)
- Play-Doh (used as part of the “intestines”)

- Tissue Paper (used as part of the “intestines”)
- Glue Gun (for attaching the foam “skin”)
- Scissors, box-cutter, and/or scalpel
- Hair dryer
- Mesh or gauze piece (to represent the mesh used for surgical “repair”)
- Needle and thread (for sewing the incision) or steri-strips, as appropriate for what the child will experience

Instructions:

1. For the body, cut the top off of the juice container, cutting horizontally about a quarter of the way down from the top of the container until the top is completely off (see Figure 1).
2. Next, cut the container vertically down the sides to create two unevenly-sized pieces, a larger “body” and a smaller “skin,” which should fit snugly over the body (see Figure 2).



Figure 1. Cut the top off of the container.



Figure 2. Cut into two uneven pieces for the body and skin.



Figure 3. Make a slit for the hernia.

3. Make a rectangular slit in both pieces to represent the hole in the muscle tissue that is allowing the intestines to peek through. The rectangular slit can be wherever the patient's hernia is located (see Figure 3).
4. Papier mache the "body" with pieces of cut up paper and modge podge (or glue and water; see Figure 4). If needed, use the hair dryer to help assist the drying time.
5. While the papier mache is drying, start making the "intestines" with the patient. Have the child roll out Play-Doh into a thin line and then wrap in tissue paper (see Figure 5). This combination will allow the "intestines" to be pliable, yet hold its form when pushing through the hole in the "muscle tissue." This time provides a great opportunity to explain the importance of intestines and what happens when they get constricted.
6. When papier mache is completely dried, have the child paint the "muscle lining" however he/she would like.
7. Next, hot glue the foam sheets to the "skin" and sides of the "body" (see Figures 6 and 7). Feel free to trim foam if it is too long.
8. Once everything is dry, it is time for the demonstration. Have the child

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Figure 4. Papier mache the body.



Figure 5. Form intestines from Play-Doh and wrap with tissue paper.

continued from page 37

Loose Parts: How to Repair and Inguinal Hernia



Figure 6. Glue foam sheets to skin and body.



Figure 7. Skin (purple) and body (pink) ready to demonstrate hernia.

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push the “intestines” through the hole in the “muscle lining” from underneath the body without the top attached. This will help gain an understanding of why and how a hernia is present (see Figure 8).

9. Place the top “skin” layer on the body with exposed “intestines” to demonstrate the lump the child can feel on his or her own body (see Figure 9).
10. After providing developmentally appropriate surgery preparation, make a slight incision where the hernia is, using scissors or scalpel to demonstrate surgery.
11. Have the child explore the newly opened incision on the model.




Figure 8. Push intestines through opening in body.



Figure 9. Hernia can be felt through the skin.

12. Remove the “skin” layer again to show loosely what happens during surgery on the “body,” i.e., the doctor will push the “intestines” back behind the “muscle lining” and place a mesh padding (see Figure 10) behind the hole to prevent this from happening again.
13. After “surgery” is done, have the child sew or use steri-strips to close the wound in the “skin” layer.

Being able to visualize what is causing a hernia and examine how it is repaired can help a child understand and cope with the experience in a more positive way. 

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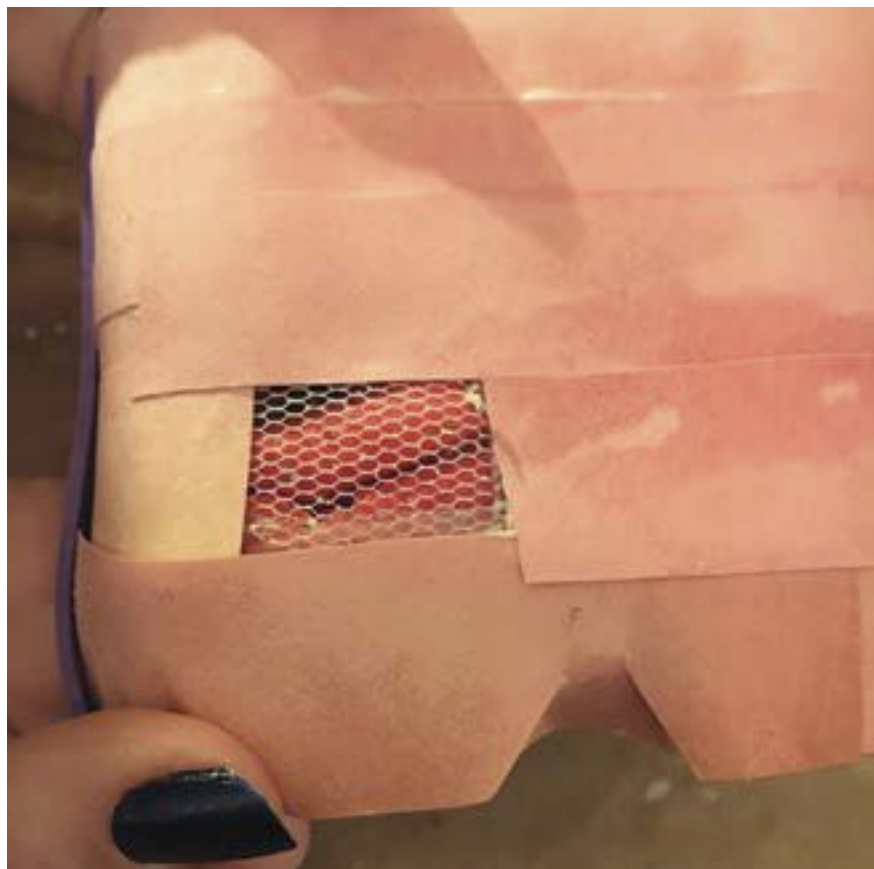


Figure 10. Demonstrate how the hernia is repaired by replacing the intestines in the body and reinforcing the weak spot with mesh.



PATHWAYS TO PROFESSIONAL INQUIRY

QI, Step by Step

STEP 6:

Scale Up Successful Interventions and Plan for Sustainability and Spread

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RANKEN JORDAN PEDIATRIC BRIDGE HOSPITAL, ST. LOUIS, MO

This article is the final in the “QI, Step by Step” series on implementing evidence-based practice and evaluating change in the provision of patient care by child life professionals. All specialties that provide healthcare to children strive to provide the highest possible quality of care. Quality Improvement (QI) gives opportunities for child life specialists and other healthcare professionals to improve patient care by measuring and analyzing processes, and then identifying ways to make them better

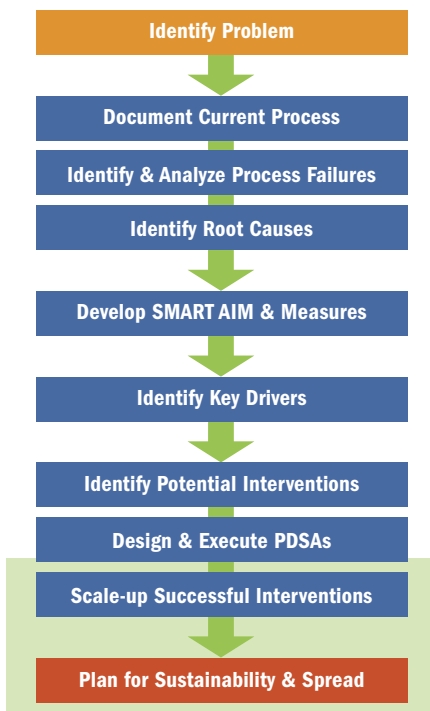
(American Academy of Pediatrics, n.d.). Child life specialists can use QI projects to formalize projects and interventions by using the steps from this series. The previous five articles in the *ACLP Bulletin* highlighted the introduction to QI and problem identification (Birkett & Froh, 2018), analysis of process failures and root causes (Cassani & Bonjour, 2018), development of SMART aims (Calvert, 2018), identification of key drivers (Wittenberg & Jones, 2018), the identification of potential interventions, planning and executing Plan-Do-Study-Act (PDSA) Cycles, and scale up successful interventions (Bonjour & Birkett, 2019). This article will revisit the concept of scaling up successful interventions and discuss plans for sustainability and spread.

Scaling up successful interventions requires intentional and guided efforts for evidence-based interventions to be implemented widely (Barker, Reid, & Schall, 2016). The phrase “scale up” addresses the system/infrastructure issues that may arise during full-scale implementation (Barker, Reid, & Schall, 2016). Models have been created to scale up these evidence-based interventions to successfully spread them through publication, policy, training, and example (Barker, Reid, & Schall, 2016). Despite several frameworks, there are three common components to scaling up that are utilized: use of a clear sequence of

activities needed to take interventions to scale, articulation of the context and environmental factors that will foster scale-up of best practices, and describing the infrastructure that is required to support scale up (Barker, Reid, & Schall, 2016).

For successful scale-up, start in one small area; for example, utilizing oral sucrose for IV starts in infants 4-6 months on a general surgery floor. After the first round is successful, scale up by including two more areas such as the NICU and emergency department. With each successful round, continue to scale up until all areas have been reached (Bonjour & Birkett, 2016). It is important to continually obtain outcome measures and concurrent feedback on the implementation of the EBP (Bonjour & Birkett, 2016). Outcome measures essentially measure the change from one specified time point to the next. For example, the change prior to EBP implementation and post EBP implementation. In order for staff to be successful in obtaining these measures, the following tips are beneficial: collect data on five to seven measures, collect data in real time and implement it into current work activity, and clearly define roles of who will measure and record each data item (National Institute for Children’s Health Quality, n.d.).

Since outcome measures may take a greater length of time to obtain due to multiple years for process improve-



ment, it is important to additionally collect process measures and balancing measures. For example, it may take years to track the effects of child life interventions on the development of a NICU graduate. Therefore, process measures are found closer to where the work gets done and are impacted more quickly. For example, a process measure may be tracking how many families receive a take-home developmental guide for their child at discharge. Lastly, a balancing measure helps to ensure that you're not improving one aspect of the system at the compromise of another. An example of a balancing measure might look at whether the repeated focus on educating families on the benefits of developmental play and milestones are negatively affecting parent's feelings of competency (National Institute for Children's Health Quality, n.d.).

"Sustainability and spread" refers to the adoption and replication within a healthcare system (Barker, Reid, & Schall, 2016). More specifically, sustain can be defined as making improvement "stick," and spread can be defined as improvements at one site being transferred or adopted by another location or team (Bonjour & Birkett, 2016). Sources have found several properties to exist in organizations that sustain improvement. The first necessity is a supportive management structure that treats quality of care as a high priority. For example, providing staff with adequate training and materials in order to successfully implement and measure change (Institute for Healthcare Improvement, 2008). Second, structures to "foolproof" change require a concrete plan of measuring assessments, checklists, flowcharts, etc. These are

important to both measure change and ensure all steps of implementation are being completed. An example of this would be a flow chart or check list of child life services offered throughout a NICU admission. Next, success requires transparent feedback systems, including measurement systems that are shared publicly with staff. A shared sense of importance for improvement with engaged staff is necessary for sustainability and spread. Thus, it is important for the collected measures to be shared and adjusted for every specialty (Institute for Healthcare Improvement, 2008). Lastly, formal capacity-building programs ensures that training of all staff is a high priority and is budgeted for appropriately (Institute for Healthcare Improvement, 2008). As a whole, the main goal is to successfully spread the improvement to additional groups and departments when appropriate (Bonjour & Birkett, 2016).

The team working to sustain and spread the proposed intervention needs to involve all those affected rather than a small group of interested stakeholders (Institute for Healthcare Improvement, 2008). During this phase, aims will not change greatly from prior aims. Measuring of these aims should be completed and shared regularly. Review the previous articles in this series on our blog for a through overview of the QI process and implementation on how to effectively build a real-world QI project in your setting. Together, child life specialists and healthcare teams have the opportunity to identify problems and create lasting-change to best meet the needs of children and their families. ✨

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MOMENTS FROM THE PAST

The ACLP Historical Archives Collection of Oral Histories

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An Oral History is the collection and sharing of historical information using sound recordings of interviews with people having personal knowledge of past events for the purposes of academic and professional study.

The Association of Child Life Professionals has supported a range of methods for building the child life historical archives since the establishment of the Child Life Council (CLC). In addition to instituting the physical archives at the Frank E. Gannett Library at Utica College in Utica, New York (2001), the Archives Management Group has been collecting program histories, sharing information via postcards and posters at the annual conference, and supporting the work of member volunteers. One outstanding effort for the documentation of the profession is represented in the collection of oral histories of child life pioneers and leaders. This collection offers students, practitioners, and academics the opportunity to engage in primary research for the purpose of incorporating a historical perspective into their work.

Oral histories represent one historical research method that is readily available for adaptation and application. Our existing oral histories in the archives take the form of cassettes, videotapes, and digitized videos of approximately 43 leaders including BJ Seabury, Mary Brooks, Sally Francis, and others. Originally initiated in the 1980s, the one-on-one interviews followed a semi-structured script emphasizing perspectives on the progress and future of child life as a profession. Clips from many of these interviews are integrated into the CLC anniversary videos available on YouTube ([Yesterday, today and Tomorrow; Celebrating 30 Years: A Monumental Year, A Monumental Profession](#)) and also ground much of the firsthand details presented in the *Pips of Child Life* series



Civita Brown, MEd, CCLS, and Lois Pearson, MEd, CCLS, interview T. Berry Brazelton, MD, in his Cape Cod, MA, home in 2007. Photo courtesy of the Child Life Archives.

(Turner & Brown, 2014, 2016). The two most recent contributions to the collection were created in a group format with a specific discussion topic: memories of Emma Plank, and perspectives on the separation of the child life group from the Association of the Care of Children's Health.

In the past, CLC (and now ACLP) supported the establishment of a series of oral interviews of our pioneers. Not only did the CLC provide the finances necessary to employ videographers to travel to our annual conference location and document the interviews, but most importantly, also fostered a spirit of embracing the value of our history. As the most recent oral history project was completed in Denver in 2012, the time is

now ripe to bring a renewed energy for the further development of our library. Although we have been fortunate to capture the thoughts and ideas of our early pioneers, a second generation of pioneers are waiting in the wings to share their oral histories. One just has to pause and reflect on recent retirements, program leadership changes, and board membership to generate a lengthy list of candidates. Further, the range of topics is abundant given the grand shifts seen in the profession over recent years. Certainly, within our ever-expanding membership there exists a number of students, practitioners, and academics willing to engage in the creation of media applications relevant to the documentation of the next cycle of oral histories to be housed at the Child Life Archives. You too can share your appreciation for

our past with enthusiasm and engagement and an attitude of commitment and recognition for the compilation of our professional history and the role that history plays in establishing our professional credibility.

A call to action in support of a renewed effort to collect and archive the lives and times of our pioneers is in order. Students, practitioners, and academics looking to make a lasting contribution to the shared repository of knowledge and understanding can start with the identification of just one inspirational individual in their community and go from there! ✨

Contact the Archives Management Group via the ACLP office for a discussion of the process for developing an interview script and identifying a media platform for recording and sharing appropriate to your needs and level of commitment.

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Celebrating 30 Years: A Monumental Year, A Monumental Profession CLC 30th Anniversary Video

Turner, J. & Brown, C. (2016). *Pips of Child Life: The Middle Years of Play Programs in Hospitals*. Kendall Hunt Publishers: IA.

Turner, J. & Brown, C. (2014). *Pips of Child Life: The Early Years of Play Programs in Hospitals*. Kendall Hunt Publishers: IA.

Yesterday, today and Tomorrow CLC 25th Anniversary Video

2020 ACLP Annual Conference Call for Papers

The 2020 Annual Child Life Conference will be held in San Antonio, TX, May 21-24, 2020, and it's time now to start thinking about presenting. Do you have an innovative idea or a research project you'd like to share with your colleagues? Consider sharing your work with more than 1,000 child life professionals at the Annual Conference. It is never too early to start planning an engaging presentation on a topic of importance to your profession.

The Conference Program Committee invites you to plan now to submit an abstract during the submission window of June 1 to June 30, 2019. Member and attendee feedback continues to indicate a need for presentations related to advanced-level topics, leadership, and child life in alternative settings. In addition, there is demand for topics addressing the core competencies, especially ethics and assessment. Conference presentation formats range from posters to panels, so there is a format to fit your topic and presentation style. Participate in making the 2020 conference a rousing success!

ACLP's New Learning Management System Offers Exciting Strides in Professional Development

Emily Eagon, MS

ACLP MANAGER OF PROGRAM STANDARDS

In December, ACLP made professional development more accessible and systematic with the launch of our new [professional development site](#). This comprehensive learning management system (LMS) has many exciting capabilities that can help you design a robust professional development plan that meets your learning goals. We wanted to highlight a few of the impressive things our new platform can do for you and your team:

- **Easy Access:** Your time is valuable, and we want to help you find the content you need quickly and easily. Our professional development content is now organized by domain to help you best identify programming relevant to your professional development and recertification goals. Still not finding what you need? Our new search feature lets you search our content by key categories to help you and your team identify content that's right for you.
- **Targeted Content:** Our 2019 live webinar programming is designed to meet learners where they are in their professional journey. Webinars included in our Established Professional programming are designed for participants with 7+ years of experience and incorporate themes of management and leadership. Our Emerging Professional webinars were created for professionals who are newer to the field to help build, develop, and refine the core skills that all child life specialists have in

their toolkits. Visit our [live webinar page](#) to learn more.

- **Access Content Through your Dashboard:** Log in on the [professional development site](#) using your regular ACLP login information, then click on "Dashboard" to access the content you've purchased, all in one place. Webinar handouts and resources will be made available here, and you'll come to your dashboard to gain entry to the webinar room—no more re-registering with a separate webinar software provider.
- **Watch a Webinar Now or Later:** We know that your schedule as a child life specialist is busy and subject to change. If you're registered for a live webinar but are called to assist with a procedure during a webinar's scheduled date and time, you will be able to view the recording of the webinar and earn PDUs through your professional development dashboard. In addition to live webinars, our catalog is full of recorded versions of previous webinars and conference sessions, greatly expanding the number of learning opportunities and allowing you to hone in on just the content that will enhance your professional development. Need a refresher? No problem! All webinar registrants will retain access to the webinar recording for one year from the date of registration. This means you can watch the webinar live and revisit the webinar recording as many times as you like.

- **Flexible Options for Group Registration:**

When you register a group through our new LMS, we will add the webinar to each group member's individual dashboard. This means that your group can watch together for a team learning experience, but those who are unable to attend the live webinar will still be able to view the recording and earn PDUs. To register your group simply email webinars@childlife.org with the number of participants, their names and member numbers if available. We'll take care of the rest.

- **On-Demand Group Registration:**

Does your team need to drill down on a particular topic or exam domain? We're proud of our robust library of webinars, and excited to make this content available to groups. All on-demand content is now available for group registration.

ACLP remains committed to offering targeted, relevant, and accessible professional development. Please take a moment to visit our new [professional development site](#) to learn more about all that we can do to support you in meeting your professional development goals. Already checked us out? Be sure to continue to visit our professional development page regularly for the latest updates, information about our free member pop-up webinars, and more important information related to professional development. ✨



ACLP Calendar

APRIL

- 1 [CLPDC data entry for 2019 annual data and 2019 Q1 data begins](#)

11-14 [2019 Child Life Annual Conference in Chicago, IL](#)

JUNE

- 1-30 [Abstract submission for 2020 Child Life Annual Conference in San Antonio, TX](#)

JULY

- 1 [Submission deadline for ACLP Bulletin and Focus articles for consideration for the Fall 2019 issue](#)

AUGUST

- 31 [Initial Mary Barkey Clinical Excellence Award nominations due](#)
- 10 [Deadline to apply for the August administration of the Child Life Professional Certification Exam](#)
- 15-30 [Child Life Professional Certification Exam Administration Testing Window](#)
- 31 [Initial Distinguished Service Award nominations due](#)

SEPTEMBER

- 28 [Supporting documentation for Mary Barkey Clinical Excellence Award nominations due](#)
- 28 [Supporting documentation for Distinguished Service Award nominations due](#)

OCTOBER

- 1 [Submission deadline for ACLP Bulletin and Focus articles for consideration in the Winter 2019 issue](#)
- 27 [Deadline to apply for the November administration of the Child Life Professional Certification Exam](#)
- 31 [Deadline to apply to recertify through PDUs](#)



Upcoming Events

APRIL 8-10

Annual Association of Pediatric Oncology Social Work Conference

Phoenix, AZ
Visit the [APOSW website](#) for more information.

NOVEMBER 9-10, 2019

Annual Midwest Child Life Conference

Presentation proposals accepted before May 1, 2019
Springfield, MO
[Visit the online registration page](#) for more information.



Webinars

The 2019 webinar programming is well underway, but there are plenty of opportunities to join some exciting sessions in the coming months. Visit our new [professional development page](#) to learn more about our offerings, and complete your professional development plan for 2019.

ACLP is committed to offering our members relevant, high-quality, and accessible professional development. Our 2019 webinar lineup provides members the opportunity to access content that aligns with their background and experience. Whether you're an emerging professional who is new to the field, or an established professional who wants to stay sharp, our updated webinar programming has something for you.

MONDAY, APRIL 22

Scope of Practice in the Profession of Child Life

This webinar is intended for emerging professionals with 0-7 years of experience.

WEDNESDAY, APRIL 24

Implementing a Child Life Clinical Lead Program

This webinar is intended for established professionals with 7+ years of experience.

MONDAY, MAY 13

Meta-Parenting Among Parents of Hospitalized Children

This webinar is intended for emerging professionals with 0-7 years of experience.

WEDNESDAY, MAY 22

Okay, So What's Next? Successfully Navigating Mid-Career Transition, Advancement, and Development

This webinar is intended for established professionals with 7+ years of experience.

JUNE IS RESEARCH MONTH!

Become more research-savvy by learning from research experts in the field:

MONDAY, JUNE 10

A Crash Course on Reading and Interpreting Empirical Research Articles

This webinar is intended for emerging professionals with 0-7 years of experience.

WEDNESDAY, JUNE 12

Pushing Our Professional Paradigm: Developing Data-Driven Teams and Practices

This webinar is intended for established professionals with 7+ years of experience.

Please be sure to visit our new [professional development page](#) to learn more about these webinars, view our 2019 lineup, and register for upcoming webinars. Browse the many offerings and make your professional development plan today!

Greater than the sum of its parts...



...the Child Life Professional Data Center (CLPDC)

Enter the data for your programs and build this powerful resource for the child life profession worldwide. The more programs that participate, the more robust the data set, and the conclusions that can be drawn from it.



Go to www.childlife.org/resources/datacenter