ACLP Bulletin

In Focus:

Continuing the Discussion on Therapeutic Relationships, Professional Boundaries, and Self-Care Practices in Child Life

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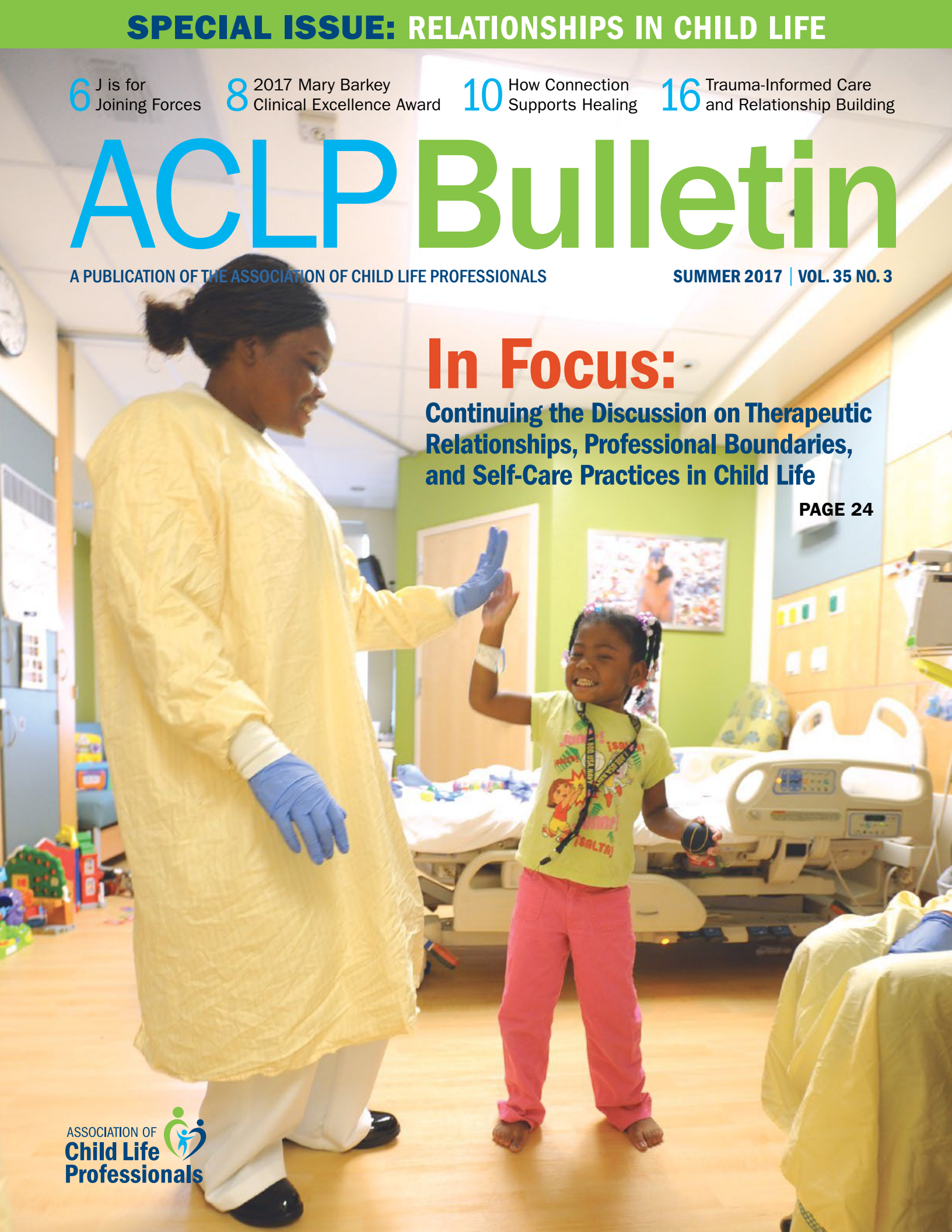
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CHILD LIFE FOCUS:

from the Executive Editor

Katherine L. Bennett, MEd, CCLS

Building Relationship Capital

"Strange, isn't it? Each man's life touches so many other lives. When he isn't around he leaves an awful hole, doesn't he?"

— CLARENCE THE ANGEL, *IT'S A WONDERFUL LIFE*

One of my favorite movies is *It's a Wonderful Life*. This is traditionally a film that most would consider a "holiday movie." So why am I choosing to talk about it in this, the Summer issue of ACLP *Bulletin*? Maybe it's because I love the juxtaposition of a snowy, cozy movie in the warmer months and the idea of "Christmas in July." It could also be because I've just had the need to sort through all my holiday decorations (and there are a LOT of them) due to an unfortunate incident in my basement involving a skunk. However, I think the real reason this movie has been replaying in my head lately is because of the theme of this entire issue: relationships.

While I love all the classic quotes and comforting, feel-good aspects of the film, what sticks out to me is the approach to people of the protagonist, George Bailey. At one point, George's company, a local building and loan offering reasonable, flexible loans to those without large paychecks, experiences a tragic and devastating financial blow. His integrity, the homes of those who have trusted him with their money, and the welfare of his own family are at stake. He is desperate, wishing he was never born, and at the point of taking his own life when he sees a stranger floundering in the icy waters beneath the bridge from which he is about to leap. Of course, George jumps in the water to save the stranger's life instead of ending his. He learns, through a series of magical events that can only happen in the movies, that if he had not impacted the world with his efforts to encourage growth in others, his community would have been completely changed. In the end, his financial ruin is erased by the generosity of his community: the very people who invested all they have with him. They come to his rescue, generously contributing what they can, simply because they hear that George is in trouble.

Why would the people in the movie do this for someone who, by nature of his profession, was expected to keep their money secure? This is where I realize that George Bailey worked with more than just financial capital in the way he did his work. It was the relationship capital he cultivated throughout his life that, quite literally, sustained him, both professionally (he was kept afloat financially) and personally (he, thankfully, did not take his own life and returned to his family). While this may not sound like a "wonderful life," it has some "real life" implications for child life professionals who must be intentional and thoughtful in initiating, maintaining, and sometimes terminating relationships.

Relationship capital is a term I've used in the past, but it was only recently that I learned that this is a "thing." In the business world, I'm hearing about organizations making efforts to create intentional emotional connections with their customers in order to make a difference on a personal level. This is something that is certainly related to the organization making money, but it also has something to do with companies doing the right thing for the individuals they serve in the marketplace.

Although this is a relatively new term in the increasingly online world of financial and social interactions, relationship capital is something that I think child life specialists have always built as part of our daily work. We are making emotional transactions through support and trust whether we are working with patients and families, colleagues, students, or hospital administrators. The nature of relationships, if healthy and appropriately bounded, increase the effectiveness

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of our work and sustain us, professionally and personally.

In this issue of *ACLP Bulletin*, you will have the opportunity to consider the nature of different types of relationships in child life. During play, valuable, supportive relationships are built with children. "Therapeutic Relationships and Play: How Connection Supports Healing," describes how this happens and why play is such a powerful relationship-building tool. This issue's *Focus* article examines the benefits as well as the potential drawbacks and costs of the therapeutic and supportive relationships necessary for influential child life practice. There are so many current conversations about self-care, professional boundaries, and compassion fatigue in the child life profession. I challenge you to reflect on the connections between your own relationships and how they impact your responses, coping patterns, and stamina for a profession with a high expectation (and need) for emotional engagement with patients, families, colleagues, and students. I also encourage you to be open to facets of relationships you may have not even considered. Reading "A Function of Paradox: The Missed Opportunity of the Resident Referral," I was challenged to consider the implications of the unexpected outcomes of the author's conversation with a physician/researcher who appeared to have neglected an important aspect of pediatric healthcare.

Regardless of whether *It's a Wonderful Life* is a favorite of yours or a movie your parents made you watch when you'd rather be watching *Rudolph the Red-Nosed Reindeer* in Claymation, I think there are some valuable lessons to learn from George Bailey. Throughout his fictional, on-screen life, he consistently demonstrated genuine caring for people and a desire—followed up with action—to do the right thing. He was constantly building relationship capital, even if he was not making any money. The choices he made were not always easy, but they were often simple, in that he was committed to his values. His values, established ahead of time, determined his actions well before the time came for a decision. In the same manner, we must also establish our values concerning the nature of our relationships to increase our ability to navigate through "real life," wonderful or not. This, I believe, will also sustain us professionally and personally. ⭐

Past President's Reflection
Kristin Maier, MS, CCLS

Together, We are Strong

My year as president of ACLP was a whirlwind: a time of change that precipitated an exciting journey full of opportunity, strategy, and intention. We are on a good path, and the excitement our members feel about the direction that we're choosing to take as an organization was evident to me in the positive energy I felt at this year's conference in Las Vegas. The enthusiasm was palpable as more than 900 child life specialists and friends of child life celebrated our profession with networking and learning opportunities. The opening session set the stage for the weekend as our interim executive director, Jennifer Lipsey, MA, modeled the values of authenticity and integrity in her honest and sincere remarks. The positive ambience extended to the exhibit hall, where members and exhibitors alike remarked on the upbeat experience there. The educational sessions were outstanding and stimulated vigorous discussion in the halls, and the high level of excellence displayed in the posters, many of which exemplified interdisciplinary collaboration in research, was especially satisfying. One of the most memorable moments for me was during the Closing General Session, when Shola Richards, founder of The Positivity Solution, introduced us to one word that I'll always remember: *Ubuntu*. This word, of African origin, roughly translates to "I am because we are." This is the perfect word to sum up the relationship of ACLP to its members. We, as an organization, make it possible for me, and for each of you, to be child life specialists and the human beings that we have become.

The work we continue together is inspiring: The change in our association's leadership brings the opportunity to intentionally and strategically step back and look at our direction and goals for the coming years. We have formed an advisory council to inform our decision-making about the best leadership structure for our organization. We have a goal of beginning the selection process for the new executive leader in the fourth quarter of this year, with the aim of bringing that person on board in the first quarter of 2018.

Another intentional process that we are undergoing now is benchmarking child life work in the *Child Life Professional Data Center*. The database has been open since April of this year, and as of early June, 188 programs have entered the data center; of those, 59 have started entering data. Our objective is to have full participation from all child life programs, large and small, as the more complete our data set is, the more useful this tool becomes. Programs entering at least 50% of their data will have free access to the database for the first year. Individual programs can use the data to help justify the need for additional child life positions in their institutions, and as an organization, this data will allow us to initiate partnerships that will benefit our profession. Having information about the impact of child life will give us the power to attract the attention of those who have the resources and influence to enable expansion, increase donations, and provide support in many other ways. With this goal in mind, we've established a Partnership Development Committee to identify and build relationships with potential partners who can help us on our journey as we grow.

Speaking of partners, we've received a grant from Disney that will fund a two-day Emotional Safety Summit. At this event, we plan to engage experts in the field of pediatric emotional trauma to identify standards that will improve outcomes and lay the groundwork for advocating for emotionally safe environments for children in pediatric healthcare settings. You'll hear more about this as the planning continues.

One other development that I would like to highlight is on the education front. We are moving forward at a steady pace with both the undergraduate and graduate endorsement processes. The undergraduate endorsement application portal opened in June, and the graduate endorsement application process will open in the fall. Programs that are endorsed by ACLP will demon-

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strate excellence in meeting competencies in preparing students for clinical internships and for professional work in child life. The deadline for programs to complete the process is in 2019. In addition, ACLP is looking ahead to early next year, when we plan to apply to CAAHEP (the Commission on Accreditation of Allied Health Education Programs) for accreditation of graduate programs in child life. This step will enhance the credibility of our accreditation by ensuring that our standards and processes follow industry best practices.

Over the years, child life began to form my life: It shaped who I would become as a human and formed the person I am today. I often credit this profession for teaching me all the things that matter in life: how to be present, how to connect, how to be quiet and listen, how to play, how to live, and how to die.

As I think about my year as your president, I've also been reflecting back to 1988, when I attended my first child life conference in my hometown of Cleveland, Ohio. To this day, I can remember the energy and the excitement—I walked around just soaking it all in, thrilled to be among the buzz. I came away from that conference with my first job and the sweet confidence

that I was now a child life specialist. I didn't know a soul, but I knew I wanted to do child life more than I wanted to do just about anything. I remember growing up in my first job and realizing that my growth was similar to the development of a young child: I started that job barely rolling over, and all I wanted to do was to be able to run. I would watch my peers in awe and think, "Someday I will be as good as them." Over the years, child life began to form my life: It shaped who I would become as a human and formed the person I am today. I often credit this profession for teaching me all the things that matter in life: how to be present, how to connect, how to be quiet and listen, how to play, how to live, and how to die. I remember learning about professionalism, about boundaries and about perseverance. I remember figuring out that this was my passion.

I'm not sure when it actually hit me that one day I might be representing all of you, my fellow child life specialists, but this year I have been humbled and proud to partner with you on this journey. As I mark the end of my term as your president, it is with great joy, confidence, and pride, that I place the leadership of this great organization into the very capable hands of our next president, Eileen Clark, MSM, CCLS.

You, as child life specialists, are doing incredible work, and together, our future is bright. I am grateful to each and every one of you who digs deep to make an impact. I thank you for staying connected to our mission and for supporting and walking with me on this journey. It is often said that if you want to be successful, surround yourself with people who lift you up. Thank you to each and every one of you for lifting me up. *Ubuntu.*

Building on the Strengths of Child Life

In my nine years with ACLP, I have worked as a program assistant, certification coordinator, certification manager, director of operations, and currently, as the interim executive director. I have had the privilege of speaking with senior-level program leaders; newly-inspired students; fresh graduates; excited, newly-certified child life specialists; and enthusiastic partners and champions of child life. I have also been witness to disappointed applicants who have struggled through the process of applying to numerous internships; deflated candidates who did not pass the exam; and child life specialists challenged by the lack of demand, community support, and/or financial compensation for their skills. As an organization, we have listened to these subsets of members and attempted to provide relief and assurance, but I suspect it's time to change up our strategies and efforts. It's time to re-assess the child life landscape and its key stakeholders and align organizational priorities and resources for long-term sustainability.

ACLP has been, and will continue to be, a member-based organization whose primary focus is member support. While we will continue to provide members with accessibility and exemplary customer service, I believe support and engagement should expand beyond ACLP and the member to include the member's (potential) employer, community advocates, and colleagues. In other words, ACLP needs to engage with its members *and* the "world" in which they'll need to thrive. This shift involves engaging diverse individuals who significantly impact our members' environments: physicians, nurses, donors, allied association executives, parents, and multidisciplinary colleagues. Engagement with the child life community (beyond just child life specialists) is a key factor in educating ourselves in *how* best to market the value of child life to further develop interest in the expansion of the field. ACLP hopes to build upon partnership leads from our members; the first opportunity to submit any leads will be in the member survey that we have scheduled for the fall.

With that in mind, we are aiming to diversify our membership and widen our educational content and events to include other health professionals and child life champions. Let's open our door and invite others to join! Collaboration is something that ACLP members do naturally and successfully, and I have yet to meet someone who has been exposed to a child life specialist who didn't walk away feeling positive about the experience. Let's harness that positivity and develop it into inspiration for creating momentum for the profession rather than letting it walk away and fizzle out! I've always struggled with how to market the value of child life, as I believe it's an *experience*, not a title, a skill set, or a department. Rather than relying solely on creative marketing techniques aimed at recreating the experience of child life, what better way to make child life widely known than to provide direct exposure to our members and their expertise? Collaboration will allow us to do this through opportunities aimed at creating meaningful content, connections, and lasting impressions while simultaneously allowing us to learn about the community we need to support us and our future.

Looking out to the horizon ahead, I foresee ACLP continuing its major programs: education, certification, endorsement/accreditation, and communications, with hopes of producing revenue and reallocating existing resources toward the rising priorities of marketing and technology management. As an organization, we are committed to open communication and transparency, and will continue to share news of progress in our work and the decisions we make in a timely manner. I expect ACLP's new executive leader to be identified in early 2018 and have high hopes for what that person will produce in the way of a new strategic plan, partnership development,

J is for Joining Forces

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Helen Keller once said, "Alone we can do so little; together we can do so much" (Lash, 1980, p.489). Joining forces is an important part of child life. As child life specialists, we recognize we can only do so much on our own; we must work with others if we want to achieve our goals and objectives. Joining can be thought of as the act of connecting one thing to another (Joining, 2017). In child life, joining means connecting with others in a reciprocal relationship in which each person contributes and gains something in efforts to reach an outcome. Take a second to think about whom you might join forces with every day to accomplish the job of a child life specialist. Patients, families, medical team members, students, and child life specialists automatically come to mind. What are the benefits of joining forces? As Helen Keller said, collaboration allows us to accomplish so much more.

Family-centered care utilizes a collaborative relationship between the patient, family, and healthcare providers during the planning, delivery, and assessment of the patient's healthcare (American Academy of Pediatrics Committee on Hospital Care & Institute for Patient- and Family-Centered Care, 2012). Child life specialists are an integral part of family-centered care (American Academy of Pediatrics Committee on Hospital Care & Child Life Council, 2014). Through relationships with the patient and family, child life specialists learn about the patient and family (e.g., cultural preferences, coping styles, family availability, stressors, previous healthcare experiences and responses) to design appropriate interventions (e.g., medical play, procedure preparation, pain management, comfort positions). Patients and families gain information, coping styles, support resources, and roles in the healthcare event, which improves their experiences. The outcome of such a collaboration is an active and comprehensive plan of care which is able to be implemented by the healthcare team with the family leading the charge (Thompson, 2009). Such a collaboration helps child life specialists fulfill the profession's mission of helping "infants, children, youth, and families cope with the stress and uncertainty of illness, injury, and treatment" (Child Life Council, 2015, para. 1). In addition, joining forces with patients and families leads to increased satisfaction among families, patients, and staff; decreased patient and parent anxiety; improved cost efficiency; and improved patient health outcomes (American Academy of Pediatrics Committee on Hospital Care & Institute for Patient- and Family-Centered Care, 2012). Such positive outcomes would not be achievable without child life specialists, patients, and families joining forces.

According to the ACLP Values Statement, child life professionals value professional collaboration: "The shared and reciprocal efforts of individuals, disciplines, organizations, and communities are an effective means of meeting the diverse needs of infants, children, and youth" (Child Life Council, 2015, Professional Collaboration, para. 1). As we all know, child life specialists are members of a multidisciplinary healthcare team. In a day, child life specialists interact with physicians, nurses, social workers, occupational therapists, physical therapists, psychologists, therapeutic recreation therapists, and speech pathologists, to name a few. During these interactions, the multidisciplinary team members are joining forces. Each member of the team provides a different perspective and area of expertise that contributes to the overall plan of care for each patient and strengthens the multidisciplinary team as a whole. By working together, an environment for the most optimal outcomes of the patient is created. A benefit of a collaborative relationship is the ability to have a discussion with another person and share problems, knowledge, solutions, and enthusiasm. In such a discussion, a person continues to learn, feels empowered by

offering solutions, and minimizes stress through problem solving. More importantly, patient outcomes are discussed utilizing different perspectives and expertise, creating an outcome that addresses the whole patient. Benefits of multidisciplinary teams include improved communication, decreased adverse events, increased patient satisfaction, and improved patient outcomes (Epstein, 2014). A reflection of the Values Statement summarizes what we know: Joining forces through collaboration with other professionals is the most effective way to meet the needs of our patients.

If someone asked you who helped you become the professional you are, a child life specialist who was in the teacher role would likely come to mind. This person helped shape your child life philosophy and theoretical foundation. Whether it was a professor lecturing on the value of play, a practicum instructor teaching you the foundations of assessment, or an internship coordinator walking you through your first preparation, that teacher helped shape you by sharing their experiences, passion, knowledge, and expertise. At the same time, any teacher can describe the benefits of being part of a student-teacher collaboration. Examples include growing in leadership and communication, staying abreast of evidenced-based practices and tools, and remaining in touch with feelings of enthusiasm for the field. According to the ACLP Values Statement, "The commitment to excellence and integrity in our professional practices involves lifelong learning" (Child Life Council, 2015, Professional Standards of Practice, para. 1). When students and child life specialists join forces, we are upholding this value as both parties engage in learning.

As child life specialists, it is important we join forces with other child life specialists. Looking back at our history, the ACLP was created when a group of child life specialists joined forces as part of the Child Life Study Section of the Association for the Care of Children in Hospitals. This group recognized the importance of the profession and the need for professional practices and policies. Through teamwork, this group shared information, resolved conflicts, encouraged and supported each other, and shared tasks to create the Child Life Council and the foundation of the profession's policies and statements. One person alone could not accomplish this task; joining forces was necessary and allowed for so much more to be accomplished. Today, the ACLP stands on the shoulders of the giants of our history and continues to offer child life specialists a home for collaboration. The ACLP

Forum is a place where child life specialists can communicate with others in the field to gather information, support, creative solutions, and professional development. Committees and tasks forces are opportunities for child life specialists to join forces in areas of interest and share expertise in order to help support and shape the future of the profession. When child life specialists join forces with one another, the benefits are numerous. A moment that starts as a need for support, enthusiasm, guidance, or information from a fellow child life specialist can turn into improved patient care, continued professional development, or improved self-identity. As the pioneers of the Child Life Study Section showed, when child life specialists join forces, positive changes happen.

Joining forces through collaboration with patients, families, medical team members, students, and other child life specialists is part of being a child life specialist. It allows us to accomplish so much and fulfill the mission of our profession by serving patients and families to the utmost of our abilities. The reason joining forces with others is so important can be summed up by something Bill Nye (The Science Guy) once said: "Everyone you will ever meet knows something you don't" (Nye, 2015, para. 32). Here is to being willing to always join forces and learn from others through collaboration. 🏃

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Qi Cheng, MS, CCLS, accepts the 2017 Mary Barkey Clinical Excellence Award from Kristin Maier, MS, CCLS at the Opening General Session of the 2017 ACLP Annual Conference.

Qi Cheng Awarded 2017 Mary Barkey Award

Anne Luebering Mohl, PhD, CCLS

Qi Cheng, MS, CCLS, describes the culture surrounding introducing new services in hospitals in China as a doorway: Many people are interested in opening the door and standing in the doorway looking in, but the decision to walk through the doorway comes after much time and deliberation. Qi, though, is not one to hesitate long at the doorway. As the first child life specialist in Mainland China, Qi opened up many doors, and marched right in. Her inspiring story earned her the 2017 Mary Barkey Clinical Excellence Award, which was presented to her at the Opening General Session of this year's ACLP conference in Las Vegas.

When Qi learned of child life as a student in the master's program in applied developmental psychology at the University of Pittsburgh, she began reflecting on a highly traumatic medical experience she'd undergone when she had surgery as a child. Unfortunately, the traumatizing treatment Qi experienced is still largely the norm for many children in China, where doctor to patient ratios are low and there is little time to prepare and support children and families through confusing and frightening medical experiences. Qi saw child life as an opportunity to change that. After graduating and completing internships at the Children's

Hospital of Pittsburgh and KK Women's and Children's Hospital in Singapore, Qi returned to her native China and began knocking on the doors of public and private hospitals, introducing the concept of child life, and passing out her resume. Although her introductions were met with interest, hospital decision makers were hesitant to take a chance on the new services that Qi was promoting. She finally was able to step through a doorway when she was offered a position at a private hospital, Beijing United Family Hospital, in 2013. Qi describes the first two years as challenging, but her successes built her passion for child life and compensated for

the nights she went home in tears. She credits the support of an informal network of psychosocial professionals in Asia for sustaining her through the difficult initial stages, and she also gains support from her child life colleagues thorough the ACLP Forum.

Qi's entry into the hospital was in the well clinic, where she began by building a relationship with one nurse and gaining positive feedback from families. Each day, when she finished her work in the clinic, she found time to explore other areas of the hospital, following one nurse at a time, learning and teaching wherever she went. By 2016, her practice had become so well respected throughout the hospital that she now works through referrals, and patients make billable appointments to see her.

Establishing a successful child life practice in one hospital hasn't been enough to satisfy Qi's passion for the field. In addition to her full-time work at Beijing United Family Hospital, Qi volunteers every weekend at local public hospitals as a child life specialist. She also makes time for frequent travel to other cites in China to provide child life seminars

and supervision for other pediatric psychosocial professionals in public hospitals, teaching them how to start child life work in their medical settings. Additionally, she works with the social work department at Beijing Normal University, providing education and supervision for students. Qi also serves as a child life specialist for Operation Smile, where she has led two research studies demonstrating improved cooperation in patients who receive child life services in a surgery center and in a well child clinic.

Qi's passion for child life is clear to anyone who has met her. Her colleagues marvel at her clinical skills: her abilities to calm frightened children, connect with parents, and make their jobs as medical professionals easier. But perhaps most impressive about Qi is her energetic persistence and belief in her ability to facilitate culture change. She has had to change minds about the value of play and perceptions about involving parents in their child's care in the process of building her practice. In just four years since bringing child life to Mainland China, Qi Cheng has made an enormous impact, worthy of one of the child life profession's highest honors. Congratulations, Qi! 🏃

THE MARY BARKEY CLINICAL EXCELLENCE AWARD

Since 2010, the Association of Child Life Professionals has honored some of child life's most skilled professionals each year with the Mary Barkey Clinical Excellence Award. This award recognizes child life specialists who have demonstrated exemplary child life care and a high level of clinical skill. Award recipients are nominated by their peers in August, and the winner is announced by the Awards Committee later in the year. The recipient is honored at ACLP's Annual Conference, with formal presentation of the award during the Opening General Session. To nominate a deserving child life specialist, watch your email for the call for nominations. To read about previous recipients of the Mary Barkey Clinical Excellence Award, please visit the _ACLP website_.

Milestones

Jenny Chabot, PhD, CCLS, Associate Professor of Child and Family Studies at Ohio University in Athens, OH, was recently honored with the Outstanding Teaching Award for the College of Health Sciences and Professions. This is an especially high honor since this award is completely driven by students. The Student Advisory Council nominates a candidate from each of the college's programs, and members of the council interview candidates and observe them as they teach classes to select a winner.

Jenny oversees the child life program at Ohio University. She conducts research on families of hospitalized children, ambiguous loss in patients' and families' hospitalization experience, and emotion work among child life professionals. She has shared her expertise in teaching and learning with the child life community by serving as a member of ACLP's Education and Training Committee.

THERAPEUTIC RELATIONSHIPS AND PLAY:
How Connection Supports Healing

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Play is essential to the development of children and adolescents. Ongoing and developing research continues to affirm the fundamental principle in child life and the use of play as a highly effective way to establish and maintain relationships with children in the healthcare setting. Through this research we continue to learn more about the healing benefits of connection through these therapeutic, positive relationships.

Child-Directed Play

Play that specifically enhances the therapeutic relationship—such as child-directed play—is a critical tool to use with children and adolescents dealing with healthcare experiences. Child-directed play allows the child to lead the play. It is not based on adult direction or goals and allows children to use their own familiar language of play to communicate their feelings and needs. This type of play is spontaneous and enjoyable, and decisions made during play allow for symbolic expressive processing of what they are experiencing (Landreth, 2012). Child-directed play supports the formation of the therapeutic relationship. Landreth (2012) describes six important objectives that assist in the development of a positive therapeutic relationship:

- Establishing a safe atmosphere

- Understanding and accepting the child's world

- Encouraging expression of the child's emotional world

- Establishing a sense of permissiveness

- Facilitating decision-making by the child

- Providing the child an opportunity to develop self-responsibility and self-control

These are all elements of play that child life specialists can provide to enable a therapeutic relationship to be formed and maintained with children and adolescents in the healthcare setting. In child-directed play, the child will gain a sense of permissiveness by being allowed to decide how to spend their time in play. Providing toys and materials such as plastic dinosaurs, dolls, blocks, or open-ended art supplies allows for the freedom of expression. Therapeutic responses used during play, such as reflecting the child's feelings to communicate acceptance and returning the responsibility to encourage children to make their own choices and decisions during play, can help provide children with this type of child-directed play experience. In addition, using tracking statements to verbally observe their play communicates full attention and presence instead of asking questions which can shift into adult-centered experiences (Giordano et al, 2005). Each of these responses helps the child know that they are being heard, that they are cared for, and that they are understood, which in turn helps form the positive therapeutic alliance within the relationship (Landreth, 2012).

Forming the Therapeutic Alliance

Defining the therapeutic alliance, the connecting factor of the relationship, is important when examining this subject. It is helpful again to turn to our allies, therapists and play therapists, for clarification and guidance. Carl Rogers was a well-known therapist, and is recognized for his work using person-centered theory, which highlights the use of the therapeutic relationship as a therapy technique. He defines the therapeutic relationship as a relationship containing the following core conditions: empathy, unconditional positive regard, and congruency (Rogers, 1957).

Kirschenbaum and Jourdan (2005) examined the current status of the Rogerian approach and found that research continues to validate the importance of these core conditions for an effective therapeutic alliance. Other researchers include similar factors when defining therapeutic relationship, such as warmth, encouragement, and acceptance (Thomas, 2006). Therapeutic alliance has also been more broadly defined as "the collaborative and affective bond between therapist and patient" (Martin, Garske, & Davis, 2000, p. 438). Some consider the relationship between patient and therapist as one element of therapy, while others view the relationship as a "curative factor in its own right, bringing about a corrective emotional experience for the patient" (Messer, 2013, p. 411).

Current literature brings further clarity to why the therapeutic alliance is so important. When a therapeutic relationship is established, patients are able

to experience a relationship and connection that is helpful, honest, and caring (Messer, 2013). This may be different from relationships they have previously experienced. The therapeutic alliance can allow for a "safe environment for self-exploration and honest expression of both negative and positive feelings" (Messer, 2013, p. 411). By integrating this model of relationship, patients are able to seek out healthier interpersonal relationships in their lives.

The question is, as child life specialists, how do we form these therapeutic alliances with children and communicate warmth, encouragement, and acceptance? It seems that in child life, play is almost always the answer. A therapeutic relationship with children is best established through play. As the Association of Child Life Professionals (ACLP) Mission Statement states, child life specialists "embrace the value of play as a healing modality as we work to enhance the optimal growth and development of infants, children and

youth through assessment, intervention, prevention, advocacy, and education" (Child Life Council, 2011, p. 1). Additionally, the ACLP has a Values Statement focused on play stating that "play is an essential, natural part of childhood, important in its own right. Play facilitates healing, coping, mastery, self-expression, creativity, achievement, and learning, and it's vital to a child's optimal growth and development. Play is an integral aspect of child life practice with infants, children and youth of all ages" (Child Life Council, 2011, p. 1).

As child life specialists, we know that the most effective way to build trust and rapport with a child is through play. Possibly more important, play enhances the therapeutic relationship (Schaefer & Drewes, 2014). This relationship is key for providing the variety of supports needed while children and adolescents cope with their healthcare experiences. Play therapy practice today is still largely based on the work

of Virginia Axline, one of the founders of play therapy. She is responsible for developing child-directed play in therapy settings, basing her principles on those of Carl Rogers. Just as Rogers' approach focused almost entirely on the therapeutic relationship between the client and the therapist, so did Axline's approach with children. They both believed that this relationship was the key agent for change and healing. This parallels child life work in building and maintaining relationships. Axline noted that the most effective relationship was characterized by warmth and caring with a genuine interest, unqualified acceptance, safety and freedom, a sensitivity to the child's feelings, a deep belief in the child's capacity and inner direction (believing that the child knows exactly what they need in play), and lastly, establishing only necessary limits (Axline, 1969). Providing this type of therapeutic, child-directed play allows for the therapeutic alliance to form.

Therapeutic Relationships and Play: How Connection Supports Healing

Evidence from Interpersonal Neurobiology

Further rationale for the significance of the therapeutic alliance can be seen from research examining interpersonal neurobiology. This research supports the impact of positive relationship and connection, going further to state that positive relationships can actually help change the brain and provide greater healing (Siegel, 2012). Essentially, all of the work child life specialists have been doing for years in building and maintaining relationships is now being affirmed by research from multiple fields of study.

If we consistently default to play, no matter the needs or circumstances, it can bolster the child's defenses, facilitate expression of thoughts and feelings, and support healing.

One of the core conditions established as critical in the therapeutic alliance is empathy. The study of interpersonal neurobiology has identified that the mirror neuron system can be engaged during interactions, allowing the child or adolescent to experience a mental attunement with the therapist—or in our case child life specialist—helping the child feel the empathy being provided. This occurs for the child simply by connecting with the person expressing empathy. The resonance that occurs during this mirror neuron process allows for greater connection between client and therapist (Siegel, 2012). This can create an interceptive awareness or internal perception, which is the process and neurobiological mechanism needed to produce empathy (Siegel, 2012).

Through the alliance which includes empathy, the person providing support can significantly change the way the other person's brain is activated by these positive experiences, thus helping the patient to feel heard and understood. Siegel further explains that these experiences may also "establish new neural firing patterns that can lead to neural plastic changes" which can lead to healing (Siegel, 2006, pp. 255-256).

Connection to Child Life Practice

Play makes child life work unique and distinguishes our role in the healthcare setting. Words don't always connect with children, but our offering of play, whether it's facilitated as part of an emergency room visit for a laceration repair or weekly inpatient play sessions with a chronically ill child, sets us apart and creates a relationship that stands out in the child or adolescent's healthcare experience. A critical purpose of the child life specialist is to bring play to the healthcare setting. If we consistently default to play, no matter the needs or circumstances, it can bolster the child's defenses, facilitate expression of thoughts and feelings, and support healing. Initiating and maintaining a therapeutic relationship through play provides powerful benefits and outcomes for the patient, validating the child life profession while serving as a role model for the family and other healthcare providers. ✦

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With the assistance of a toy car, a PICU patient ambulates two days after surgery.

Impacting Unit Culture through Interdisciplinary Collaboration

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Over the last three years, an interdisciplinary group of colleagues in the pediatric intensive care unit (PICU) has had the privilege to collaborate in an innovative effort to improve care for critically ill patients through an early mobilization program called PICU Up!. There are many facets to PICU Up! that we would like to share, but there is no question that the most critical factor in moving from where we started to where we are now is the impact of strong teamwork and interdisciplinary collaboration.

In January of 2014, a nurse practitioner in the PICU at the Johns Hopkins Children's Center noticed that acute rehabilitation was not prioritized in caring for critically ill children, and gathered an interdisciplinary group to address this need. Based on a strong foundation of data demonstrating benefits in adult patients, we set out to create a culture of mobility for pediatric patients and prove it makes a difference. The PICU Up! team was comprised of a nurse practitioner, a clinical nurse specialist, two child life specialists, an occupational therapist, two physical therapists, a respiratory therapist, and a physician. Together, we considered different ways to approach this goal. Our group was well aware that

Impacting Unit Culture through Interdisciplinary Collaboration

mobilizing critically ill patients would have not only physiological effects, but would have a significant psychosocial impact. Early discussions focused on which patients should be included or excluded, what the barriers and facilitators would be, and what resources were available, to name a few. With each weekly meeting, many decisions were made, some were changed, and some thrown out, but a structured program began to take shape. Creating and implementing PICU Up! took over a year, and none of us could have predicted at the beginning where this project would take us.

PICU Up! was an interdisciplinary endeavor from the beginning, and the role of each person as we went through the process of creating the program was fluid and ever-changing. In the earliest phases of brainstorming and thinking about how to create PICU UP!, our team developed in a way that gave every person a voice. In its infancy, it was a small enough group that it was possible for everyone to actively participate in discussions. Additionally, the means of accomplishing our goal was undefined enough that we really had to take the time to consider all perspectives and opinions. The tone set during these early meetings has been maintained and the dynamic of the group is truly positive and collaborative. Roles became more obvious for the implementation aspect of the program as it mostly entailed each discipline simply continuing their work but in a more coordinated way and with a larger scope. Team members had the opportunity to come back to each weekly meeting and share in real time what was and was not working with implementation, and the whole group would put their heads together to create possible solutions.

Over time, the "core" group for PICU Up! has grown significantly, as an important aspect of our collaboration was expanding the scope of the program after initial implementation to continue to "push the envelope." This second phase has included the addition of an assistive and augmentative communication program, expanding our levels to include ECMO patients, and optimizing sedation approaches and delirium prevention strategies to promote mobility. In addition, the collaborative nature of our team is highlighted by the fact that each involved discipline is encouraged to publish and present our work within our respective fields. The group now includes members of the ECMO perfusionist team, respiratory therapy, additional physician representation, additional nurse practitioners, palliative care, and

more. Many of the medical team members have specialized interests that fall within the program including delirium, sleep, ECMO, safety and quality, and ICU survivorship. Perhaps even more impactful on our success as a team than the addition of staff is that the staff who have joined feel passionately about mobility and are actively pursuing collaboration and work with this group. The PICU Up! team now meets monthly to review active projects and discuss new ideas and next steps. As a team we have created a pediatric track at the annual Critical Care Rehabilitation Conference held at Johns Hopkins, which had a solely adult focus in the past, giving us the opportunity to educate PICU teams from around the world about creating a culture of mobility.

The formal collaboration between disciplines stemming from PICU Up! has translated to a significant shift in the culture of our unit. However, it is the day-to-day operations of PICU Up! that have truly made the difference. On a daily basis, mobilizing patients in the PICU requires that bedside nurses, respiratory therapists, medical providers, physical and occupational therapists, and child life specialists work together with our patients and their families. No single member of the team could function separately from another. Clear and timely communication with all stakeholders is necessary to set a patient up for a successful early mobility experience. The coordination to move from bed to chair involves a certain level of involvement with other disciplines, as does walking outside the patient's room, and certainly when trips off the unit are considered. You cannot "keep it simple" by skipping steps and you cannot work in isolation. Coordination and timely communication are crucial. When a team member identifies a patient for mobilization, we may have a team huddle with a provider, bedside nurse, respiratory therapist, rehab therapists, and child life specialists to discuss a systematic plan for moving and identify who is responsible for what equipment and what the process will be. Parents and the patient can contribute their perspectives to the plan, and any member of the team can ask questions or express concerns. It can be beneficial to continue to huddle prior to moving out of bed or ambulating so that as new people are involved, a clear plan is always agreed upon. An additional factor in shifting the unit culture was promoting our successes. With patient and parent consent, we took pictures and videos that we shared with staff so that those not present or directly involved could see the successful outcomes of our teamwork. This daily work and collaboration has been a significant factor in achieving a culture of mobility in our PICU.

Working with the PICU Up! project has created a truly unique opportunity for us as PICU child life specialists. We

Our PICU colleagues recognize that we are the experts on psychosocial needs and support, and we are identified as one of the first points of contact when mobilization of a patient is being considered.

are an integral part of helping critically ill children and adolescents experience an increased quality of life while in the intensive care unit, not only through environmental enhancements and other therapeutic interventions, but as active participants in their physical recovery. Our PICU colleagues recognize that we are the experts on psychosocial needs and support, and we are identified as one of the first points of contact when mobilization of a patient is being considered. Alongside the patients' families, we determine how to best prepare children and adolescents for mobilizing. We continually assess and consider a patient's mental status, taking into account the patient's delirium screening, alertness, and ability to communicate with nonverbal cues or assistive communication devices, and we take seriously our job to advocate on their behalf during early mobility experiences. While we work with the entire medical team to create an environment where mobility can happen safely, we also aim to make it as enjoyable as possible. Due to decreased use of heavy sedation, the need for child life support has increased and the number of patients that are awake enough for us to work with directly has increased. By investing our time and expertise into an initiative that has changed our unit's culture as profoundly as PICU Up!, we are able to impact patient's experiences far beyond the hours we work. We have had the opportunity to present at pediatric grand rounds, and will present on several topics in collaboration with other team members for the Critical Care Rehabilitation Conference this year. The PICU Up! team, including child life, has participated in a collaborative with the Society for Critical Care Medicine to create a bundle to promote a culture of mobility that aims to become standard practice for PICUs across the country. Being a part of the PICU Up! initiative has given us the opportunity to share our experiences with our child life colleagues at other institutions as more PICUs begin their journeys into implementation of early mobilization. Our center's experience confirmed that child life champions play a key role in acute rehabilitation efforts, and our success would not have been possible without fostering collaborative relationships. 🏃

Trauma-Informed Care and Relationship Building in the Pediatric Intensive Care Unit

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"*Oh, he's not a trauma case,*" the nurse leans in to tell me as I approach the glass-walled ICU unit with a fleece blanket and a toiletry bag in hand. I can understand her confusion; these items are, after all, my staple techniques for normalizing the hospital environment as I introduce child life services to newly admitted trauma patients and families.

"You're right," I reply to the nurse. "Medically, he isn't a trauma – he's got the flu, right?"

She nods as I continue. "I just saw mom's face when I walked by and I recognized the look in her eyes. He may not 'be' a trauma, but I think she is experiencing this as a trauma right now."

Throughout this exchange outside the door, I notice that mom has not moved or broken eye contact with her son's sedated, intubated face this entire time. In fact, this is the same position I have seen her

in each time I have walked by the door this morning. She is still wearing the clothes she arrived in at the emergency department, when they came seeking care for what seemed like a routine fever and infection. Two hours later, her son was unresponsive and intubated. Two hours later, he was transitioned to the oscillator as he continued to decline. Two more hours later, and he was on the maximum ECMO (extra-corporeal mechanical oxygenation) settings that a child his size, a five year-old, could tolerate.

I quietly walk in the room, draping the

blue and green blanket in my arms across his bed, gently tucking in the sides to keep him warm. Mom continues to watch his face.

I then grab another blanket and drape it around mom's shoulders. She still does not shift her gaze. I leave the toiletries at the bedside, and kneel down next to her so that I can also see her son's face. Then the loud sobs come bursting out, and mom's proclamation that "this is all my fault," as she reaches into her pocket to show me a Tamiflu prescription bottle with her name on it.

This is the part where it is tempting to share staggering statistics about the number of medical traumas that occur in our country each year, and the unsurprising truth that half of the population has or will experience a traumatic (or potentially traumatic) event during childhood (American Psychological Association, 2008). It is alluring to follow with a reminder that unintentional injuries remain the leading cause of death and disability for individuals under the age of 44 (Sleet et al., 2011). Next, to put it all into perspective, perhaps we can reflect on the fact that "injury accounts for 16% of the global burden of disease" (World Health Organization, 2004, p. v). Ironic that many articles about trauma can leave their readers quite traumatized after the first few sentences!

Trauma, as we understand it as psychosocial care providers, isn't always the victim of the ATV accident, the toddler battered and bruised by abusive caregivers, or the preteen sibling that was the first to find her sister's body hanging in the closet. Though sometimes it can be seen in the mother that gave her child rescue breaths in the middle of traffic, or the school teacher that rescued a student from a chemical explosion, there are many other times where trauma is less obvious, less dramatic, less predictable. Instead it can be the shock of a sudden and rapidly progressing illness, an unexpected diagnosis, or even a planned intensive care unit admission that prompts intrusive memories of previous distress.

Medically, traumas are defined as "serious injuries to the body" that can involve contact, blunt force, or penetration, through either an unpredictable and unforeseen force, or a controlled mechanism, such as in the case of surgical injury (National Institute of General Medical Sciences, 2017). Psychologically, however, this definition feels inadequate as we know that trauma is not so much about the set of circumstances in which a person finds themselves, but rather the cognitive appraisals and emotional reactions that

are elicited – whether these are immediate, delayed, or even vicarious. In the words of the Substance Abuse and Mental Health Services Administration (SAMHSA):

> Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. (SAMHSA, 2012, p. 2)

Trauma, therefore, is not only an illness, injury, or affliction; rather, it is an experience, an interpretation, and a process.

Historically, the academic and public perception of trauma has been one of symptomatology and pathology – a mental health issue to be recognized, treated, and cured. Recently, however, the trauma-informed care philosophy and movement has challenged care providers and larger communities to reconsider trauma as a universal experience that manifests in individualized ways. Trauma-informed care thereby requires recognition of a patient or client's subjective experiences, validation and normalization of the effects of trauma, and the importance of individualized support and/or treatment (Bonanno & Mancini, 2008).

Research since the September 11th, 2001 terrorist attack in New York has shown that only 5-10% of individuals exposed to trauma will develop post-traumatic stress disorder (PTSD), and that only around 10% of bereaved individuals will experience chronically elevated grief reactions akin to PTSD (Bonanno & Mancini, 2008). In addition, "genuine resilience to potentially traumatic events is not rare but common and not a sign of exceptional strength or psychopathology but rather a fundamental feature of normal coping skills" (p. 371). Thus:

> A key point is that even resilient individuals may experience at least some

form of transient stress reaction; however, these reactions are usually mild to moderate in degree, are relatively short-term, and do not significantly interfere with their ability to continue functioning. (Bonanno & Mancini, 2008, p. 371)

Difficult events will elicit difficult responses, and patients and families enter into traumatic experiences with different developmental histories, coping strengths, and external resources. Much like with any other stressor, children and adolescents need:

- Age-appropriate education about events and coping skills
- Choice and control when possible
- Opportunities to express their feelings (often through play)
- Emotional support and validation
- Attention to basic needs
- Normalization of environments and routines, and
- Close connection to their parents, families, support networks, and community.

There will be times when additional treatment is warranted and beyond the scope of what can be provided by a child life professional; therefore, it is important to make appropriate referrals should the child demonstrate self-destructive behaviors or violence towards others, severe distress or severe absence of emotion, psychological impairment, or if changes in behavior, mood, and function last more than four weeks (SAMSHA, 2014).

Trauma-informed care begins with the first contact a person has with an agency (SAMSHA, 2014); for many children and families, this may be the voice of an emergency medical dispatcher, or the arrival of a first response team. When the child life specialist enters the situation to introduce services and assess for needs, the patient and family have likely already met

Trauma-Informed Care and Relationship Building in the Pediatric Intensive Care Unit

many people, heard many new things, and felt an onslaught of emotions and thought processes that are difficult to describe. As a child life specialist in the pediatric intensive care unit, much has happened before the child is transferred to our unit, before I am able to make this first contact with the family.

Building therapeutic relationships with children and families who are experiencing stress is always a challenging process, though it is the most important aspect of what we do as child life professionals.

Building therapeutic relationships with children and families who are experiencing stress is always a challenging process, though it is the most important aspect of what we do as child life professionals. Trauma-informed care reminds us that any situation can be potentially traumatic, that each and every relationship we build not only has the power to heal, but is also dangerous because it creates or adds to the vulnerability patients and families may already feel. Yet at the same time, it is also primarily through relationships that patients or families experiencing trauma can garner the support they need to maintain or build resiliency even in the face of the most unbelievable conditions.

When initiating and building relationships with patients and families experiencing medical or psychological trauma, I find myself incorporating a different level of intentionality to the skills that I would typically employ when introducing services and assessing for needs. First, I consistently prepare myself, the staff that I work with, and even the family members of patients to anticipate, recognize, and normalize a variety of presentations and reactions

when it comes to medical or perceived trauma. To communicate this openness to a variety of responses, I tend to stay away from introductory questions such as "how are you?" or, "how is [patient] doing today?" Instead, I start with a validating statement, such as "I can't imagine the different things

you must be feeling and thinking right now," or "lots of parents here tell me that the question 'how are you today?' feels impossible, so what if we just start with 'what's something I can do for you right now?'"

When introducing myself, I err on the side of purposeful communication without too many details, definitions, or forced choices. Rather than the traditional explanation of child life services as promoting coping through play and/or education (which makes it seem like these are the only two pertinent dimensions during a very unpredictable and chaotic time), I find myself instead sticking to, "My job is to help families deal with the hard things that bring them into the hospital, and any new or hard things that might happen while you are here." Occasionally, I get questions and requests best directed to other services, such as FMLA paperwork, insurance information, or a letter for the child's school. However, being able to communicate these to the appropriate channel on the family's behalf saves them one additional step, promotes control in what can feel like a helpless situation, and gives me an opportunity to transfer rapport and

help the family to perceive the social support system of the multidisciplinary team (thereby promoting resilience).

At the same time, I have found that broadly introducing my role in this way lends to accommodating and responding to a variety of trauma-induced feelings or needs that may not have otherwise fit within the categories of play and/or education. For instance, it's hard for a patient or family member to describe their need for a supportive presence in a moment of silence, a hand to hold as they tell the story of watching their child's accident, or disclosing perceived feelings of guilt or responsibility. Or, a child may not know how to help themselves when every time they close their eyes, they are plagued by intrusive thoughts that throw them back into the moment of the traumatic experience. Then there's also the teen who literally just wants to Snapchat his friends to prove that he is, indeed, still alive. By adopting a broad introduction of services, I am able to communicate an inclusive orientation that can triage a variety of needs, rather than narrowing my support from the outset into defined realms that may or may not be of concern in that particular moment. The more flexible I feel I can be in my description of my role, the more I feel that this displays a similar flexibility to needs, experiences, and communication styles.

Asking questions used to be one of my primary modes of assessment; however, questions can easily be interpreted as criticisms or judgments when one is in the throes of trauma. Now I find myself relying more on observation, on silence, on slowing down and being present. Silence, much like speech, is a skill that takes time, practice, and dedication to learn; simultaneously, growing comfortable with silence

requires an emotion-focused coping orientation, as there are many situations and predicaments that cannot be solved with words. Like the opening vignette, a small action or validating statement seems to open the door for more in-depth assessment information than I could have gotten from asking the tried-and-true, "tell me what brings you to the hospital today." Sometimes the incident is purely accidental; other times there has been non-accidental trauma, parental oversight, or other tension in the family that somehow connects to the child's hospitalization. Therefore, explaining the reason for hospitalization may be very complicated, confusing, or palpably tenuous.

Finally, I find myself using every chance I can to point out the child and family's strengths and opportunities to build resilience. Even though a parent may feel utterly helpless in their current situation, I praise and validate their abilities to be present for their child, to reach out for help in their community, to accept support from hospital staff. Even though a child may feel similarly helpless, I intentionally recognize and praise their abilities to indicate their needs, to make choices (even when

they choose not to engage with me), or to find the strength and desire to play. Most of all, I seek out occasions to reinforce the child and family's support of one another, and their instinct to pursue support from one another. Though there are situations when this approach may not be appropriate, it can help to model 1) healthy and supportive relationships, 2) social connection as a source of resilience, and 3) open communication within the family unit.

depending on an individual's cognitive and emotional appraisals of the event and the coping resources they believe to be available. Although this makes trauma seem more common, it also reminds us that trauma is a normative developmental experience that, like other challenging experiences such as grief, can be a transformative process with the appropriate relationship-based supports. When we are aware of and intentional about the potential

Silence, much like speech, is a skill that takes time, practice, and dedication to learn; simultaneously, growing comfortable with silence requires an emotion-focused coping orientation, as there are many situations and predicaments that cannot be solved with words.

Twenty years ago, trauma was viewed as a life-shattering event with deep and enduring psychological consequences that could only, if at all, be resolved through intensive cognitive behavioral therapy. Today's trauma-informed care approach acknowledges that any and every situation can result in trauma,

effects of trauma, it is possible to not only build therapeutic relationships with patients and families experiencing trauma, but to lay an important foundation for the skills and resources that will foster resilience in the years to come. 🏃

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Commitment to Relationship and Reflection in Child Life Practice

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I am often asked, "What is your advice for success in this profession?" My answer to this vital question is always the same. The two most important capacities that must exist to flourish and thrive in child life are a commitment to fostering relationship and a focus on reflective practice.

"Relationship" is a concept in child life that I believe is essential to understand early on and to embrace throughout one's profession. To focus on relationship is to acknowledge the critical significance of the interconnectedness between staff, patients, and families that must be a part of the work we do to serve children and families in pediatric environments. A focus on relationship also helps us deepen our sense of commitment to each other and the opportunities that we have to support and enhance our collective growth and development in the child life profession

Clinical supervision and reflective practice in child life have been discussed and explored, as they represent a fundamental activity that supports clinical growth, development, and professionalism. This has been reinforced through the formulation of the ACLP's Clinical Supervision Position Statement (Child Life Council, 2008) and through ACLP preconference intensives and other training opportunities.

In our Child Life and Creative Arts Therapy Department, we have collectively embraced a commitment to reflective practice through clinical group supervision. Our approach to reflective practice in our group supervision process is relational – that is, we seek, in an appreciative inquiry framework, to listen, to respond, and to offer our full intelligence to each other in the spirit of respect, curiosity, and a shared commitment to our individual and collective growth.

In the context of relational dialogue, I wanted to explore directly with our child life staff how they understand the notion of relationship in the workplace, as well as what they experience as the value added and the challenges of our own clinical supervision/reflective practice (CS/RP) groups. I specifically chose a range of staff engaged in our collective practice of CS/RP to answer my questions: child life specialists, a music therapist, a child life specialist/art therapist, a broadcast studio coordinator, and a child life assistant. I posed three questions, and through the staff responses, several themes emerged which are summarized below.

1. How do you define relationship in the context of your work relationships with others in our department? To what extent is relationship important in terms of collaboration and clinical growth?

Trust

Relationship was described as a connection rooted in mutual trust, and it is that trust that enables one to open up to their own vulnerabilities and seek collegial input about new strategies and clinical interventions. Developing and maintaining trust provides the foundation for successful relationships, transparent communication, and cohesion. Trust is a necessity.

Teamwork

When relationship is strong, our child life department works as a team and strives to achieve the same goals and objectives: excellence in patient and family care. Each member of the department brings a unique resource or talent to the work relationship and contributes their knowledge and skills to deliver quality care, solve problems, and complete projects. The team works within a system of checks and balances.

2. What do you think is the value of our CS/RP groups in your experience of relationships with staff in our department?

Deeper Understanding

Through CS/RP groups, child life specialists expressed their ability to deepen an appreciation of the obstacles and challenges of their colleagues as they share their thoughts and concerns about patient care. The groups are uniformly seen as supportive and as a setting that allows for learning about the strengths of staff members and an awareness of a wide range of situations we face every day. Listening to each other, we grow as a whole.

Greater Outcomes

From CS/RP groups, staff members describe witnessing how others in the group reflect and process both clinical encounters and group feedback. This provides the opportunity to reflect in a supportive and safe setting and receive

feedback on how to approach a situation from a different angle.

3. What is the main challenge you have experienced in regard to intergroup relationships as it relates to our CS/RP groups and why?

Vulnerability

Revealing vulnerabilities is a struggle, especially in clinical work. It's difficult to say, "I don't know." Feelings of resistance toward opening and expressing vulnerabilities can be a hurdle in the CS/RP group setting. Time and trust ease the challenges of exposing areas of need.

New Thinking

When facilitated well, the CS/RP group is an impactful learning opportunity, as it challenges one's way of thinking. Support and encouragement are provided to try a different approach to a situation. As a result, child life specialists walk away from this time of reflection with a new set of ideas to put into practice.

These collective responses and themes offer a window into the thoughts and impressions of staff who have embraced a commitment to relationship and reflective practice that is both mindful and dynamic. When we acknowledge the importance of this focus in our interactions and clinical practice, we have the opportunity to powerfully affect how we relate to each other within our programs, to the patients and families we serve, and to stakeholders throughout the organization and beyond. By reflecting on clinical challenges and encounters in a group forum, staff recognize that they are united by common themes and feelings, regardless of experience level. In addition, by witnessing how others in the group reflect and process both clinical encounters and group feedback, we learn how to communicate with one another with greater understanding and empathy.

As discussed in the Clinical Supervision Position Statement of ACLP (Child Life Council, 2008), reflection involves stepping back from the direct, intense experience of clinical work, and exploring the thoughts, feelings, and issues the child life specialist is experiencing and managing. In the group supervision/reflective practice process, specialists share their own perspectives in an atmosphere of active listening and thoughtful questioning; in other words, in a mutually constructed relationship environment. The relationship between group participants and facilitators can be nourishing, rewarding, and enriching. The group works to build a foundation of trust, shared power, safety, mutual expectations, and feedback. When child life programs establish commitment to relationship and reflection, we build contexts to embrace our obligation to the patients and families we serve to collaborate and thoughtfully reflect upon our practice. 🏃

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A FUNCTION OF PARADOX:

The Missed Opportunity of the Resident Referral

Divna Wheelwright, MA, CCLS

A strikingly assured publication on managing pediatric anxiety was published in the April 21, 2016, edition of the *New England Journal of Medicine*. Soon after, I initiated a conversation with its author, an emergency physician at a prominent freestanding children's hospital, on what I perceived to be a critical omission: his failure to include child life services in his litany of best approaches. The physician's response to my question of whether or not he was able to draw upon the robust child life presence in the Emergency Department was swift. "Yes," he acknowledged. "Have you had the opportunity to view the supplementary instructional videos to the article? Look closely; you will notice several specialists in the background."

My response:

April 29, 2016

Dear Dr. X,

Thank you so much for your response. I experienced both the videos and the written supplement.

When I first read your piece, my immediate hope was that the physician who wrote it did not know about the field of child life. To learn that you are exposed to child life, and beyond this, have chosen to feature child life specialists in the background of your teaching material with no direct acknowledgement, was troubling to me.

I couldn't agree more that medical practitioners and humanity at large should be exposed to the observations, techniques and recommendations that your paper posits. Your insight is excellent. My concern lies in the fact that if your true intention is to educate on how to best manage procedural anxiety in children, how then could the one service that exists solely to mediate pediatric anxiety, be excluded from your teachings? Please help me to understand what would shift your perspective to move child life from the distant background of your material to the foreground where, in relation to this topic, it truly belongs.

I appreciate your time and insight.

Gratefully,
Divna

For one year my question went unanswered. Fortified by the charge of writing this article, first imagined as a fire and brimstone call for increased professional visibility in national publications, I sent the email again. This attempt yielded a direct response from the physician, more specifically, the invitation to speak by phone.

My throat was dry when the phone rang. The physician's voice echoed through the receiver congenially, requiring no invitation to dismantle the storyline of professional disregard I had committed the last year to perfecting. With earnest immediacy he stated, "I am a fan of child life in every way. Child life is an incredibly well-integrated service in my Emergency Department whose function, due to fastidious requirements set by the *New England Journal of Medicine*, I was forced to generalize."

"And if there had been no constrictions set, would you have directly acknowledged child life in your review of best practice?" I lobbed.

"Absolutely!" was his return.

What I had fantasized would be an exploration of clinical repentance surreptitiously broadened into a discussion of the training of medical students at large. Knowing that research shows that empathy declines in medical school, I asked the physician if medical students are taught approaches to minimizing pediatric anxiety and further, how they learn to accurately assess a child's emotional state. "Could this be a potential area of growth?" I asked. The physician had stronger words, stating that the lack of formal training on assessing the child's emotional state, the parent's emotional

state, and the impact of the child's previous medical experiences, was in fact an "educational problem and deficiency in medical education that demands a systematic methodology to correct." "Residents and fellows are taught by example," he said, "it is entirely operator-dependent how much a medical student is exposed to effective empathic approaches to interacting with anxious children. At times, it is not even taught at all."

At this point in the conversation I had melted into my chair, sure that the focus of the conversation had moved beyond child life and the potential need to recalibrate clinical understanding of services. When the physician, animated by what he identified as an unreliable and largely ineffective transmission of skill set from today's attending physicians to medical students, residents, and fellows, shifted focus to the role of child life in perpetuating this problem, I straightened. "If we know that physicians at all levels are attempting to engage children and having intermittent success," he asked, "why then is child life not moving more aggressively toward a teaching role? It's as though the validation of the referral is enough."

The quality of remaining open, specifically in moments of dissent, is a skill that requires lifelong vigilance. I flashed back to my clinical days and the distinct expression of relief that would spread over the resident's face when I would arrive; burgeoning distraction bag slung over one shoulder, to move the child from a state of fear to one of trust. As I lowered myself to meet the child, whose tiny knees trembled beneath the sheet, the resident, now unencumbered by the pressure to create an emotional connection, could turn to the clinical objective at hand. From across the gleam of the sterile field, one resident had emptied his suturing kit with a satisfied sigh. "Yes! Child life will take care of this!" This being the three-year-old boy, intricate threads of blood

converging across his face like lace, whose wails only ceased in the moments required to breathe.

All clinicians have a specific skill set. One could argue that the quality of care that patients receive is directly in proportion to how generously clinicians utilize their skill set to enhance the skill set of those they work alongside. To extend this argument, a team-focused approach to providing emotional care would have involved me, the child life specialist at the precipice of a laceration repair, conveying to the resident that developmentally-appropriate approaches to reducing patient anxiety can be taught. "It really is a missed opportunity," the physician continued. "Residents and fellows call child life and then don't focus on how child life is engaging the child. What they lose is the opportunity to pick up pieces of the skill set."

"It really is a missed opportunity," the physician continued. "Residents and fellows call child life and then don't focus on how child life is engaging the child. What they lose is the opportunity to pick up pieces of the skill set."

What, then, does the patient lose in the absence of systematically approaching this area of knowledge? If clinical observation is the cornerstone of resident education, why then does the specialist's ego, activated by the resident's referral, often not submit to the larger didactic opportunity at hand? As the dial tone echoed dimly, I wondered if the same vacuum that allowed me to persist for one year under the impression that this physician did not value child life services, was responsible. 🏃

Child Life Focus

Continuing the Discussion on Therapeutic Relationships, Professional Boundaries, and Self-care Practices in Child Life

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A s child life professionals, we are granted the privilege of providing support to children during what is likely the most frightening and overwhelming experiences of their lives. Through therapeutic interventions such as medical play and procedural support, Certified Child Life Specialists (CCLSs) provide a voice to children in healthcare who are oftentimes unheard. We are advocates for the most vulnerable among us, engaging in a profession that encapsulates both the highs and lows of the medical environment. As a profession, we as CCLSs are bound by our collective desire to make a difference for our patients and their families; this desire is often what first brings us into the world of child life, and it is what continues to sustain us through the difficult times. Conversations with working child life specialists regularly reveal that relationships with patients are our favorite part of our job, yet they can also be the most challenging part as well.

The benefits of engaging in professional therapeutic relationships have been well documented in the literature. Research on comparable professions indicates that therapeutic relationships are highly correlated with individual commitment to a profession (Rohan & Bausch, 2009), feelings of satisfaction with a job, and overall psychological well-being (Van Hook & Rothenberg, 2009). When healthcare professionals, including CCLSs, are placed in position to help others, they experience an increase in satisfaction for their individual contribution to society and the greater good (Decker, Constantine Brown, Ong, & Stiney-Ziskind, 2015; Stamm, 2002). Likewise, interacting with individuals in helping professions has benefits for patients, including increased recovery outcomes and satisfaction with care provided (Graham, Shahani, Grimes, Harman, & Giordano, 2015).

There is no doubt that child life as a profession continues to leave a positive mark on healthcare; yet within the field there is awareness that the same emotional engagement with patients and families that sustains specialists can at times also undermine professionals' psychological well-being (Fisackerly, Sira, Desai, & McCammon, 2016). Consistent exposure to high acuity patients in units such as the intensive care unit or emergency department has been linked with a wide range of consequences, from physical symptoms such as sleep disturbances, to indicators of emotional instability such as loss of self-confidence (van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015). Research has also suggested these patient interactions place CCLSs at risk for developing compassion fatigue and burnout, which may impact quality of life outside of work (Brinson, 2012; Fisackerly et al., 2016; Meadors, Lamson, Swanson, White, & Sira, 2009).

While most professionals might individually argue that for themselves the emotional and psychological rewards from working with the pediatric population is well worth the risk, it is also true that a lack of awareness and support for these conditions can be detrimental to the overall well-being of the field. Many human service professions continue to see turnover rates as high as 50%, with burnout and job-related stress remaining among the most significant factors related to intention to leave (Mor Barak, Nissly, & Levin, 2001). For CCLSs, turnover has also been highly correlated with role ambiguity and insufficient

boundaries between professional and personal life (Holloway & Wallinga, 1990; Munn, Barber, & Fitz, 1996; Snow & Triebenbacher, 1996).

In light of these issues, the present article will use current literature to explore the nature of therapeutic relationships and how professional boundaries might protect the emotional health of child life specialists. Armed with this knowledge, the article will then move to a discussion on the role of self-reflection and mindfulness practice in fostering effective boundary setting for child life specialists, and conclude with an exploration of the role of education for incoming and established professionals in maintaining the longevity of the field.

Therapeutic Relationships and Professional Boundaries in Child Life

Among CCLSs there is consensus that the influence and efficacy of the profession is contingent upon successful and purposeful relationship building with patients and families. A cursory glance over the profession's official documents, competencies, and tests reveals repeated use of the phrase *therapeutic relationship*. For instance, within the Association for Child Life Professionals' (ACLP; formerly Child Life Council) *Mission, Values, Vision* statement (Child Life Council, 2015), therapeutic relationships is third on the list of values, accompanied by the following elucidation:

> We are committed to relationships built on trust, respect, and professional competence that contribute to the development of confidence, resilience, and problem-solving skills that enable individuals and families to deal effectively with challenges to development, health, and well-being. (Child Life Council, 2015, Therapeutic Relationships, para. 1)

The root of the term 'therapy' comes from the Greek word *therapeia*, translating roughly to 'curing or healing' (McCue, 2009). As a profession, child life remains committed to fostering and maintaining therapeutic relationships. Through the intentional development of therapeutic relationships with patients and families, CCLSs are in fact offering a type of restoration: emotional, psychological, and (perhaps even indirectly) medical. Sandhu, Aricidiacono, Aguglia, and

Priebe (2015) argue that the relationship between healthcare practitioner and client (and the communication patterns within these interactions) can in fact be seen as integral to the healing process. Successful therapeutic relationships require commitment, open and honest communication, and above all else, mutually established trust.

The value of trust in healing is supported throughout the literature. When patients trust their healthcare providers, they report feeling safe (Holm & Severinsson, 2011; Wen & Tucker, 2015). Research has repeatedly indicated patient reports of healthcare providers' authenticity and honesty is positively correlated with adherence to medical protocols and recovery times (Farrelly et al., 2014; Graham et al., 2015). Many scholars argue that when individuals believe a healthcare practitioner is focused on their best interests, they are in turn more likely to have confidence in

the suggested treatment plan (Anderson & Dedrick, 1990; Hall, Dugan, Zheng, & Mishra, 2001). While these studies did not directly look at the work of CCLSs, the results corroborate what most specialists know to be true through their own anecdotal experiences: Building trust is critical to patient cooperation and compliance. This phenomenon was demonstrated in a study exploring the relationship between empathy and patient outcomes for the adult oncology population; The results indicated a significant correlation between patient satisfaction for care and a provider's ability to perspective take (Lelorain, Brédart, Dolbeault, & Sultan, 2012). When professionals are viewed as compassionate and understanding, patients feel more comfortable with their plans of care.

In the context of non-clinical relationships (e.g., friendship, intimate partnership), trust is often built through affection, long-term exposure, and, perhaps most importantly, through mutual vulnerability (Brown, 2012). However, in the realm of healthcare, many of these tools are considered off-limits for the

child life specialist. Therapeutic relationships in the medical setting often entail inequities of power and knowledge, in part because patients and families are inherently at their most vulnerable (Adshead, 2012). Without proper instruction on the essential differences between professional and personal relationships, a patient's dependency on the healthcare provider for knowledge, support, and advocacy may in fact transform into an expectation for friendship and mutual openness from that provider.

These expectations become even more salient for the work of CCLSs, as many of our tools of the trade (i.e., play, emotional processing) lie quite adjacent to friendship on the spectrum of relationships. As child life specialists, we are asked to earn our patient's trust and confidence while still maintaining a certain level of professional detachment (McCue, 2009). Preserving the delicate balance of compassion and composure takes careful and thoughtful planning, a process that Adshead (2012) suggests culminates in the institution of professional codes of

ethics, and more specifically, standards for professional boundaries.

By definition, boundaries are used to "define space with an inside and an outside" (Adshead, 2012, p. 13). A national boundary differentiates one country from another. A property boundary separates your yard from your neighbors'. In the context of therapeutic relationships, professional boundaries are the ethical guidelines that set rules and expectations for how healthcare workers are to engage with their clients (Cooper, 2012). Effective boundaries differentiate between professional and personal domains, underscoring behavioral expectations that set the stage for patient safety and comfort. Within therapeutic relationships, professional boundaries can be conceptualized as mutually agreed upon guardrails (emotional and physical) between the professional and patient that keeps the relationship from straying too far from the healthcare goals (Adshead, 2012).

When implemented thoughtfully, these guidelines can create an environment that

promotes therapeutic interactions between specialist and patient. Cooper (2012) argues that professional boundaries set the stage for effective therapeutic relationships by providing consistent care, implementation of best practices, success in building and maintaining patient trust, behavioral expectations for both parties, and opportunity for the professional to both model and teach boundaries to the client. Cooper also recognizes that within the world of helping professionals, building these relationships is akin to balancing on a tight rope; the responsibility for navigating the dueling tensions of building rapport with patients while maintaining professional detachment ultimately lies with the professional.

Setting Boundaries Through Self-Reflection

One of the most important skills for a professional to utilize when setting therapeutic limits with patients is intentional self-reflection. All individuals operate on subconscious patterns of behaviors based on past experiences, and as professionals there is a necessity to be aware of how those patterns affect professional competence (Cooper, 2012). By engaging in self-reflection, professionals are better able to identify ways in which their own desires, reactions, and fears may interfere with their ability to take the patient's perspective and provide individualized care (College of Physiotherapists of Ontario, 2013). It is only through honesty with oneself that a specialist can accurately assess relationships with patients.

Self-reflection can take many forms (e.g., train-of-thought journaling, structured prompts, artistic expression), but lately much of the literature has focused on the benefits of *mindfulness practice*. There are many definitions of mindfulness, but most scholars and practitioners agree that mindful practice involves fully attending to, and engaging in, present circumstances. It is to be "fully present, aware of where we are and what we're doing, and not overly reactive or overwhelmed by what's going on around us" (Mindful Staff, 2014). Mindfulness practice then is a deliberate and consistent exercise in which the individual focuses on using a metacognitive approach to identify underlying patterns and thoughts that may direct outward behavior. In identifying these undercurrents of thought, patterns of insight may emerge, providing meaning and

reason for an individual's actions. Examples of self-reflective mindfulness questions that may be useful for CCLSs are included in the section entitled "Self-Reflection and Mindfulness for Child Life Specialists" (See Appendix A). This exercise can be of benefit for any specialist intent on self-improvement, but will be of particular use for individuals navigating professional boundaries in complicated or delicate patient scenarios.

Regularly practicing mindfulness techniques such as the ones listed here has been linked with increases in emotional intelligence, as well as the ability to control or redirect emotions in high intensity environments (Burke, Dye, & Hughey, 2016). Similarly, regular reflective practice has been shown to improve metacognition, or the ability to think objectively about one's thoughts and actions (Weil et al, 2013). With repetition, mindfulness can lead to increased problem solving and decision-making skills, heightened awareness of professional boundaries, and more clearly defined professional goals (Karakowsky & Mann, 2008; Lew & Schmidt, 2011; Tariman, 2010). Mindfulness-based practice has been shown to significantly impact quality of life, health, and mood (Carlson, Speca, Patel, & Goodey, 2004; Richards, Campenni, & Muse-Burk, 2010). Ultimately the goal of regularly asking reflective questions is to increase awareness of one's actions and emotions, allowing the individual to prevent immediate emotional responses and instead enact intentional behaviors. Engaging in these types of activities can also provide a framework for analyzing an individual's particular strengths and weaknesses, which can in turn be used for goal-setting. While many of these abilities may not come naturally to all individuals, evidence suggests that practice makes perfect (Burke et al., 2016).

Self-reflective exercise is considered best practice in a variety of related professions, including education (Taylor, 1994), mental health services (Richards et al., 2010), massage therapy (Derick, 2016), and physical therapy (College of Physiotherapists of Ontario, 2013). Additionally, the value of reflective practice can be found integrated in the very foundation of the child life profession. Inherent in many child life professional documents is a recognition that self-reflection is vital to the success and psychological health of CCLSs. Self-reflection is included as the second component of Professional Responsibility

in the *2016 Child Life Competencies*:

Competency: The ability to continuously engage in self-reflective professional child life practice.

Knowledge:

- Recognize and describe how personal challenge and learning needs in knowledge and practice skills may impact service delivery.
- Identify resources and opportunities for professional development
- Articulate reasons for and impact of underinvolvement and overinvolvement of professionals with children and families.
- Articulate the impact of one's own culture, values, beliefs, and behaviors on interactions with diverse populations. (Child Life Council, 2016b, Professional Responsibility, para. 4-5)

If we as a profession continue to place value on the role of self-reflection in maintaining our qualifications and proficiencies, then it stands to reason that emphasis on teaching these skills needs to be present at all stages of the professional lifecycle.

Education and Future Efforts in Child Life

The topics and exercises that have been discussed in this article are important for all professionals to consider, but have particular significance when discussing students and young professionals. As previously stated, most healthcare professions have incredibly high turnover in staffing (Mor Barak et al., 2001). One explanation for this trend is found in the realization that professionals with less experience are at increased risk for developing compassion fatigue (Bush, 2009), a salient issue as Brinson (2012) found that over half of child life specialists are at risk for developing burnout and compassion fatigue. When appropriate patient/specialist boundaries and self-care are modeled early in the educational process, it allows these concepts to be embedded into the very core of the student's professional identity. When self-care techniques are intentionally introduced into curriculum, students are more apt to purposefully engage in these behaviors throughout their professional careers (Shannon, Simmelink-McCleary, Hyojin, Becher, & Crooke-Lyon, 2014).

For example, in this author's experience, students at the start of their clinical experiences often have difficulty processing and analyzing interactions with patients beyond surface level description. Typically, when asked to 'reflect' upon the previous week, the introductory practicum or internship student will simply recount their experiences in chronological order, without any insight into their own patterns of behaviors or contextual understanding of the patient load. In an effort to demonstrate effective self-reflection, one recommendation is to have students categorize interactions in an activity entitled *Green, Yellow, Red*. In this assignment, students are expected to classify experiences based on factors such as personal comfort level, success of outcomes, and insight into patient (or staff) encounters. An outline of this activity, including a script for instructors, can be found in the section entitled "Activity for Improving Student Reflections" (See Appendix B). Engaging in this activity facilitates discussion on student progress and comprehension of context, and provides a framework for a student to self-identify where he or she might be struggling. When this activity is completed on a weekly basis, it allows for demonstration of progress over time, and can assist students in learning how to set and achieve personal goals for improvement.

Research in comparable fields provides evidence that dedicating time and effort to teaching professional skills and values (such as self-reflection and boundary setting) to students at the beginning of their professional career will contribute to their success and emotional health throughout their entire lives. When mindfulness techniques were incorporated in experiential learning, social work students reported being better equipped to deal with the job-related stressors they encountered (Christopher & Mathis, 2012). Additionally, students who regularly engage in self-reflection are judged as better able to separate and balance their professional and personal lives (Burke et al., 2016). Finally, a study on speech language pathology students revealed that those who regularly engaged in self-reflective practice (specifically by writing self-directed letters), viewed the practice as highly influential in developing their professional identity (Jagoe & Walsh, 2009). The students exhibited significantly higher levels of confidence in navigating some of the more complex (and less clear cut) relationship boundaries with clients. We

can take these findings as evidence that early introduction of the inherent value of reflection into education will set a strong foundation for our upcoming professionals.

The good news is that efforts to increase proficiency in developing and maintaining professional boundaries through self-reflection are already underway within the field of child life. There have been several sessions in the past three years at the Annual Conference on Professional Issues that have focused on providing upcoming specialists with tools needed for success, such as the 2016 session on "The First Five Years: Surviving and Thriving as a New Child Life Professional" (Child Life Council, 2016a). Additionally, the profession's *Evaluation Tool for Child Life*

Interns includes an entire section devoted to self-reflection, with the following specific competencies listed:

- Recognizes and demonstrates willingness to explore how personal challenges, learning needs, cultural and personal beliefs impact professional practice.

- Engages in self-reflective practice, demonstrating realistic and critical thinking regarding own performance, and incorporates insights into practice. (Child Life Council, 2012, Professional Skills, para. 1)

While it is certainly encouraging to know that the next generation of child life specialists is being equipped with tools for success, it is also important that attention is given

to providing continuing education to those already practicing in the field. Given the strong evidence linking self-reflective practice to effective therapeutic relationship building, it is this author's hope that leadership (both in the ACLP and individual programs) will continue to seek out and provide education via webinars, conference sessions, and publications on the importance of self-reflection and mindfulness. This becomes even more salient with the new emphasis on professional responsibility in continuing education. Examples of sessions to offer might include: navigating the growing world of social media; learning to leave work behind at the end of the day; recognizing the signs of PTSD and compassion fatigue; and yoga or meditation instruction.

Additionally, it would be beneficial for child life supervisors and mentors to find ways of regularly reinforcing these skills (i.e., self-reflection and mindfulness) for more established professionals, perhaps through inclusion in weekly meetings, or even separately planned in-services. The research of McCann and Pearlman (1990) demonstrated the benefits of weekly discussion groups in fostering self-reflective skills (particularly when dealing with professional boundaries) for healthcare professionals. Providing regular opportunities for child life staff to come together and process their experiences would encourage collaboration and accountability between specialists, as well as providing chances for more experienced specialists to

...learning to establish and sustain healthy professional boundaries through self-reflection is a skill that can be nurtured with deliberate effort. Instruction on techniques such as mindfulness should be introduced early in the educational career, but must be continually emphasized throughout one's professional career. By focusing on the importance of such efforts, we as child life specialists can ensure the health of our profession for years to come.

mentor the newcomers on techniques they have found helpful.

Moreover, supervisors have the unique opportunity to set the tenor for their departments by making self-reflection a priority (Brinson, 2012). Munn and colleagues (1996) found one of the most important factors for increasing job satisfaction (and decreasing intention to leave) in child life specialists is managerial support. This finding was corroborated by Fisackerly (2011), whose research indicated that instrumental support from child life supervisors decreased the likelihood of burnout for specialists. Most child life supervisors are experienced professionals with years of practice navigating the world of therapeutic relationships and boundaries. By emphasizing these values in settings such as staff meetings and clinical supervision, managers can build the foundation for a department

that prioritizes healthy therapeutic boundaries between specialists and patients.

The importance of fostering the development of healthy professional relationships between CCLS and patients cannot be understated. As mentioned previously, this bond is critical for the success of our therapeutic interventions, yet it is to the benefit of both patient and professional that proper limits be maintained. Luckily, learning to establish and sustain healthy professional boundaries through self-reflection is a skill that can be nurtured with deliberate effort. Instruction on techniques such as mindfulness should be introduced early in the educational career, but must be continually emphasized throughout one's professional career. By focusing on the importance of such efforts, we as child life specialists can ensure the health of our profession for years to come.

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APPENDIX A

SELF-REFLECTION AND MINDFULNESS FOR CHILD LIFE SPECIALISTS

Situational Questions:

- What emotions am I experiencing right now? How is my behavior reflecting those emotions?
- What is my current body language conveying to the people around me?
- What techniques (e.g., deep breathing) might be useful to regain control of my emotions?
- Why did a particular patient/situation/environment trigger a positive or negative reaction for me?
- Are there any experiences in my past that are affecting the way I am engaging with a patient?
- What could I have done better with this specific patient and what approaches might I try differently in the future?

Boundary Questions:

- Is my relationship with this specific patient appropriate?
- Am I avoiding talking to my supervisor or colleagues about my interactions with a patient?
- Do I find myself actively avoiding/seeking out this patient?
- Am I finding myself preoccupied with this patient outside of work?

General Professional Integrity Questions:

- What are the gaps in my knowledge for a particular situation?
- What efforts should I take to improve my skillset?
- Are stressors from my home life interfering with my ability to do my job effectively?
- Am I able to disengage from work when I return home or do I bring work into my personal life?
- What are activities that can help me reduce stress in both my professional and personal lives?

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APPENDIX B

ACTIVITY FOR IMPROVING STUDENT REFLECTIONS
(adapted from Nash, Stupans, Chalmers, & Brown, 2016)

Activity Description:

Students reflect upon experiences (typically from the week between supervisory sessions) and categorize them into three groups (Green, Yellow, Red) based on outcomes and personal comfort. This activity can be completed in written form (journals) or orally (group reflection).

Note: The instructor's role is to facilitate the reflection process, not necessarily to provide concrete answers.

Learning Objectives:

Through this activity students should be able to:

- Recognize how discrete patient interactions fit within greater context of plan of care.
- Assess personal growth and competence.
- Build professional confidence by identifying areas of success and growth.
- Identify areas for improvement and create goals to further personal development.

Introduction of Assignment Framework (sample script):

When you approach a stoplight, you will see one of three colors: Green, Yellow, or, Red. What you do next will be impacted by the meanings associated with each of those colors:

Green means we keep going at the same pace without stopping or slowing down.

Yellow means approach with caution; sometimes you might start slowing down, other times you will simply have to proceed with heightened awareness to your surroundings.

Red means stop. When we approach a light that is red we must not continue any further until we have been given a green light or are completely sure there is nothing in our way.

Reflective Questions:

Tell me about your *Green* experiences this week: What is going well for you? In what areas are you experiencing success? What is coming naturally and does not require intentional focus? Can you give me an example of a patient (or staff) interaction that had positive outcomes?

Tell me about your *Yellow* experiences: Where are you exhibiting caution? Were there any interactions with patients or staff about which you felt unsure? What concerns do you have about your progress?

Tell me about your *Red* experiences: What is stopping you from being successful? Were there any interactions with patients or staff that made you feel uncomfortable or that did not seem appropriate? What issues need to be addressed right here and now before you can move forward in your career?

Goal Setting:

Given the answers to the above questions, identify 3 skills (or areas of competence) that you want to work on this week. For each skill list at least two distinct ways in which you will measure your progress.

STEP 4:
Critically Appraise the Evidence

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After conducting a search for evidence, the next step in the evidence-based practice (EBP) model is to critically appraise the collected literature. Critical appraisal refers to the process of evaluating, examining, judging, and interpreting the quality, validity, and relevance of research (Young & Solomon, 2009). This systematic evaluation of the gathered information ensures objectivity and that high level evidence informs clinical practice. This process includes evaluating the quality of individual studies and then assessing the strength of the comprehensive body of evidence relating to the clinical question (Cincinnati Children's Hospital Medical Center Evidence Collaboration [CCHMCEC], 2015).

While this article is designed to go in depth for those currently working on EBP projects, broad considerations for evaluating the quality of individual research studies are highlighted throughout for those interested in developing this practice. A few definitions are helpful in the critical appraisal process. Quality refers to "the extent to which all aspects of a study's design and conduct can be shown to protect against systematic bias, nonsystematic bias, and inferential error" (Lohr, 2004, p. 12). Internal validity is the extent to which a study is designed to measure what it intends to measure, and external validity is the extent to which a study's outcomes are relevant to broader populations (Lohr, 2004). With the vast amount of material available to "support" many claims, it is important to understand methods and components of research studies in order to ensure that practices are based on strong evidence. For those unfamiliar with research design, it may be helpful to seek out a mentor at your institution who can provide guidance and assistance along the way.

The ACLP endorses the LEGEND (Let Evidence Guide Every New Decision) Model, a standardized tool developed at Cincinnati Children's Hospital Medical Center. Numerous resources to aid in the critical appraisal process can be found in the Evidence-Based Care Guideline Development Manual created by the CCHMCEC (2015, p. 12-13), and online at https://www.cincinnatichildrens.org/service/j/anderson-center/evidence-based-care/legend.

Seven steps can be followed to complete the appraisal process, and the end result will be increased understanding of the body of literature's strength supporting the evidence-based practice guideline being created. These steps

Evidence-Based Practice Model in Child Life

Assess Practice Need → Develop Clinical Question → Search for Evidence → Critically Appraise Evidence → Strong Evidence / Inconclusive/Weak Evidence → Incorporate Clinical Expertise and Experience from Interdisciplinary Team → Incorporate Patient and Family Values and Preferences → Develop EBP Statement → Implement EBP into Practice → Evaluate EBP → Assess Practice Need

are explored in more detail to follow: (1) select an article to review; (2) determine the domain of the clinical question in the article; (3) determine the study design; (4) select the appropriate appraisal form; (5) complete the appraisal; (6) repeat for all articles; (7) assign a grade to the body of evidence based on your appraisals.

(1) The first step is to **select an article** to review from the compilation of relevant literature that remains after the search for evidence. Remember, all of the articles remaining should answer your specific clinical question (CCHMCEC, 2015). Choose one publication to start with.

(2) Next, **determine the domain, or area of focus, of the clinical question** in the article. This can often be found in the abstract and can be assigned to one of the following categories. The *intervention* field includes research in which the clinical question addresses therapy, treatment, prevention, or harm. Other areas of focus may center on a specific *diagnosis/assessment* or *prognosis* (if the clinical question considers outcomes or the likely course of a diagnosis). If the clinical question evaluates causes or characteristics that increase likelihood of a diagnosis, the domain falls into *etiology/risk factors*. Studies that inquire about the rate or current number of a particular subject/diagnosis are included in the *prevalence/incidence* domain. Clinical questions focused on knowledge, attitudes, and beliefs are categorized into *meaning*. *Cost-analysis/decision analysis* clinical questions center on strengths and weaknesses or the assessment of risk in decision making (CCHMCEC, 2015).

(3) After determining and documenting the domain of the clinical question in the article, the next step is to **determine the study design**. This can typically be identified by reviewing the abstract or methods sections. A useful algorithm for determining the study design can be found as part of the LEGEND model on the CCHMC Evidence Collaboration page. The

following series of questions and definitions from the LEGEND glossary (CCHMCEC, 2015) may be helpful in determining the study design. Note that study designs are not always obvious and some research studies have mixed methods.

First, is the publication being evaluated a *systematic review*? This is a synthesis of empirical articles that answer a clinical question (Higgins & Green, 2011). Systematic reviews provide strong support for evidence-based practice statements.

If the literature being reviewed is not a systematic review, next consider whether the study is quantitative or qualitative in nature. Quantitative research studies test hypotheses and yield numerical data suitable for statistical analysis while leading to deductive conclusions. Qualitative research gathers information or descriptions that are not numerical in form and often leads to inductive inferences (CCHMCEC, 2015).

If the article is qualitative in nature and has an area of analysis, the study design remains *qualitative study*. If there is no analysis, the design may be a *case report* (observations on a single individual), an *expert opinion*, or a *guideline* (CCHMCEC, 2015).

If the article is quantitative in nature, does the quantitative analysis involve a comparison?

If there is no comparison but there is an analysis, the study may fall into a *bench study* (conducted in controlled, laboratory setting aiming to develop knowledge), *decision analysis* (calculates optimal strategy considering all alternatives), *descriptive study* (describes characteristics of variables with no relationship of causality), *psychometric study* (measures human traits, e.g., personality or interest surveys), or *quality improvement analysis* (CCHMCEC, 2015).

If the quantitative study does have a comparison, next consider whether or

not there is more than one analysis. The following study designs all have a single analysis. In *cross-sectional* studies, data is collected at one particular point or range in time. *Longitudinal study* designs follow the same group of participants (or processes/systems) and data collection occurs at more than one point in time. For study designs that follow more than one group of participants and data collection occurs at more than one point in time, the next consideration is whether the intervention in the study was assigned by the principal investigator or if the groups were selected based on an outcome (cohort/case-control). In *randomized controlled trials* (RCT), the participants are assigned to intervention groupings in a fully randomized way. In *controlled clinical trials* (CCT), participants are assigned to intervention groupings but with non-random assignment. Studies following more than one group, with data collection occurring at more than one point in time and with groups that were not assigned by investigators will be either *cohort studies* (groups assigned by factors other than the outcome – can be retrospective or prospective) or *case-control* studies (groups are selected based on outcomes; CCHMCEC, 2015).

If a study does have more than one analysis, this constitutes a *mixed methods* study design. In this instance, determine the quantitative and qualitative components and then complete the appropriate appraisal form for each component. A mixed methods form will also be completed to complete the appraisal (CCHMCEC, 2015).

Determining the study design may seem daunting, however it should not cause undue stress. In the critical appraisal process, initially determining the study design is useful for the next step, selecting the appropriate appraisal form (Step 4). A bit of trial and error is acceptable here as you can start with one appraisal form and if it isn't helpful, try another.

EBP: Critically Appraise the Evidence

(4, 5) The next steps of the critical appraisal process are to **select and complete the appropriate appraisal form** for the article being reviewed. Appraisal forms are located on a grid found at https://www.cincinnatichildrens.org/service/j/anderson-center/evidence-based-care/legend. Select the appropriate form using the study domain and design. Each appraisal form uses prompts specific to the domain and study design to guide the evaluation of the research. Consider using questions from more than one appraisal form if appropriate. Other questions may not apply to the study being reviewed. Items center on validity, reliability, and applicability to your specific clinical question. The following are verbatim examples of considerations in a study appraisal:

- Is the study congruent with the author's study aim/purpose/objectives?
- Did the study have a sufficiently large sample size?

- Were the study methods appropriate for the question?
- Was there freedom from conflict of interest?
- Were the results statistically or clinically significant?
- Were all appropriate outcomes clearly defined?
- Can the results be applied to my population of interest? (CCHMCEC, 2015)

At the end of each appraisal form, the level of quality will be determined based on your review. The Table of Evidence Levels found in the CCHMCEC materials provides guidance around the assignment of the level of quality for each study. It is important to remember that all types of evidence can contribute to an evidence-based practice statement.

As each appraisal form is completed, it is recommended to synthesize the evidence for ease of future reference. An

example evidence synthesis table can be seen in Figure 1.

Additional columns can be added to include other key aspects of the research such as risks, inclusion/exclusion criteria, independent/dependent variables, and adverse events. Be sure to consider how the results and evidence of each study relates to your specific clinical question. Page numbers and table/figure/graph numbers are also helpful to keep track of when documenting key components.

(6) **Repeat** the above steps for each article that makes up the body of evidence. Continue to update the evidence synthesis table upon completion of the appraisal forms. It will be easier to grade the entire body of evidence with an organized approach.

(7) The final step in the critical appraisal process is to **grade the body of evidence**. The number of studies, quality of each study, and consistency of results among the reviewed studies will be considered when grading. At

FIGURE 1
Evidence Synthesis Table Example

ARTICLE CITATION	STUDY DOMAIN	STUDY DESIGN	SAMPLE (age, #, characteristics)	INTERVENTION/ COMPARISON	OUTCOME MEASURES/ EFFECT SIZE	SIGNIFICANT RESULTS/ CONCLUSIONS	QUALITY/ EVIDENCE LEVEL	ADDITIONAL COMMENTS
Lacey, C., Finkelstein, M., & Thygeson, M. (2008). The impact of positioning on fear during immunizations: Supine versus sitting up. *Journal of Pediatric Nursing*, 23(3) 195-200.	Intervention	Cross-sectional	Convenience sample with random assignment N=107 Ages 4-6	Group 1 – supine position Group 2- sitting up position	Preinjection/ Post injection; Child Medical Fear Scale, Fearometer, FACES scale, occurrence of crying (Y/N), procedure time, total crying time	Crying significantly more likely with supine positioning (65.5% vs 41.5% sitting up), Group 1 had significantly greater crying time than group 2, Fearometer score significantly greater for Group 1 (9 vs 5 in group 2).	4a	
Next article here								

the end of each appraisal form (and also documented on your evidence synthesis table) a level of quality has been assigned to each study. After considering these individual study levels, a comprehensive grade will be assigned to the body of evidence falling into one of these tiers: High, Moderate, Low, or Grade Not Assignable (CCHMCEC, 2015).

A *high grade* is assigned when a sufficient number of high quality studies with consistent results is found. These studies have strong internal validity, are clinically important, and have adequate statistical power. "Further research is unlikely to change our confidence in the answer to the clinical question" (CCHMCEC, 2015, p.17).

A *moderate* grade is assigned when a single well-done study or multiple studies of lesser quality have been found. These are studies in which there is less confidence surrounding validity, consistency, or the strength of study designs in answering the clinical question.

A *low* grade is assigned when the body of evidence reveals inconsistent results, threats to validity, and/or insufficient quality of articles. Often many of these articles establish consensus, but there is a lack of research to answer clinical questions.

The body of evidence may be considered *grade not assignable* if too few studies have been found, or the literature appraisal concludes with inconsistent results and a lack of consensus to answer the clinical question.

A worksheet in the LEGEND model titled, "Grading the Body of Evidence" provides additional direction in assigning a grade to the body of evidence (CCHMCEC, 2015).

Once you have completed a critical appraisal and graded the body of evidence, you are ready to move onto step 5 in the EBP process: "Incorporating clinical expertise and experience from the interdisciplinary team." Our next *ACLP Bulletin* article will outline this step in detail. Continue to follow this series as we dig deeper into each step of the EBP process! 🏃

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Building on the Strengths of Child Life

and overall representation of the integrity, passion, and ambition integral to child life. I hope for a leader who internalizes what makes child life unique and beautiful: the ability to connect when the rest of the world seems to be looking away or down at their phones, the skill of assessing where others are in their development and ability to process information in various manners, and the art of remaining present and grounded in vulnerable moments. There's a lot on the horizon—dips and peaks—and I'm confident in our ability to ride them as only child life will…with grace, glee, poise, and wonder. 🏃

#ChildLifeTakesVegas

Our historic first conference as the Association of Child Life Professionals (ACLP) was a great success, as more than 900 attendees converged on Las Vegas May 26 to 28 to share valuable knowledge and experiences, learn best practices, and network with peers. Attendees hailed from 48 U.S. states and territories and from 13 other countries.

Before conference officially kicked off on Friday, Thursday's pre-conference intensives were well attended and were followed by a "Welcome to Las Vegas" reception in the exhibit hall that evening. The exhibit hall continued to attract attendees throughout the conference as they enjoyed buffet breakfasts, networked with colleagues, met with more than 65 exhibitors, and participated in a series of raffle drawings.

During the Opening General Session on Friday morning, energy was high as many member volunteers in leadership and committee activities were

recognized and their contributions acknowledged and applauded. ACLP relies on its dedicated and talented volunteers, and conference is the perfect opportunity to acknowledge their hard work. Kevin Spencer delivered the Emma Plank Opening Keynote Address: "The Therapeutic Impact of Magic." He endeared himself to the audience with his infectious energy and heartwarming anecdotes of his unique and successful approach to healing. Also during this session, the Mary Barkey Clinical Excellence Award was presented to Qi Cheng, MA, CCLS, by Kristin Maier, MS, CCLS, ACLP President.

Opportunities to learn, increase skills, and earn PDUs were abundant throughout the weekend, during sessions of varying lengths and formats. Three Plenary Sessions were offered on Saturday. More than 600 attendees chose the presentation "Everyday Ethics: Identifying the Impact of Ethical Decision-Making on the Delivery of Compassionate Clinical Care." In addition to participating in high-quality professional development sessions, attendees also had the opportunity to attend several networking roundtables, visit the poster presentations, and converse with ACLP leadership in the Town Hall.

After a busy weekend, conference came to a close with another gathering of all attendees. During this session, the Distinguished Service Award was presented to Anita Pumphrey, MS, CCLS, and the ACLP presidency was handed off to Eileen Clark, MSM, CCLS. To close conference on a high note, Shola Richards delivered the Closing General Session Keynote Address: "The Power of Positivity." Shola's optimism was contagious as he shared his moving personal story and advice about how to live and work more positively, and was the perfect way to end an uplifting and inspiring conference.

Two lucky attendees found the hidden Washington, DC, ornaments and won free registrations for next year's conference, which will take place May 3 to 6, 2018, at Gaylord National Harbor, Maryland, in the Washington, DC, metro area. Congratulations to Jennifer Berube and Miranda Dunnam! We hope you'll join Jennifer and Miranda in DC next year! 🏃

If you were unable to attend conference, you may purchase the All Access PDU Pass for $160—a savings of $35 off the non-member price. The pass includes 50+ recorded sessions and the opportunity to earn PDUs after completing the quiz at the end of each session. Visit the _Playback Now website_ for additional information.

Don't Forget the Exhibitors You Met at the ACLP Annual Conference

SHARED GOVERNANCE:

Enhancing Team Relationships through Collaboration

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CHILDREN'S HEALTHCARE OF ATLANTA

Shared governance is about having a voice, being informed, heard, and included in decision-making.

(Moore & Hutchinson, 2007, p. 564)

Shared governance is a model that is derived from two main principles: facilitative leadership and structural empowerment. In this model, staff members work as a team to make decisions that affect their daily practice. All voices are equal and everyone contributes. It does not replace traditional top-down leadership, but inspires leaders at all levels. Shared governance promotes collaboration, shared decision-making, and accountability across all individual members of the department, with a goal of improving quality of care and provision of services, as well as enhancing work-life balance. Issues addressed through shared governance can range from restructuring holiday coverage to implementing clinical supervision. Cultivating the environment of shared governance takes time and effort, but the result is a culture that is empowered and committed to the organization.

Monroe Carell Jr. Children's Hospital and Johns Hopkins Children's Center have each developed a unique version of shared governance within their child life departments. Although there are differences between models, the consistencies lie in the structure of the model; both models include a shared governance board (select members of the team/department), a charter (a document that defines the scope and purpose of the group), a bin list (a designated area on a shared drive for members of the group to place proposed topics and issues), and a monthly meeting where topics are discussed with the entire department. These meetings include child life specialists, librarians, art therapists, music therapists, administrative assistants, and child life assistants. Another overlying commonality is the development of teamwork, working relationships, trust, and shared vision through the use of this model. Shared governance fosters a workplace culture of equity in which each person's voice is heard and validated no matter their title, position, or length of time with the department. This model allows all members of the team to work together from various perspectives and expertise to tackle difficult decisions. This question-and-answer article will outline the similarities and differences between the two hospitals' models to inspire and educate those hoping to adopt shared governance at their institution.

1. **Why did your department decide to adopt the shared governance model?**

JHCC: There was a desire within the child life department to create a structured venue for creating solutions to common issues and sharing new ideas. One staff member stated, "There was a need to bring conversation and acknowledgement to topics that many of us have opinions about but have never had an official outlet for discussion and action in the past."

MCJCHV: Our hospital has a long-standing tradition and culture of shared decision-making under the shared governance model. This model began with nursing departments and was adopted by the child life department in the 1980s. Child life leaders felt this model was an exciting opportunity to promote programming, increase work/life balance, and improve patient care.

2. **What steps did you take to create your model?**

JHCC: The department made adopting shared governance a goal in 2015, which was a shift from our previous model in which all staff members were required to work on a year-long committee. This previous model did not allow for as many leadership opportunities or for choice in working on projects team members were passionate about. A committee formed to benchmark and develop the model. This began with a search of the ACLP Forum and outreach to five child life programs with shared governance models. The committee

GROUND RULES
1. All thoughts should be heard.
2. Come prepared and on time (please keep thoughts/ideas on the bin list to yourself).
3. Be respectful of others' opinions and keep an open mind.
4. Be mindful of time.
5. Be mindful of where we are in the process.
6. Ascom/pager FREE.
7. Only one person may speak at a time.
8. No side conversations.

created a charter that included the purpose, scope of work, agenda process, decision-making process, roles and responsibilities for members, and the requirements/process for becoming a board member. During our first shared governance meeting, our department decided to adopt the title "Shared Leadership," as it felt that it best described the model we were creating. See Figure 1 for the ground rules that were developed.

MCJCHV: When adopting the shared governance model, the entire child life staff received training on the model and its benefits. The team learned how to engage and empower staff members by giving them a voice in the decisions that affect their daily practice. Two representatives

volunteered as the board chairs and participated in additional training geared toward meeting facilitation under the shared governance model. As our model has developed, staff has agreed to ground rules (See Figure 2) and are trained on the expectations of the meetings. Our department uses the title "Child Life Unit Board."

3. **What are the board roles? How do the board members collaborate?**

JHCC: The board roles are chair, co-chair, and secretary. The chair is responsible for soliciting agenda items from staff members, planning a formal agenda for each meeting, leading the shared meeting, following up with staff members leading

GROUND RULES
1. Be on time.
2. Listen to others.
3. One person speaks at a time.
4. When returning pages, please leave the room.
5. Minimize leaving meeting.
6. Work for consensus.
7. Value each others' opinions and expertise.
8. If you don't speak up, we assume you agree.
9. No side conversations (keep the meeting in the meeting).
10. Brainstorming ideas (list all, don't eliminate, discuss).
11. Have stakeholders notified and prepared prior to discussion.
12. Have someone appointed to represent your view when absent.

projects, and creating a timeline for review of progress. The co-chair assists and supports all responsibilities of the chair, acts in the role of chair when chair is not present, and prepares to take on the role of chair after one year. The secretary takes meeting minutes and places them in the shared drive for staff to review, keeps a record of time, and emails important updates to staff. The board meets for about an hour once a month prior to the meeting to discuss and develop an agenda, and works collaboratively to ensure the meeting runs successfully. Additional time away from clinical responsibilities is needed for follow up on topics from previous meetings and for preparing members of the department who will present at meetings on topics they added to the bin list. Each board member devotes around two hours of time to shared leadership outside of the department-wide meeting each month.

MCJCHV: The chair and co-chair and the department leadership (manager/director) make up the board roles. The chair and co-chair serve one-year terms. The co-chair transitions to the chair after completing the one-year term, and the board elects a new co-chair. The chair and co-chair meet monthly or as needed with the manager to plan the agenda based on items elevated by the unit board members. One of the important things they discuss is potential staff responses to some of the more difficult or challenging topics, working on strategies to help all members feel validated and supported, yet keep the meeting effective and efficient. Shared governance meetings are typically scheduled for an hour, but can be shorter or longer based on the items discussed. The chair facilitates the meetings and helps refocus the group when needed. The co-chair is responsible for recordkeeping during the meetings, distributing the min-

Shared Governance: Enhancing Team Relationships through Collaboration

utes to all members, and stepping in when the chair is absent. In addition to planning meetings with the manager, the chair and co-chair may meet to prepare for an upcoming meeting or wrap up any items from a previous meeting. The chair and co-chair work hand-in-hand to ensure that all members are kept up to date with the progress on previously discussed and upcoming agenda items. The time commitment can vary due to the bin list and particular agenda items, but on average the chair and co-chair invest another two to four hours per month on shared governance work in addition to the overall departmental meeting.

4. **How is the shared governance board chosen?**

JHCC: The shared leadership board is chosen by self and peer nominations before each term. If more than one person is nominated for a given position, a letter of intent is submitted by each interested candidate and the child life department votes anonymously to fill the position.

MCJCHV: A new chair and co-chair are selected annually by the child life staff. Interested individuals meet with the child life manager to gain support before submitting a letter of intent. If more than one candidate expresses interest, the unit board will vote. This is the only time voting is utilized within the shared governance model.

5. **What is the decision making process during the meetings? How does the group come to consensus for decision-making?**

JHCC: Our goal is to come to an agreed-upon consensus without voting. The chair and co-chair facilitate discussions in a manner that strongly encourages all team members to share their opinions and explore others. Once all perspectives are considered, the team openly discusses and decides on a solution together. The chair then checks in to ensure that everyone agrees to the solution. With more challenging topics, we typically do not make a decision in one meeting, but return to the topic at a subsequent meeting(s) once everyone has had time to process all of the information. With most decisions, there is a plan to re-evaluate after a decided on amount of time, which we have found helps team members feel more comfortable when the decisions were not their preference.

MCJCHV: We use a consensus decision-making process with a goal to establish agreement without voting. A consensus decision is one agreed to after all perspectives are heard and understood. The more people involved in a decision, the more time it takes, but the benefit of this is greater ownership and commitment. By agreeing to consensus, staff members can live with, support, and help implement the decision. Consensus is not possible unless we have considered all perspectives and all key stakeholders have had an opportunity to provide input. Key decisions include evaluation criteria and a timeline for revisiting the decision.

6. **What challenges have you encountered in shared governance?**

JHCC: One of our biggest challenges has been balancing our desire to have a full meeting with rich topics and discussions with not wanting the outcomes to lead to too many projects that may ultimately overwhelm our staff. One staff member commented, "Time may be the biggest challenge related to our shared leadership model. We meet once a month for an hour and a half and sometimes that time goes very quickly."

MCJCHV: Shared decision making can be time consuming. Sometimes it takes several meetings, weeks, or months to address an issue. There are situations when consensus is not easy to reach. The structure of the meetings can be hard to get used to at first, because they "feel" a little different than our typical staff meetings. A colleague facilitates the meeting and the manager of the department sits at the table as a peer with a voice that is equal to everyone else at the table. For newer staff members, it can take some time for them to get used to this shift in roles.

7. **What are you most proud of related to the model?**

JHCC: The shared leadership model has transformed the way we manage the workflow in our department and how annual goals are accomplished. With the shared leadership model in place, we moved away from a committee-based model and transitioned to creating goals when they are most relevant throughout the year. This has allowed staff members to volunteer for projects that they are passionate about when they are able to balance the work with their current load.

MCJCHV: The shared governance model is a tremendous tool for the professional growth of all frontline staff. The board leaders gain experience in leadership and meeting facilitation and the staff grows through participating in shared decision making.

One of our most difficult "hot topics" was evaluating how to provide optimal child life coverage on weekends. It was difficult because of the growing clinical needs, but also the desire to maintain work/life balance. We held several meetings to discuss this challenging topic. Though exhausting, in the end we were all able to provide coverage that both meets patient care needs and maintains professional boundaries.

8. **What types of topics are brought to shared governance? What are not?**

Topics appropriate for shared governance are considered action-oriented topics, or ones in which staff can work together to assess needs and create change. Accomplishments celebrated by these institutions include:

- Created/ updated weekend coverage

- Revised holiday coverage sign-up

- Created a process for managing and ordering supplies

- Discussed uniforms/dress code

- Formed a clinical supervision model

- Created a volunteer orientation and fair

Topics not appropriate for shared leadership include decisions that would require manager approval and information-oriented topics. Examples include:

- Topics that require manager approval: salary, budget, and hiring

"During the meeting, the director really needs to listen and contribute as a team member when needed. It is important for the team in place to process, create, consider, and develop a plan. It is in ownership of decision-making that true partnership occurs and leaders grow."

- Information oriented topics: hospital-wide hand washing initiative, new parking policies, budget information, and documentation system updates

9. **What is the involvement of the director/manager?**

Both departments involve the director/leader in agenda planning and the identification of key stakeholders. The director ensures all items are appropriate for shared leadership forum. During the meetings, the child life director acts as a participant and peer. When the board is unable to reach consensus, leadership evaluates the item. They make the ultimate decision or reframe the topic before returning it to the board. The child life director at Johns Hopkins commented, "During the meeting, the director really needs to listen and contribute as a team member when needed. It is important for the team in place to process, create, consider, and develop a plan. It is in ownership of decision-making that true partnership occurs and leaders grow."

Creating a shared governance model is a great way to empower staff, allow them to be champions for change, and provide leadership opportunities. Shared governance can be successful for departmental and institutional groups of varying size when the concepts of shared governance are upheld. The model can be individualized to meet specific group needs when creating the purpose, ground rules, and charter. When exploring this model, it is important to invest in a strong foundation by discussing and agreeing upon elements such as a charter, appropriate topics, how meetings will be facilitated, participant roles, and utilizing consensus decision making. Amazing things happen when all staff come together to agree on tough decisions. Although it can be unfamiliar and uncomfortable at times, we encourage you to have faith in the process and don't be afraid to take risks. 🏃

RESOURCES:

Shared Governance at Vanderbilt: http://www.mc.vanderbilt.edu/documents/nursingoap/files/TICKLE%20SHARED%20GOVERNANCE%20APN%20Retreat%20Presentation.pdf

Consensus Decision Making: https://ww2.mc.vanderbilt.edu/Shared%20Governance/23892

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THERAPEUTIC RELATIONSHIPS:

From Classroom to Experience

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As child life students, we are taught and tested on therapeutic boundaries: the goals, stages, and concepts. We are also warned that not everything in a hospital will be textbook perfect. As a student facing a practicum, my expectation of therapeutic relationships was that they were complex and took gumption to successfully maneuver; however, I also amusingly thought doctors and nurses would cling to every word I spoke as a child life professional, and expected to make every child stop crying. While it was during my internship at St. Barnabas Medical

to provide academic tutoring services to a fellow student who has a neuro-cognitive condition. For context: this young woman, whom I will refer to as K, struggled with a minimally functioning short term memory, though she had an above average long-term memory. My challenge in tutoring was to help her find ways to integrate new material into long-term memory, in order for her to pass her classes and earn a degree. We met regularly twice a week for 15 weeks, and through the struggles of the semester, began growing closer. I knew about the importance of therapeutic relationships from my child life classes; I could have

official rules prohibiting friendship, I realized this could be considered an ethical dilemma. Looking back at my theoretical understanding of therapeutic relationships, I began to realize I could not be her friend *and* her "clinician." I admit the conversation that followed could have been handled with more grace because my frozen expression and faltering speech appeared to deliver the message, and K was really let down. For my internship, I paid careful attention to long-term relationships, because I hope to never have that particular conversation in the professional setting.

This experience taught me other practical lessons about professional boundaries that proved useful during my internship. K's condition made tests challenging—hence the reason I was hired—and she often experienced immense frustration. During one test, she became upset and had to leave the room for a few minutes. I wanted so badly to take her pain away, but it was not under my control and she urgently needed to complete the test. The feeling was far from pleasant in those moments when I had to encourage her to continue, and it reinforced the idea of separating friend and clinician. It also helped me understand that "best care" was not giving into her feelings; it was helping her learn to cope with a difficult task. I studied the concept of best care for class, but did not fully comprehend what it meant until I lived it. In my internship, I applied this to a particular case where a chronic

> *It was not pleasurable to sit there holding his hand and positively verbally encourage him for five very long minutes. Yet his ability to benefit from post-procedural play proved to me that helping him learn to cope was more important than giving into his feelings in that moment.*

Center in Livingston, New Jersey, that I first practiced building therapeutic relationships in the hospital, I was able to use previous experiences in building professional boundaries to guide me in that process. I will explore therapeutic relationships by describing these previous experiences that mirror my work in child life, and relate the lessons I learned in these experiences as those I applied during my internship.

In college I was given the opportunity

recited the material verbatim. Yet, I never thought to apply it practically to my work with K, until one day she asked if I would like to go shopping with her. I recognized then that she considered me more than a tutor and more than a listener; she considered me a friend. It would understandably have been inappropriate for me to engage with her socially since our interactions were financially funded, but were we friends? Although there were no

school age child needed an NG tube placement. It was not pleasurable to sit there holding his hand and positively verbally encourage him for five very long minutes. Yet his ability to benefit from post-procedural play proved to me that helping him learn to cope was more important than giving into his feelings in that moment.

The final lesson I began to learn with K is something we all experience in child life: With some it's one step forward, two steps back. K worked hard to memorize one theory in one session, and she would be able to remember it during that session. By the next session she could barely remember it and would become exceedingly distressed. This was heart-breaking to me to see her lose the progress that had been made, and I started internalizing those feelings by thinking I had done something wrong. The truth was that I had done nothing wrong, but the situation was the cause of her discontent. I applied this lesson during my internship while caring for a chronic patient in the burn unit. I would make enormous progress with this patient one day—engaging him in an activity was an accomplishment—but the next day he would not even make eye contact. No fault of mine caused this change in his behavior; his reaction was due to the course of his treatment. I was able to recognize that I was internalizing his rejection of me, just as I had internalized it with K, and I redirected those feelings. I learned that this job is not about solving every problem a child may have, but rather focusing on the things we can change.

Through my relationship with K, I learned invaluable lessons that I applied to my internship experience, and will apply further in my career. From setting relational boundaries, to learning the meaning of best care in child life, to not internalizing the emotions of my patients, I confidently can say that my time with K has been vital to growing my child life practice. Although working with K proved to be a challenge, I would not trade my time with her for anything because of the lasting impact our relationship had on me. How we learn to cope with our own challenges effects the way we help our patients learn to cope in the hospital, which is why experience is so necessary for child life students. To learn how to draw success from a failure is a valuable skill that we as child life professionals (and students) should practice for the rest of our lives.

CHILD LIFE AND PEDIATRIC NURSING:
A Collaborative Partnership

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In healthcare, individual professions cannot effectively work alone. A team-based approach to the provision of direct care to pediatric patients and their families is essential for the optimization of patient outcomes. In this article, a pediatric educator and a child life specialist respond to questions they have selected detailing how they have built a collaborative partnership between pediatric nursing and child life, and provide guidance to readers looking to enhance their own professional relationships with allied members of the healthcare team.

What does multidisciplinary collaboration mean to you?

Julie Albright Gottfried, Pediatric Educator: I think of multidisciplinary collaboration as the sharing of professional expertise across disciplines in healthcare. For example, as a pediatric nurse, although I am well-versed in the developmental stages of childhood, I really rely on my partnership with child life to be able to deliver their expertise, which is even more advanced on this subject area, when teaching new nursing hires at Rochester Regional Health. Multidisciplinary collaboration is really about taking the best of what different professions have to offer and combining that into a whole new level of expertise that can be used to directly benefit staff, patients, and families.

Margaret Armstrong, Child Life Specialist: Multidisciplinary collaboration is key to being an effective child life specialist. I am part of a 2-person child life team at a community hospital, so I spend much more time working with members of the multidisciplinary team

than I spend working with other child life specialists. It has been my experience that working independently as a child life specialist is not as effective as working collaboratively with nurses, physicians, respiratory therapists, and allied members of the healthcare team. For example, it is much more effective in my practice to work with respiratory therapists during breathing treatments than for me to prepare a child for a breathing treatment, then leave while respiratory starts the treatment, then come back if the treatment is being poorly tolerated.

When child life collaborates with pediatric nursing for the delivery of pediatric nursing orientation, what is the benefit for healthcare professionals and their pediatric patients?

JAG: The benefits of this collaboration are endless! Child life specialists are the experts in the stages of psychosocial development in children, and I have learned so much working with the child life team at our hospital. When I was hired, I was tasked with developing an orientation program designed to meet the educational needs of nurses in primarily adult units, who also work with children. Based on my professional experience, I believe there are three major pillars of knowledge that differentiate caring for children from adults that I want to impart to nurses who work with mixed patient populations. Being able to talk with children (tailoring nursing actions based on the child's stage of growth and development), medication administration, and resuscitation measures. Of these three pillars, child life specialists are experts in being able to talk with children, and they are extremely helpful in being able

to get children to take oral medications, as well as comply with other medical treatments. After my first six months of teaching pediatric orientation, I reached out to Margaret to ask for her help in creating an interactive session on pediatric oral medication administration, as I have watched her be highly successful in getting resistant children to take oral medications when others on the healthcare team were unable to do so. Since then, I have watched new pediatric nursing hires integrate the knowledge that Margaret has shared into their own nursing practice. This is the power of multidisciplinary collaboration—taking the knowledge of one profession and using it to enhance the care delivery of another profession.

MA: By teaching a section of pediatric orientation, I am able to help provide developmentally supportive care not just to the patients I see, but to patients across the health system. The vast majority of the nurses who attend pediatric orientation work with mixed patient populations, and most of them do not feel as comfortable working with pediatric patients as they do with adults. Through a combination of child life providing knowledge and skills based on developmentally-appropriate practice, and Julie's "medical side" of pediatric nursing, nurses increase their skills and comfort level working with children. I love hearing the stories of the nurses who apply what they've learned from day one of pediatric orientation during their clinical work before attending day two. At the end of each session, nurses provide written feedback about the class and feedback has been very positive, with comments

Margaret Armstrong, CCLS, teaching newly-hired pediatric nurses during Pediatric Orientation at Rochester Regional Health.

such as: "demonstration of techniques was helpful," "useful information," and "it is always helpful to review strategies for administering oral meds." Additionally, we ask nurses how they plan to incorporate the information they have learned into their clinical practice. One nurse shared that she learned the need for "preparation with sensory information… I think that is a really good idea because so often we just go in and sort of bombard them." I experience a profound sense of professional satisfaction knowing that so many more children have the opportunity for increased success in coping with healthcare experiences due to child life's impact on nurses who attend this orientation program.

How has working together on the creation and delivery of pediatric nursing orientation impacted your collaborative partnership?

JAG: It has helped me take a "deeper dive" into the strong theoretical and practical knowledge base that Margaret has as a child life specialist. I have so much respect for Margaret—she is an upbeat, positive person who brings her clinical expertise into each and every care delivery interaction she has with patients and families. What we are really talking about here is interprofessional collaboration, which is enhanced through the delivery of interprofessional education, or IPE. In 2010, the World Health Organization defined IPE as instances where "two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" (World Health Organization, Nursing and Midwifery, 2010, p. 10). I strongly believe in the power of IPE for strengthening interprofessional collaboration, and I have seen it work to enrich the delivery of content for pediatric oral medication administration at pediatric orientation.

MA: Through my work with nursing education to create a section of pediatric orientation, I was able to build a foundation of a working relationship with this department. Julie is the pediatric nursing educator for our healthcare system, and I work with pediatric patients throughout this hospital. Since Julie is the only other person who works with all of these units, I'm able to utilize her as a resource to increase continuity and quality of care throughout the hospital. I love having someone I can go to when I have questions about things like medication side effects and medical co-morbidities that are outside my scope of practice.

What was the biggest challenge you have encountered working together?

JAG: I think the biggest challenge has been time! Margaret's role is very clinically-focused, so it is a balancing act to be able to weigh the pros and cons of pulling her out of direct patient care to spend time developing and teaching the content for pediatric orientation. This is where communication is essential—I rely on Margaret to feel empowered to tell me when she is feeling like she is spending too much time away from the bedside. Time is a double-edged sword though—without spending the time together to create and deliver this content, we don't have the opportunity to promote our interprofessional collaboration, thereby positively impacting staffing and patient outcomes!

Child Life and Pediatric Nursing: A Collaborative Partnership

MA: Time is definitely a challenge! The majority of my clinical time is spent in the pediatric ED, so my evening and weekend shifts are not very conducive for meetings. I make it a goal to try to find a clinical/office balance, so that I see as many patients as possible while not getting overwhelmed being behind in office work. Due to my role's primarily clinical nature, the majority of my multidisciplinary partnerships are with the staff members I work with clinically. It's definitely a challenge to

straight nights for eight years at the bedside. We did not have access to child life services on the overnight shifts. I was used to doing procedures on children without child life present, and did not understand how beneficial having child life there really could be. It wasn't until I switched to day shift that I really started to spend time with child life and began to see what their professional expertise brought to the patient-family experience. As I spent time with child life, I found myself

child life specialist. Some of the ways I've attempted to help increase understanding is to increase face time and to be present as much as possible for the off-shift. Rounding on the inpatient unit in the evenings when the ED has a lull and attending the off-shift unit council for my respective units has helped to build relationships.

As we reflect on our work together, there are three key points that we have found helpful as we've built our collaborative relationship. The first has been spending time together in the planning and delivery of educational content for staff. This has been a great way to showcase the individual strengths of both professions and has allowed for the enhancement of content delivery. The second has been spending time together at the bedside. Seeing each other interact with patients has helped us increase our understanding of each other's roles and responsibilities and how they impact the patient experience. The third has been enjoying time together in a social setting. Last fall, we spent time together serving dinner at our local Ronald McDonald House and getting to know each other better in a more relaxed social setting. This allowed us to strengthen and foster our ability to relate to one another, not just on a professional level, but also on a personal level. The common ingredient to building collaborative relationships: spending time together! ☆

Seeing each other interact with patients has helped us increase our understanding of each other's roles and responsibilities and how they impact the patient experience.

form a collaborative partnership with team members I do not naturally work with during my day-to-day work, so I have to make an effort to nurture these relationships.

How can you build relationships between child life and nursing when there is resistance? Are there barriers to building collaborative relationships?

JAG: I have found one of the biggest barriers to building collaborative relationships between nursing and child life has been lack of face time. At my previous organization, I worked

starting to integrate child life practices into my own delivery of nursing care even when they weren't there. Again, this is the power of multidisciplinary collaboration—taking the knowledge of the child life profession and integrating it into my own nursing practice. I think we can overcome this barrier through the creation of opportunities to learn about one another's practice.

MA: I agree. One of the biggest barriers is a mutual lack of understanding of each other's roles. As a child life specialist, I don't know what it's like to be a night-shift nurse, and this night-shift nurse may not understand my role as a

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WORKING WITH A BAD APPLE:

A Guide to Managing Interpersonal Conflict at Work

Amanda Moatz, MEd, CCLS

Child life professionals receive education and hands-on training for establishing therapeutic relationships with the patients and families they serve, as well as guidance about maintaining professional boundaries in any supervisor/supervisee relationships in which they engage. For these relationships, there are clear guidelines directing professional behavior and even steps to take should the integrity of these relationships be compromised. There are, however, other relationships that

child life professionals engage in on a daily basis at work that may be even more important in terms of job satisfaction and overall happiness. The relationships among colleagues and co-workers can make going to work a pleasure or a dreaded daily chore. The latter experience is often a result of interpersonal conflict in the workplace. This article seeks to define the types of interpersonal conflict that child life professionals may encounter and describes what steps may be taken to address conflict when it occurs in order to maximize both efficacy and enjoyment at work.

Research on intragroup conflict and

conflict management divides interpersonal conflict into a few main types (De Dreu & Weingart, 2003; Greer, Saygi, Aaldering, & De Dreu, 2012). The categories – task content, task process, and interpersonal relationship – reflect the primary focus of a workplace conflict. Barki and Hartwick (2004) combine task content and task process into one category and for the purpose of conflict in the healthcare and academic settings, this seems a fitting approach. Table 1 demonstrates a strategy for unpacking and assessing interpersonal conflict in organizations.

Working with a Bad Apple: A Guide to Managing Interpersonal Conflict at Work

TABLE 1
A Typology of Interpersonal Conflict in Organizations
(adapted from Barki and Hartwick, 2004)

		FOCUS OF INTERPERSONAL CONFLICT	
		Task Content or Task Process	Interpersonal Relationship
PROPERTIES OF INTERPERSONAL CONFLICT	**Cognition/Disagreement**	Disagreement about what to do or how to do it	Disagreement about another's personal values, views, preferences, etc.
	Behavior/Interference	Preventing another from doing what they think should be done or how to do it	Preventing another from doing things unrelated to the task
	Affect/Negative Emotion	Anger/frustration directed at another about what should be done or how to do it	Anger/frustration directed at another as a person

Interpersonal conflict can be separated into these two categories in the healthcare setting more easily than in other organizational settings such as a manufacturing operation or a marketing company. This is due to the premise that clinical care relies on best practice guidelines or evidence-based medicine. The "what to do" and "how to do it" can often be addressed by referring to the evidence.

The other characteristic of interpersonal conflict in the medical workplace that differentiates it from other settings is the hierarchy and its impact on the "what to do" and "how to do it." In a manufacturing setting or on a marketing team the members are often a group of peers working together to address a problem or complete an assignment. There may not be inherent value given to one team member's decision-making power over another's. In the healthcare setting, a medical team is more commonly comprised of multiple disciplines, each having regulated authority with which to decide what happens and how it happens (e.g., a nurse may not select and administer a medication to a patient without a physician's order). This is not to say that conflict does not arise

among healthcare teams over the what and the how. When task content or task process conflict does arise across disciplines, however, it may mean referencing the evidence to establish best practice. Alternatively, if a patient's safety or outcome is in question, there are standardized reporting methods in every institution. An incident reporting system and ethics board are now standard features in nearly all hospitals and health systems in which child life professionals find themselves.

At one time, thinking in the conflict management field leaned toward the possible positive outcomes of interpersonal conflict among teams. However, particularly in the healthcare setting, there is a very fine line between conflict generating innovative, inspired progress and it rendering a team completely dysfunctional, and the distance to that line is very short. For example, a visibly frustrated, experienced nurse may suggest to a new attending physician that a patient be positioned differently after he has struggled for 20 minutes to perform a 5-minute procedure. This suggestion could lead to an improved clinical outcome, but it could also develop some irritation or even resentment in the physician, distracting from

the procedure at hand or cases in the future. Even when task- or process-related conflict achieves positive performance outcomes, the negative effect on group affect will eventually override these benefits in the long run (Greer, Saygi, Aaldering, & De Dreu, 2012).

The other type of interpersonal conflict - relationship conflict – may be present in both hierarchical teams (e.g., a multidisciplinary clinical team) and linear ones (e.g., a child life department). Workplace relationship dynamics—how professionals relate to one another and interact during the 40 or more hours they spend together every week—is important for the organization due to relationships' ability to impact productivity, and it is important to the individuals involved due to relationships' influence on job satisfaction, burnout, and overall quality of life (Felps, Mitchell, & Byington, 2006). In this case the evidence seems to support the old saying, "one bad apple spoils the bunch," but there are strategies one can employ to avoid a rotten outcome.

One way to approach interpersonal relationship conflict in the workplace is to identify a colleague's challenging characteristics and individualize the solution or intervention. Even with an individualized approach, there are two helpful thoughts to keep in mind as one addresses any difficult teammate. They are 1) it's not you, its them; and 2) they probably have at least some good intention or contribution to make. Acknowledging that the undesirable behavior of a colleague is often a sign of insecurity or other internal struggle and not a personal attack may allow one to react less defensively and in a more understanding capacity. It's also unlikely that a difficult colleague is all bad. It may take a great deal of

effort, but identifying any positive intention or contribution can open a line of communication or develop a common ground to build upon. It can be especially tough to recognize any positive attributes if a relationship with a colleague has turned sour, but regardless of the particular type of difficulty, maintaining a positive outlook may be the only path forward.

The next section explores the types of difficult teammates one may encounter and provides suggestions for making your work relationship work.

The Boss Basher – Dave is sure to reject every direction or criticize every effort made by your boss. His behavior is out of proportion to any negative qualities your boss may have and ends up bringing down every initiative attempted by your team. Wherever this boss-hating tendency comes from, the best approach is to ignore Dave's efforts by staying focused on the task at hand and maintaining a neutral or positive outlook on your supervisor. Without an audience to share his disdain for authority, Dave will often reign in his negativity.

The Faded Star – A long time ago Sue ruled the program and contributed in meaningful ways to its development. Sue now spends her time resting on those laurels or blocking any innovative ideas that come through the staff room door. Since it is tough to take down a matriarch, the best strategy forward with Sue is to acknowledge her past contributions and experience. Show her how they relate to new initiatives and that she is still needed. Sue may never fully engage and equally contribute, but a positive affect and open mind would be a real win in this working relationship.

The Ego Maniac – Mary is an MVP, with all the credentials, awards, and presentations to prove it. Organizations need and love their stars, therefore they are particularly hard to avoid once they're in place. The problem with Mary is that she knows she's loved, and even a bit untouchable, resulting in her tendency to assume she can bulldoze others' ideas and operate on her own terms. There's not a lot of recourse when faced with a large ego other than trying to ignore the negative traits and focusing on the positives. If you truly admire the person, sharing your praise may bring them back into line enough to make sharing your work space with them tolerable.

The Naysayer – Kristy is the colleague who always has something negative to say about others' ideas, the newly renovated first floor, or the fact that the sun is too bright today. If Kristy's negativity centers on work tasks or processes, it could be that she is a thinker in a group of doers. Her analysis and evaluation of an assignment may sound like criticism when it is really the result of a genuine desire for the best outcome. Giving Kristy the time and space to work through her process while staying focused on the goal everyone is trying to achieve should help the whole team move forward. If Kristy's negativity falls on everything and everyone around her, it is likely coming from a deeper place. It's unlikely that Kristy will suddenly turn positive in her work environment if there's greater unhappiness in other areas of her life. Avoid the pull of negativity, model a more positive perspective, and encourage anyone close with Kristy to check in and offer support.

Whether it is a task content or relationship conflict effecting one's workday, child life professionals should feel empowered by their education and experience to work through the situation. Similar to the way one may support a patient identified as having challenging behaviors, examining the underlying context of a teammate's undesirable behavior and building on his or her strengths should result in a positive change. Regardless of the individualized approach one takes, strive to maintain a positive perspective and draw upon the common mission you share to form a more effective, if not friendly, working relationship. 🏃

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Integrating Technology into Child Life Practice to Support Patient and Family Relationships

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Building, supporting, and maintaining relationships with and for patients and families is key to the child life profession. The integration of technology into practice as a therapeutic intervention has captured the interest of many child life specialists. Using technology as a modality to deliver and enhance interventions has enabled child life professionals to connect with the patient in an area of their interest with a tool they already use for entertainment, learning, and communication. Technology has been used to overcome barriers which can hinder relationships, such as isolation, mobility limitations, and communication challenges (Cantrell, 2015). By removing some of these barriers, opportunities can be created to support existing relationships, build new ones, and help patients maintain some independence, regain some form of control, and develop a sense of normalcy during diagnosis and hospitalization.

This article will explore experiences where technology can be used by child life specialists and other members of the healthcare team with patients and families to support and build relationships. For the sake of this article, we will look at four types of technology that I have used successfully in my practice to achieve positive outcomes related to patient and family relationships.

Video Calls

Using video calling platforms such as Skype and Facetime can provide comfort by connecting patients and loved ones who are unable to be together during long admissions or critical illnesses. As most child life specialists know, video call allows the parents and child to see, speak, hear, and interact with one another when separated due to hospitalization; allows siblings to be reassured about their continuing place in the family; and assists children in maintaining their connection with school, friends, or community.

An innovative approach to this type of intervention is the introduction of apps such as Kindoma Storytime or Readeo, which give participants the opportunity to share a storybook over a video call. The shared stories often change the quality and length of families' online interactions and offer an opportunity for normalization. This gives caregivers the opportunity to support their child's development remotely; research shows that at 24 months of age, children can learn words from live video-chatting with a responsive adult (Roseberry, Hirsh-Pasek, & Golinkoff, 2014). These apps can be used to support siblings by including them in story time with a new baby or hospitalized sibling, maintaining bedtime routines, and providing their own quality time with the caregiver who is away at the hospital.

Online/ Digital Journaling

Journaling can provide a controlled vehicle for youth and family members to maintain open communication in their relationships, offer a direct or indirect way to share feelings and wishes, and help them comprehend their situation. Use or introduce families to programs such as Notability, which allows users to journal in a way that works best for them, in a flow and format that they can control. Notability offers both keyboard and touch screen entries, plus the ability to add sketches, digital images, and audio clips to entries. Online photo sharing tools, such as Smilebox, can also help build and maintain relationships by allowing patients and families to update their loved ones, create birth announcements, and develop digital baby or medical journey books which could be printed, emailed, or shared via their online platforms.

Trusted and Monitored Online Patient Communities

Private online communities such as Upopolis or St-Jude Teens can provide youth and their families with password protected and safe platforms to access peer support and maintain connections with family and friends during inpatient stays or treatment. When introducing these trusted platforms, child life specialists should educate families on how to navigate these platforms to ensure privacy and control regarding self-disclosure. These types of online patient communities can be beneficial for youth in rural areas, youth being treated on an outpatient basis, and for those experiencing limitations in socialization. Online support may reduce their isolation and give them access to a new network, relationships, and opportunities (Cantrell 2015).

Online patient communities can also be used as transition tools to help reintegrate youth back into the community and peer group. Child life specialists have used these as a starting point for connecting young patients with physical changes or new medical equipment, including those with burns, feeding tubes, and hair loss, to others facing the same issues. Online interactions with those who are sensitive to the unique issues they are experiencing can empower youth to engage and give them some control over the situation. The features of these platforms allow youth to share their experiences with one another, letting them know they are not alone (Stinson et al., 2010).

Online communities may offer access to additional types of relationships through opportunities to serve as an online peer mentor or support group leader. Research has shown that youth with diabetes have a significant interest in offering their knowledge and support to others younger than them with the same illness (Nicholas et al., 2009; Pulman, Taylor, Galvin, & Masding, 2013). Online opportunities allow youth flexibility to engage from anywhere and to adapt their commitment based on their abilities, location, comfort level, and medical needs. Technology provides the tools and platform for self and group expression, encouraging patients to create, share, and learn.

Trusted Online Resources

Although online medical resources are often thought of as supporting older children's understanding of their medical issues and treatment, relying on them can also support the relationships between adolescent patients and caregivers. Respecting newfound independence and privacy can be a balancing act during hospitalization for youth, causing strain on the relationships with caregivers. Providing patients with online access to trusted, age appropriate medical content empowers patients to research about their diagnosis, tests, and procedures in their own space and at their own pace. Access to information and processing time gives them knowledge, which can be used in decision making in partnership with their family and medical team. This support of adolescents' independence can enhance relationships through the formation of mutually-respectful partnerships.

The sea of online resources are only outnumbered by the opportunities for child life specialists to integrate them into practice and take advantage of their potential benefits in supporting relationships. Child life specialists must think critically about the integration of technology into practice, explore technology's therapeutic capabilities, and engage in its development for the benefit of patients and families. With technology playing a large role in many children's lives, looking at it with an eye toward how it can enhance patients' relationships with loved ones will lead to innovative interventions to incorporate into practice, which foster building and maintaining the patient/family relationships. 🏃

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ACLP Calendar

Upcoming Events

ACLP Webinars

ACLP has planned a full schedule of webinars through mid-November, including sessions conveying PDUs in ethics and in the assessment domain, as well as a webinar on August 9 that is an advanced-level presentation. For details of each session and to register for a webinar, see the _webinar page_ on the ACLP website.

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

JULY 12
What Do You Stand For? Being an Emerging Leader in Child Life

JULY 19
Utilizing a Strength-Based Approach in Child Life Practice

JULY 26
Supporting Patients Who Identify as Transgender Within the Healthcare Setting

AUGUST 2
Infants, Toddlers and Parents . . . Oh My! Weaving the Threads of Infant/Toddler Preparation: Helping Parents Become their Child's Advocate

AUGUST 9
Bridging Research and Assessment: Techniques for Interviewing Pediatric Patients

AUGUST 16
The Continuum of Care: Providing Child Life Service in the Community

AUGUST 23
Creating an Autism-Friendly Emergency Department: A Collaborative Approach to Working with Children with ASD

AUGUST 30
From Barren to Blooming: Developing Child Life Programming From the Ground Up

SEPTEMBER 20
Ethical Considerations when Advocating for Patients with Developmental and Behavioral Needs

SEPTEMBER 27
Activities for Adolescents: Skills to Promote Rapport Building and Coping

OCTOBER 4
Talking to Children About the Tough Stuff: Suicide, Violence, Parent Incarceration, and More!

OCTOBER 18
NICU ABCs: Child Life Assessment and Intervention in the Neonatal Intensive Care Unit

OCTOBER 25
Everyday Ethics: Identifying the Impact of Ethical Decision-Making on the Delivery of Compassionate Clinical Care

NOVEMBER 1
Empathy in Child Life Practice: The Many Connotations and Risks of Moral Good

NOVEMBER 8
The Patient Experience and You; It's What You Already Do

NOVEMBER 15
When Grief Alters Hope: Anticipatory Grief Support for Children of Adult Patients

MANAGING RELATIONSHIPS WITH SPECIAL INTEREST GROUPS:
Whose Needs are Being Met?

Joan Turner, PhD, CCLS
ARCHIVES MANAGEMENT GROUP

In a 1989 Bulletin article, Doris Klein asked the question, "Whose needs are being met?" in follow-up to a Child Life Council Annual Conference panel presentation examining a variety of special event and entertainment issues. In reviewing the benefits and potential negative effects of celebrations, she challenged the CLC community to consider the potential "trade-offs" inherent in hosting public relations events. While allowing special visitors access to children and families, child life specialists welcome a flow of resources to support psychosocial program initiatives. However, these special visitors potentially lack the interactional skills and requisite sensitivity and awareness necessary for quality relations to advance. Therefore, Doris proposed, child life programs must work in collaboration with hospital administration, public relations groups, and families to ensure a balance is maintained to maximize the potential benefits and minimize any potential for harm.

Celebrations, visits by costumed characters, and media relations with donors are examples of long-standing traditions of special events provided for children, youth, and families in hospitals. The visibility of child life specialists in the hospital and in the greater community is heightened as they coordinate, guide, and chaperone activities initiated by special interest groups. Whether the activities reflect a sharing of goodwill or a major financial contribution, the mediation of relations between children's rights and outside special interests has been a feature of child life programs for decades. The ACLP Archives files hold content on issues relevant to present-day child life perspectives, such as relations with special interest groups. The goal of this short "Moments from the Past" column is to inspire programs and clinical and academic learners to explore the history and current context of managing relationships with special interest groups.

Explore! This Fall 1989 issue, with its "Focus on Special Events," includes an introduction by Chris Brown, MA, CCLS, and featured contributions by Doris Klein, Linda Jones, and Kathy Elsner-Peoples, which further examine policy and practices around celebrations, managing costumed characters, and media partnerships.

Bring history to life! We invite you to *contact the ACLP Archives* to obtain early issues of the Child Life Council *Bulletin*, which can help you examine topics in light of today's practice: What has changed? What remains the same? How does early practice compare to contemporary practice? When addressing current issues in child life professional practice, you are welcome to use the ACLP Archives files to research past perspectives from child life leaders, CLC, and its predecessor, the Association for the Care of Children's Health (ACCH). Adding historical details to literature and practice reviews or when developing persuasive arguments for new initiatives can create depth and context to a topic or issue.

For further research: start a relationship with the ACLP Archives. Use this *Archives Finding Aid* to help you identify the location of items of interest. You may then contact the Utica College librarian with your request, and the files will be accessed, scanned and sent directly to you by email.

Although history buffs seem like a natural audience for the ACLP Archives, any member can benefit from them. Using information from the past to learn more about issues that confront child life specialists today can not only be illuminating, but can inform practice and can help in developing solutions that meet the test of time.
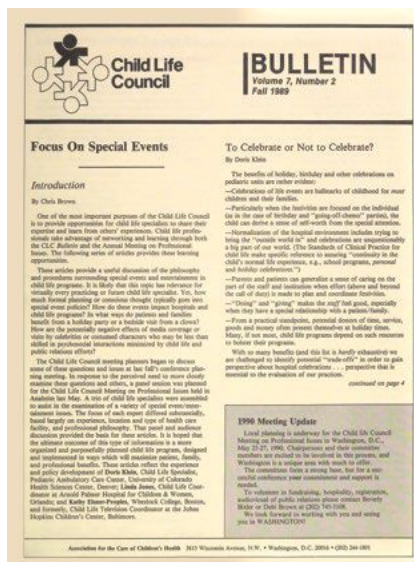
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2018 CALL FOR ABSTRACTS
Association of Child Life Professionals (ACLP) 36th Annual Conference

MAY 3–6, 2018 • GAYLORD NATIONAL HARBOR, MARYLAND • WASHINGTON, DC METRO

The 2018 Conference Program Committee is seeking submissions of presentation proposals for the **Association of Child Life Professionals (ACLP) 36th Annual Conference** at Gaylord National Harbor, Maryland in the Washington, DC Metro Area, May 3–6, 2018.

The Annual Conference is designed for and attracts representatives at every level of the child life profession in hospital, physician practice, and academic settings. Of the more than 1,100 attendees at the 2016 conference, 35% had 10 or more years of experience in child life, 24% had 5 to less than ten years of experience, 33% had less than 5 years of experience, and 8% were new to the field.

The committee is seeking all forms of professional development with an emphasis on interactive, experiential learning:

- Sessions;
- Workshops;
- Full-Day Intensives;
- Half Day Intensives; and
- Poster presentations

The committee is particularly interested in proposals of advanced level workshops developed for attendees with more than 10 years of experience in child life — thirty-five percent of the attendees at the 2016 conference.

To assist attendees in meeting their certification requirements we encourage submissions in **Assessment and Ethics.**

BENEFITS OF PRESENTING:

- Improve the child life profession
- Share creative ideas and best practices
- Demonstrate your leadership
- Expand your industry recognition
- Network with your peers
- Receive discounted full conference registration
- Earn PDUs

Suggested presentation topics for 2018 include innovative ideas and best practices in the following areas:

- Academic & Clinical Preparation
- Age-specific
- Bereavement/Grief
- Community-based child life
- Cultural Competency
- Diversity
- Diagnosis-specific (i.e., Autism, Sickle Cell, etc.)
- Documentation
- Evidence Based Practice
- Ethics
- Families
- Interdisciplinary Collaboration
- Leadership Development
- Management Strategies
- Medical Play
- Palliative Care
- Play
- Preparation
- Program Development
- Research (Completed)
- School Issues
- Self-Care/Personal Development
- Specialty Areas (i.e., Emergency, Oncology, etc.)
- Technology
- Therapeutic Play
- Other

ACLP will accept abstract submissions for the 36th Annual Conference through the website June 24–July 24, 2017.

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