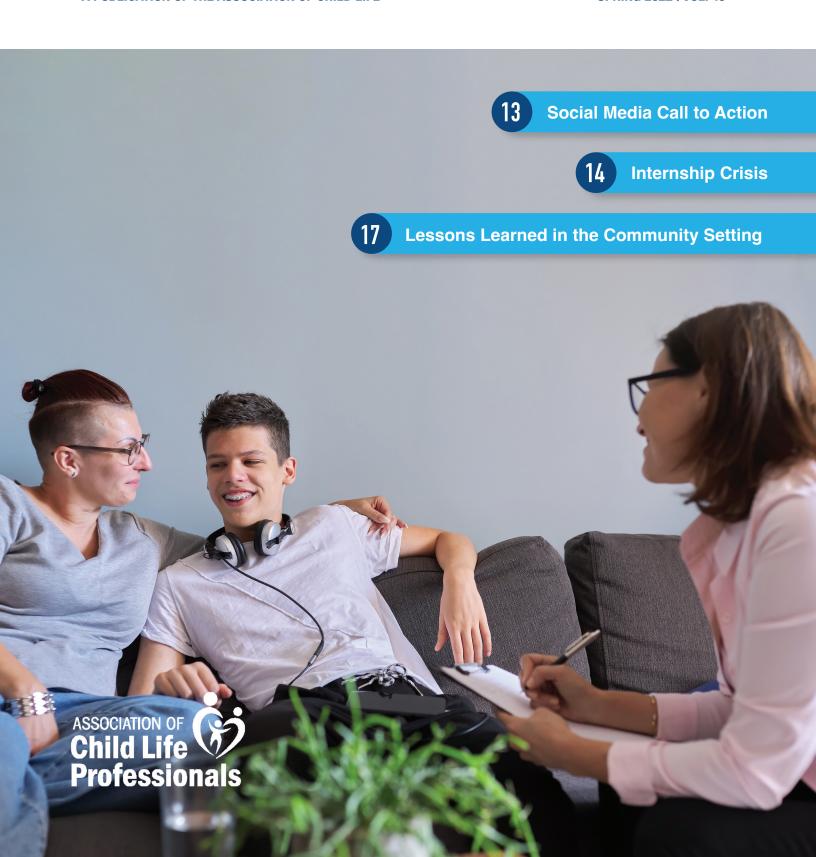
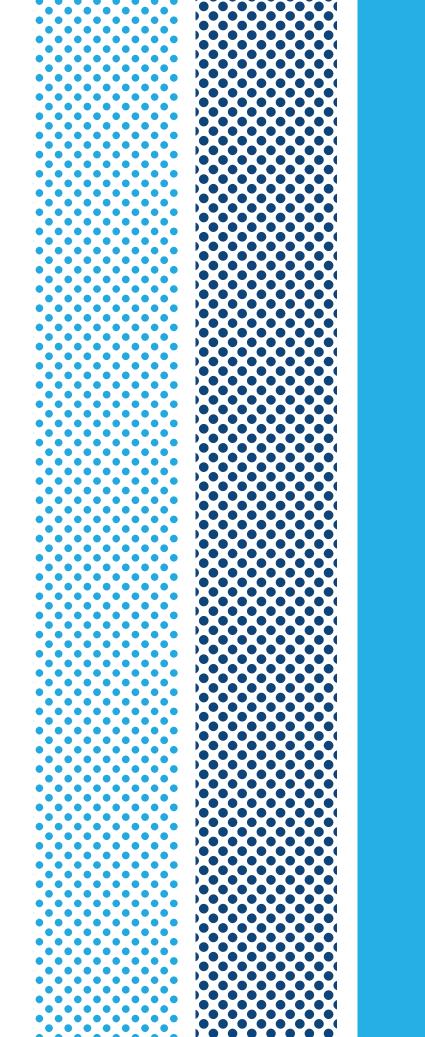
ACLP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE

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CEO Shares
by Alison E. Heron, MBA,
CAE

As we welcome Spring 2022 and the wonderful celebration of the child life community for Child Life Month in March, I'm excited to share new developments at ACLP. In October 2021, 28 leaders, students, external stakeholders, and staff of the Association of Child Life Professionals (ACLP) gathered to discuss the current position of the organization and opportunities for the future. ACLP partnered with professional facilitator Lowell Aplebaum, FASAE, CAE, IAF Certified™ from Vista Cova to conduct research and guide the attendees during the strategy retreat to create the 2022-2024 ACLP Strategic Plan, ACLP's new mission, vision, and resonating themes.

Several research surveys were distributed to organization leaders and members with diverse levels of responsibility, range of experience, and volunteer engagement to capture perspectives. Equipped with insight gained during their pre-retreat session, the participants approached the strategy retreat having identified the opportunity for ACLP to consider new, creative sources of funding; expand or reinforce the scope of practice; advance research and awareness in the field of child life; design targeted, inclusive leadership development; and clarify the pathway(s) to become certified as a child life specialist.

ACLP previously had two mission and vision statements, one for the child life profession and one for the current strategic plan. ACLP did not have a set mission and vision statement for the organization. Why is this important? A mission statement provides the organization with a clear and effective guide for making decisions, while the vision statement ensures that all the decisions made are properly aligned with what the organization hopes to achieve. Our facilitator began the session by inquiring individuals to describe their

visions of ACLP as a thriving, successful organization three years from now. We worked in groups applying the collective perspectives to craft ACLP's draft new mission and vision statements.

The group engaged in a brainstorming activity to identify resonating themes by which all goals should be measured. From this listing, the group demonstrated a level of resonance on three overlapping primary themes – diversity, equity, and inclusion (DEI); financial sustainability; and scientific inquiry and innovation. All goals and objectives created during the operationalizing of the strategic plan by ACLP staff were designed and evaluated with resonating themes in mind.

Leaving Scottsdale, AZ, there was a sense and feeling of camaraderie, accomplishment, and excitement from the participants. The rich discussion and connections between the participants were wonderful to be a part of and witness as the new CEO for four months at that time. I had the opportunity to listen intently and learn more about the child life community. We learned from each other, and our skilled facilitator shared best practices and examples from other leading associations.

ACLP staff leaders delved into operationalizing the new strategic priority areas established by the participants. Guiding principles and best practices were studied to construct our statements, core values, and ACLP DEI definitions. The ACLP DEI definitions encompass belonging and accessibility to help us visualize a better world, in which we all feel respected and welcome.

At the February 2022 board meeting, the new 2022-2024 Strategic Plan, mission and vision statements, DEI definitions, core values, and resonating themes were approved.

I would like to highlight a few key strategic area objectives for ACLP staff.

- SA #1, Promote awareness of the value of child life and emotional safety with key healthcare decision-makers and the public
- SA #2, Increase transparency in the scope and decision-making process of the organization
- SA #3, ACLP is the go-to resource for clear and accurate information for individuals entering the profession
- SA #4, Ensure all ACLP Publications are current on evidence-based practices
- SA #5, Find more opportunities to leverage the experience of Black, Indigenous, and people of color speakers, presenters, and panelists

To learn more about our new strategic plan, members can read the full report on page 8 of this issue, attend town hall meetings, and learn more in-person at the 40th Child Life Conference, May 26-29, in National Harbor, MD, and virtually in early June. We will provide quarterly updates regarding our progress to the established goals and strategies.

Thank you for your continued dedication and collaboration as we further our vision, helping children and families of every race, identity, and community.

allism E. Heroz

Respectfully,

Alison E. Heron, MBA, CAE



President's
Perspective
by Quinn Franklin, PhD,
CCLS

What a Child Life Month! Over the course of five weeks the key role that child life specialists play in the emotional safety of children and families has been celebrated by the Association of Child Life Professionals (ACLP). It is my hope that each of you were able to take a moment to recognize yourself in honor of Child Life Month.

As we head into Spring, the association will be launching the 2022-2024 Strategic Plan and with the strategic plan the association's mission, vision, core values and how the association is defining diversity, equity and inclusion (DEI).

In October 2021, a group of child life professionals, including academicians, clinicians, early professionals, program leaders, Board of Directors, DEI Summit participants, and ACLP staff all worked together to develop the association's Mission and Vision, discussed the core values of the association today and for the future and identified the association's strategic priority areas.

Part of the work of the participating child life specialists was to remain focused on thinking about and planning for the association and not specifically for the profession. We all participated in strategically scoping out the association's priorities for the next three years. Thus, the child life profession's Mission, Values, Vision and Operating Principles have not changed.

Over the next 3 years, the priority areas for the association are:

- Communicate Value & Raise Awareness
- Partnerships, Collaborations & Connection
- Optimizing the Pathway to the Profession
- Excellence in Professional Practice
- Diversity, Equity, and Inclusion

For child life professionals, the effort dedicated to each of these areas will be driven by the association's committees, task forces, liaisons, work groups members and Research Fellows. Each of the priority areas have specific strategies, annual milestones, and operational plans to ensure we are all successful in accomplishing what has been put forth as ACLP's 2022 -2024 Strategic Plan.

I look forward to hearing your thoughts and impressions of the 2022 – 2024 Strategic Plan! Please share your thoughts on the Strategic Plan by participating in the ACLP Town Hall on May 4th at 1pm EST, through engagement on social media, or in a direct message to me at president@childlife.org.

All the best,

Quinn Franklin, PhD, CCLS, ACLP Board President



From the Executive Editor

by Kathleen McCue, MA, LSW, CCLS

The Legacy of the Retired Child Life Professional.

This is it, my final Executive Editor column. I've been thinking about this particular column for quite a while, wondering how to make a connection between the articles in this issue and the reality of handing my role over to the immensely capable hands of Shannon Dier, who will now move into the Executive Editor position. As I have been considering this transition, it has become more and more clear that one unifying factor is legacy. We talk about legacy in our profession and attempt to help our patients and their families consider legacy issues as they face health and other challenges. Now I am suggesting, especially for those of you at or nearing retirement age, to consider your own legacy to the field of child life.

Legacy has a number of definitions, but the one related to this discussion, from Merriam-Webster, is "something transmitted by or received from an ancestor or predecessor or from the past." It is usually possible to look at a person or event that touched our lives in the past and understand what impact that person or event left on us in the present. But we don't always take an active role in identifying and planning our own professional legacy. What will you leave behind that will benefit our profession? Have you made plans for your best ideas, your best contributions, even your most eventful mistakes, to live on either in writing or at least in someone's thoughts? The articles in this issue,

for these authors, are part of their legacy to child life.

I remember attending ACCH conferences back in the 1980s and 1990s. Emma Plank often attended those conferences, and I recall being totally in awe of her as I listened to her occasional comments. She was always thoughtful and positive about the material being presented by various speakers. Even thought she was a leader and visionary in our field, she also modelled respect, enthusiasm and the ability to be supportive to those with ideas that either differed from her own or expanded upon her views.

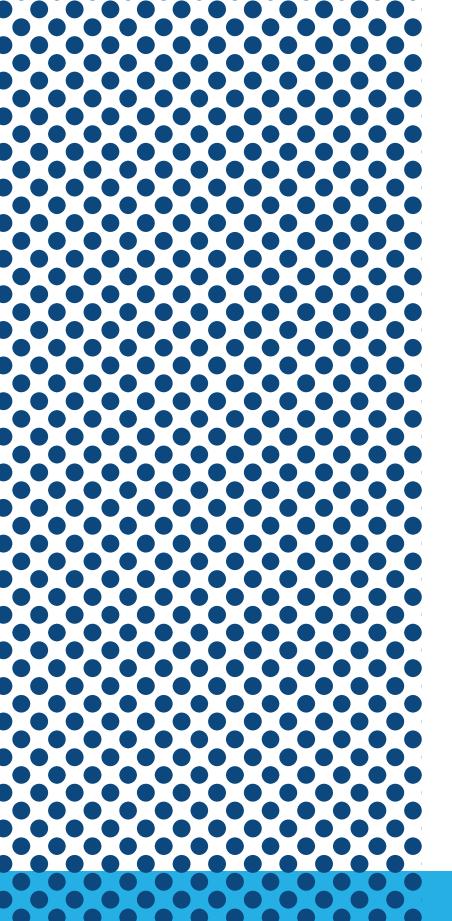
As I read Stephanie Hopkinson's article on the types of child life postings now out there on social media, I can't help but contrast the considerate and supportive approach that Mrs. Plank demonstrated to the more critical and negative comments that Stephanie documents.

Of course, child life has problems, and of course there are areas in which we need to improve, but that can only be done by self-awareness, honest discourse, and the willingness to be challenged. An excellent example of this is the article on the Internship Crisis by Annie Jacobson. She shares her views, invites comments, and attempts to find solutions. It is this approach that leaves a positive legacy for child life.

We all have areas within the field in which we have developed expertise. I really enjoyed reading Lessons Learned in Community Settings by Carissa Howard. This is the service area of child life in

which I spent the final 20 years of my clinical practice. I hope, in the books and articles I have written, that I have taken the opportunity to share my insights into this particular arena of child life practice. But after reading Carissa's article, I wondered, have I really communicated all my thoughts about community practice with my peers? Each one of you has developed skill and expertise in particular areas. Make sure, before you retire or leave the profession, that you document your amazing knowledge in some way, so that it can benefit the generations of child life professionals to come.

Not only is it important to acknowledge and embrace your expertise, it is also important to share your epiphanies and sudden bursts of awareness or uncertainty, those "Ah-ha" moments. Jenna Read, in her article on Parental Presence in the OR. discusses the process that brought her to question a strongly held and foundational belief in our profession. It is this sort of depth of thinking that leads us to our most important practice changes and our best research. If there are any doubts or questions you have developed over your years of experience in child life, make sure you voice those thoughts prior to retirement. Maybe you will not be the one to do the exploratory research, but your legacy might be to plant a question in the mind of an up-and-coming individual in the field. Your question, your alternative way of thinking, might be the catalyst for an important step forward for the profession.

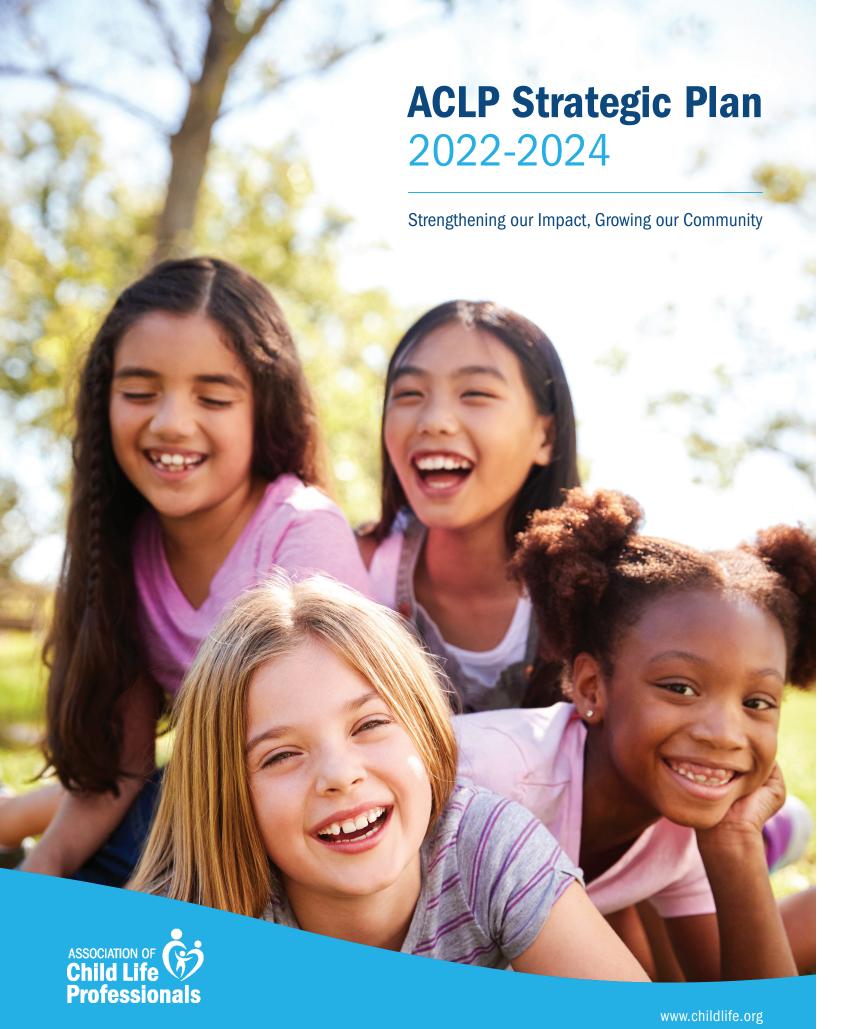


If you have been in this profession for 30 or 40 or 50 years, you have no doubt collected many books, manuscripts, articles, artwork, and more. Have you made a plan for what will happen to all of that when you are no longer active in child life? Just like making wills and writing advanced directives, legacy work can sometimes be difficult and unsettling. We know how important this sort of work is for families, and it is equally important for us as professionals. I have decided to share my materials with either younger people coming into the field, or with the Archives Committee, and several colleagues have agreed to make sure that happens when the time is right. It gives me peace of mind to know that my treasured books and other items (including a bobble-head of Sigmund Freud!) will go to a good home.

Finally, the profession of child life will only move forward based on the strength and innovation of our professional organization, ACLP. You may not always agree with the decisions made, you may be frustrated by some of the practices and rules, but we are only effective at producing change if we work together in a collective manner. All the things we have come to expect, such as conferences, Child Life Month, research summaries, the Journal and Bulletin, position papers, and so on, they all cost money and they all take an enormous amount of volunteer hours. If you are just starting out in the profession, you may not be able to make monetary contributions beyond dues and certification but don't hesitate to get involved and volunteer. And if you are getting ready to retire, please consider making ACLP a recipient of some level of donation in your advanced directives. ACLP is a non-profit organization, and even though our leadership has never really asked us for monetary contributions, I am sure that any

funds bequeathed or donated to ACLP will only go to enhance the continued development of child life.

This four-year journey on the editorial team of ACLP Bulletin is one that I treasure and for which I will always be grateful. I didn't think anything could be better than the first two years of working with Kathryn Cantrell and Anne Mohl. Then I was privileged to work closely with Jennifer Lipsey, and finally, had the amazing opportunity to culminate my editorial experience with Shannon Dier and Keri O'Keefe. We saw the birth of two babies, the establishment of a professional journal, and an entire change of leadership within ACLP. It's been quite a ride! My love and best wishes go out to all of you. Keep the faith!



A Message From the ACLP CEO



Dear Colleagues,

I am excited to announce the launch of our new strategic plan, designed to strengthen our impact and grow our community. Every day, more than 6,000 dedicated Certified Child Life Specialists provide services that touch the lives of thousands of children and families. Our mission at ACLP is to foster excellence in the profession through engagement in education, scientific inquiry, and innovation.

Created by members, leaders, students, staff, and members of the broader community, this plan sets the course for our profession's future and lays out five overarching strategic priority areas and goals that we will work to accomplish over the course of the next three years and beyond. It reflects the values and goals that inspire our work as we strive to be impactful, innovative, and member focused. From raising awareness of child life to optimizing pathways to the profession, this plan is dynamic to accommodate a rapidly changing healthcare environment, especially as we begin to navigate a post-pandemic world.

As a roadmap for our entire profession, the strategic plan will help guide everyone, no matter their role in child life, in planning and conducting the most consequential work, optimizing the use of our available resources, and delivering results for our most important stakeholders – the children and families you serve.

Now the work begins. It will take an intentional effort by the entire association to achieve these goals. I ask you to join us in working together to create an ACLP that is inclusive, welcomes all voices, and has diversity of thought and representation engrained in the culture.

Thank you for your continued dedication and collaboration as we further our vision of helping children and families – thousands at a time.

Alison E. Heron, MBA, CAE
Association of Child Life Professionals CEO

From Plan to Action

250 Days from Start to Finish

Summer 2021

June - September

- ACLP member survey data collected
- Internal & external engagement and feedback
- Research surveys
- Program Impact Matrix conducted
- Diversity, Equity, and Inclusion Summit

Fall 2021

October – November

Stakeholders meet in Scottsdale, AZ to....

- Analyze feedback
- Define ACLP's new mission, vision, core values, and DEI definitions
- Develop resonating themes
- Develop strategic priority areas
- Identify goals for priority areas

Winter 2021/22

December – February

- Strategic plan framework is reviewed by ACLP staff
- Specific tasks are created for each priority area
- Strategic plan is presented to the ACLP Board of Directors at the February board meeting
- Board of Directors unanimously approves the 2022-2024 ACLP Strategic Plan

Spring 2022

April - May

- Strategic plan is released
- Town Hall on May 4 to present the plan to the child life community and allow for Q&A

Summer 2022

June - September

- ✓ Identify short-term focus/first steps to success
- Determine metrics to measure our progress/performance
- Translate the plan for ACLP staff and ACLP committees

Who We Are and What We Do

Established as a nonprofit organization in 1982, the Association of Child Life Professionals represents trained professionals with expertise in helping children and their families overcome life's most challenging events. The association's membership is composed of almost 6,000 individuals representing more than 600 organizations worldwide.

At ACLP, our progress is fueled by the vision of our leaders and the hard work of a dedicated network of volunteers.





Phase 1: Stakeholder Engagement

Over the past year, the ACLP Board of Directors and child life leadership, along with ACLP staff, have engaged in a strategic planning process. To build the vision for the future, this group reviewed the trajectory of the profession, identified opportunities and challenges, and sought input from hundreds of key stakeholders to gain insight and perspectives into what the profession's priorities should be.

The new strategic plan was developed with input from child life specialists, external partners, board members, and staff who provided their perspectives to help shape the plan and guide the future of the profession. Taken into consideration were data from member surveys, a comprehensive program impact matrix, research surveys, action steps from the Diversity, Equity, and Inclusion summit and internal and external engagement and feedback.

28

more than 28 individuals participated in the strategic planning session

30

number of programs analyzed for the Program Impact Matrix

1,586

number of ACLP members who took the member survey



Phase 2: Strategic Planning Prioritization

In October 2021, a group of ACLP leaders and a diverse segment of our membership came together in Scottsdale, Arizona to discuss and develop the framework for the new strategic plan. Led by strategic facilitator Lowell Aplebaum, FASAE, CAE, IAF Certified of Vista Cova, the strategic planning process was an extensive, multi-day session meant to amplify voices and varied perspectives to ensure that the organization is aligned to meet the future needs of our membership and the child life community.

The session resulted in the framework for ACLP's mission, vision, and values along with ACLP's DEI definitions, and the 2022-2024 ACLP Strategic Plan. This plan was then presented to the ACLP Board of Directors at the February 2022 board meeting and was unanimously approved.

The 2022-2024 ACLP Strategic Plan addresses the opportunities and challenges currently facing child life and aims to elevate the profession – which we are confident we can and will achieve together. The plan outlines a bold vision with five key strategic priority areas. These priority areas are designed to address challenges the profession faces during this pivotal moment in the field of child life.

Several resonating themes – including diversity, equity, and inclusion, financial sustainability, and scientific inquiry and innovation – intersect with each of the five strategic priority areas and will be vital to success.

ACLP Mission, Vision, and Core Values

ACLP Mission.

To foster excellence in child life professionals through engagement in education, scientific inquiry, and innovation.

ACLP Vision.

Children and families of every race, identity, and community understand, navigate, and cope with serious life events.

ACLP Core Values.

Integrity – We promote consistent self-awareness, accountability, responsibility, and ethical decision-making. We strive for full transparency in our actions and communications.

Equity - We strive for equitable treatment, opportunities, and access to our information and resources for all. We believe achieving equity is only possible in an environment built on respect and dignity.

Inclusivity - We build a culture of belonging by actively inviting the contribution and participation of people of every race, identity, and community. We believe every person's voice adds value, and we strive to create balance in the face of power differences.

Collaboration – We bring together those with diverse perspectives, experience, and expertise to strengthen and enrich our organization.

Excellence - We integrate scientific evidence, best practices, rigorous standards, and innovation throughout our organization's work.

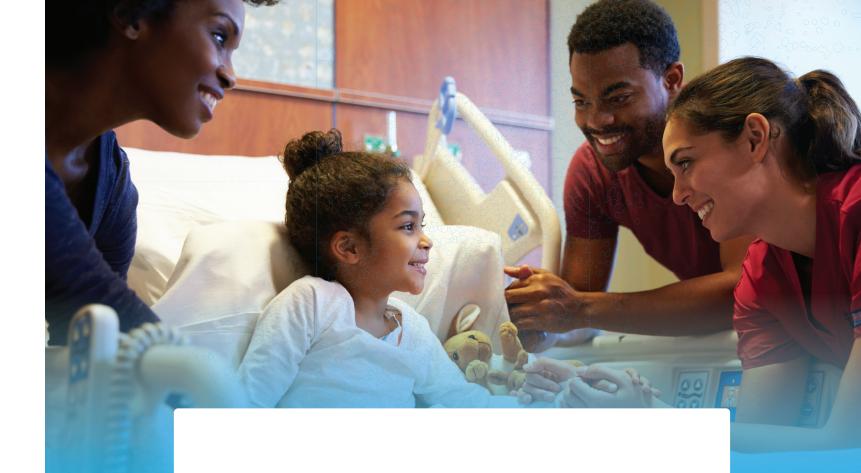
ACLP Diversity, Equity, and Inclusion Definitions

Diversity, equity, and inclusion are core to our mission and who we are as an organization.

Diversity is the representation of all our varied individual and collective identities and differences. We proactively seek out and engage with a variety of perspectives because we believe we can only advance justice when we affirm our similarities and understand and find value in our differences.

Equity is fair treatment, equitable opportunities, and access to our information and resources for all. We recognize that we do not all start from the same place and must acknowledge and make adjustments to address these imbalances. We believe achieving equity is only possible in an environment built on respect and dignity.

Inclusion is an environment and culture of belonging that actively invites the contribution and participation of people of every race, identity, and community. We believe every person's voice adds value, and we strive to create balance in the face of power differences. We believe that no one person can or should be called upon to represent an entire community.



2022-2024 Strategic Plan Priority Areas

Five Bold, Ambitious Strategic Priority Areas

Wide-ranging and long-term, the priority areas and goals defined below respond to the changing landscape in which we find ourselves. While some activities in the plan can be quickly realized, some will require efforts through 2024 and beyond.

These strategic priority areas and goals position ACLP to foster excellence in child life professionals through engagement in education, scientific inquiry, and innovation to ensure that children and families of every race, identity, and community understand, navigate, and cope with serious life events.



Communicate
Value and Raise
Awareness



Partnerships, Collaborations, & Connections



Optimizing the Pathway to the Profession

Elevate awareness of child life professionals' impact and value in the care of children and families.

Strategies for Achieving the Objective:

- Proactive and timely messaging through diverse and targeted media channels
- Improve and scale resources that provide value
- Promote awareness of the value of child life and emotional safety with key healthcare decision makers and the public

Strengthen community and collaboration through engagement and leadership among child life community, allied partners, and those we serve.

Strategies for Achieving the Objective:

- Increase and diversify ACLP's corporate partners and grant funders
- Increase transparency in the scope and decision-making process of the organization at all levels to build trust among the child life community
- Increased value of membership with tangible deliverables
- 3a. Advance engagement and collaboration amongst academic professionals and internship sites.

Strategies for Achieving the Objective:

- Reexamine and revise the internship application process to identify potential barriers and ensure alignment with the internship readiness KSAs
- Reexamine and revise the clinical curriculum process to identify potential barriers and ensure alignment with the internship readiness KSAs
- Provide resources for academic and clinical supervisors to support aspiring child life specialists
- Investigate and pursue approaches to recognize high-quality education for aspiring child life specialists
- 3b. Advocate and promote diverse pathways that will assist prospective child life specialists in entering the field.

Strategies for Achieving the Objective:

Provide robust resources for aspiring professionals that are easily accessible and improve their experience



Excellence in Professional Practice



Diversity, Equity, & Inclusion

Accelerate progress through research, innovation, advanced practices, and lifelong learning that improve clinical outcomes for children and families.

Strategies for Achieving the Objective:

- Ensure all ACLP publications are current on evidence-based practices
- Assess member needs to engage meaningfully with data, research, and evidence-based practice and develop programming to meet those needs
- 5a. Embed DEI and antiracism principles into our organization through education and training.

Strategies for Achieving the Objective:

- Educate volunteer leaders and staff on the importance of DEI and antiracism through training, workshops, and personal reflection activities
- Amplify diversity of thought by engaging BIPOC speakers, presenters, and panelists
- Incorporate DEI and antiracism as a priority in our financial budget strategy
- 5b. Identify and dismantle barriers to success and create a welcoming and supportive environment so that people of every race, identity, and community can thrive.

Strategies for Achieving the Objective:

- Conduct governance audit and job analysis to identify systems, gaps, and barriers in ACLP's policies and processes, to certification eligibility requirements and volunteer leadership structures
- 5c. Establish meaningful connections with HBCUs, HSIs and Tribal Colleges and Universities.

Strategies for Achieving the Objective:

 Develop engagement strategies with academic departments and the career center "I am confident the new strategic plan will serve as a comprehensive and powerful roadmap as we navigate the next three years and beyond as a profession. We will remain focused on the strategic plan's resonating themes of diversity, equity, and inclusion, financial sustainability, and scientific inquiry and innovation in order to better serve the profession."

ACLP CEO Alison E. Heron, MBA, CAE



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- Exceptional staff!

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~ Evelvn. mom of virtual camper

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www.sunrisedaycamp.org/VX

or contact Athena at sunrisevx@sunriseassociation.org or 516-517-7861

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- Enjoy kid-friendly content on our Sunrise Studios app.
- Make hospital stays fun with Sunrise on Wheels (contact for locations).
- Attend one of our 10 full-summer day camps (see our website for locations).





The mission of the **Sunrise Association** is to bring back the joys of childhood to children with cancer and their siblings worldwide. This mission is accomplished through the creation and oversight of welcoming, inclusive **summer day camps**, **year-round programs** and **in-hospital recreational activities**, all offered **free of charge**.



www.sunriseassociation.org

OP-ED: A CALL TO ACTION:

Child Life and Social Media Communication in the 21st Century

by Stephanie Hopkinson, MA, CCLS Huntsville Women and Children's Hospital, Huntsville, Alabama

The 21st Century continues to bring many forms of communication and we find ourselves having access to innovative technology each and every day. The ongoing expansion of platforms such as Facebook, Twitter, Instagram, TikTok, and Snapchat creates spaces for communication around the world. The intersections of personal and professional worlds meet in these spaces. Companies use them to send messages about their products and services while people choose to share their lives, their stories and their adventures in life. Often these platforms are used to send positive messages and teach others about many topics, including the topic of child life.

Although I recognize the importance of all these platforms for communicating to express thoughts, share life stories, and provide avenues for personal and professional opinions, I have become profoundly concerned about several of the posts that are appearing related to child life. I have read very negative comments about specific individuals, programs, child life services, multidisciplinary teams, and families. These comments are often anonymous and people openly respond, often reposting these,

further spreading these harmful messages. It both saddens me and moves me to action as I have been taught to be an advocate not only for children and families but for the field that I hold in high regard. I strongly offer a deep call to action as I find that the posts, memes, and words some people are sharing are often judgmental, critical, or derogatory and seem to come from or embrace bias.

How we choose to engage in social media and public communication can have a direct impact on our professional credibility. What does this mean for us in the community of child life, from emerging child life professionals to practicing Certified Child Life Specialists to child life educators and child life leaders? It is an opportunity to think about what the intent of our message is and how we engage in/with social media. Ask yourself the following: What do we want others to learn and know about child life from these communications? How do we use our words, images, and stories to express our thoughts, perspectives, and experiences in our work with students, staff, children, and families?

Laws, policies, and governance practices in several countries around the world protect,

support, and encourage freedom of speech. The questions for us to think about are: where does freedom of speech move into slander? what is speech that might be painful for or harm individuals or groups? where does freedom of speech misrepresent what we want others to know and understand about who we are, especially in our professional world? In child life we are asked to uphold and maintain objectivity, integrity and competence while exhibiting compassion in our work as Certified Child Life Specialists (Child Life Code of Ethics, retrieved March 2, 2022, www.childlife.org).

Through the lens of professional responsibility and integrity, I ask you to hear my call to action: to maintain the highest level of professionalism in all communication including that on social media. Our communication will impact and influence our identity and how others see us in child life. Think about the images, memes, and words we choose to use both in public forums and on social media. As Michelle Obama said, "When they go low, we go high." It is our professional responsibility to take a stand even when others may choose to move into an area that can be perceived as harmful to our professional identity and

integrity. We do not know who is taking in this communication. For example, after a long day, to decompress, a child life specialist might post a meme that expresses a frustration they might have had during a patient encounter that day. This post is then re-shared and circulates around social media. A family may read that meme and experience a level of hurt or harm, thinking it applies to them. A family member's emotional well-being, ultimately their emotional safety, can be impacted when they see these images and words.

Heed this call to action and hold people accountable for their behavior and actions. Speak up. When we remain silent about the harm to others and ourselves, we communicate that we agree. Use your voice, including written voice and images, to speak your truth and advocate for communication that upholds strong values of who we are.

In healthcare and in the community, child life is looked to for our expertise. As a community of practice, let us honor the foundation of who we are, work together, and continue to lead the way in representing child life with integrity, objectivity, cultural humility and strong professional practice!

INTERNSHIP CRISIS

There's a Crisis in the Field and We Have to Talk About It

by Annie Jacobson

Based on what I could find online, in an ideal scenario, there appears to be approximately 240 internship sites available across all internship cycles. However, during the most recent summer round, there appeared to be less than 40. While summer internships are often less available, this felt like a new low. Furthermore, barriers to application, like cost, exclusive affiliation agreements, and location, mean the number of sites realistically available to most students could have been drastically less.

While the reverberating effects of COVID-19 on the internship process felt previously unimaginable, for many students it seemed as though the pandemic merely exacerbated what had long been boiling beneath the surface. The lack of placement opportunities simply took the traditional barriers to internship to new heights, creating a culture of unrealistically high standards that left students with advanced degrees and thousands of hours of experience debating pursuing certification. I personally know dozens of highly qualified students who experienced shocking rejections from first round interviews, rejections that, one could argue, may not have occurred even just a few cycles ago. Moreover, as child life programs continue to remain understaffed and overwhelmed by equally qualified applicants, the system asis leaves internship committees without the resources, support, or tools to further create or pursue solutions. This added strain means

overwhelmed programs are also probably subject to higher degrees of stress and subconscious bias during decision making which may contribute to the reality that the profession remains overwhelmingly white, female, and able-bodied. Coupled with the growing prominence of video submissions, where students are forced to spend hours on their appearance and video editing skills, being told presentation is just as important as content (often while also being asked to meet difficult submission deadlines), the current system just simply does not function in a way that will allow us to begin to break the cycle of compounding inequities.

The uncomfortable reality here is that not securing an internship often results in abject harm, all the more so for those students living with marginalized identities; our entire lives and livelihoods are placed on indefinite hold. Without internships, we may not be able to graduate, we cannot move forward with certification, and we will not be able to find work in the child life field. We are stuck, in limbo, for months, and sometimes even over a year due to when application due dates fall. I know multiple students who had to put off starting a family or buying a house because they have to try yet again for another internship cycle. Additionally, there has been an elevated mental and physical toll on students that must be addressed. During this past internship cycle alone, numerous students became so despondent they could not sleep, a student with IBS mentioned experiencing several







flare ups, and more than one experienced a relapse of their anxiety and depression requiring additional medication. These experiences are not hyperbolic, and they are not uncommon.

The following is just a small sampling of how consequential the current process can feel:

Cost

The overwhelming financial burden is repeatedly pushed onto students, trapping us in a system where only those with consistent financial support can complete the process for certification. Applications for practicum and internship are a significant cost. As most hospitals explain they have too many applications to provide confirmation of receipt, it is expected students pay for tracking in addition to the cost of stamps, envelopes, paper, and printer ink. I know more than one student who has paid over \$100 just to mail out applications. Given the current landscape, it is expected students will do this over and over again until they are able to secure placement.

Despite the steady increase in cost of living throughout the country, students are still expected to afford furnished housing, gas, utilities, food, potential car rentals, and other necessities for four months while working full time during internship with no income. We know marginalized students are already more likely to experience wealth inequality, thus compounding the problems surrounding a lack of diverse candidates and, ultimately, Certified Child Life Specialists. While incredibly and inequitably taxing, students who are seeking clinical experiences understand they will (a) most likely have to move and (b) that moving all but guarantees it will cost thousands upon thousands of dollars to complete an internship. We undergo the painstaking application process anyway as, for almost all of us, there is simply no other choice.

Competitiveness

Conversations around competitiveness often feel moot as hundreds of students remain in a backlog that could take several cycles to get through (and that is if no new applicants even enter the process). Students are often told to improve their resume each cycle by simply acquiring any experience they can. The idea that students should simply continue to pad their resumes, when they already qualify for internship according to ACLP requirements, is an issue of equitable access to certification and undue burdens, not competitiveness or quality of applicants. Moreover, individuals applying to internships for the first time are not always able to compete with those who have been through multiple cycles and may have already completed multiple practicums or additional experiences. Not to mention, the turnaround time from summer to fall applications is only about four weeks and, while the turnaround from fall to the winter/spring deadline is around four months, most opportunities to apply for summer practicums or other experiences will have passed by the time internship offers are finalized. What do hospitals realistically expect students to accomplish during these time frames?

Furthermore, despite the ACLP clearly noting practicums are not required for certification, practicums have become as competitive as internships, requiring the majority of students to go through multiple rounds before being granted placement. It is expected students should now be willing to move across the country in order to obtain these entry-level experiences. Some hospitals tell students they now need to have at least two practicums on their resume while other hospitals tell students they view multiple practicums as a potential red flag, wondering if it implies they were not able to successfully complete the others. Ultimately, many students report having to "play the game" with internships,

and now practicums, resulting in severe mental anguish, confusion, and burn out before they ever enter the field.

Similarly, it is important to note we are no longer operating under a system within which applying to as many hospitals as one can afford guarantees an internship. A student who applied to 21 internship sites was rejected from all 21. However, they exceed qualifications according to both the internship readiness standards the ACLP has currently outlined and the feedback provided by the hospitals to which they applied. Another student shared with me they "did everything right" and "even asked for feedback [to see where they could improve]." But, the feedback was essentially, "there were six of you in the final round and at some point we just had to pick one." Additionally, despite knowing nothing about where else students may have been able to – or even wanted to - apply, hospitals needing to draw a line somewhere have begun recently denying qualified students based on assumptions. An anonymous, vetted Instagram post explained a selection committee "considered not offering [an internship] to a student they "...didn't think [would] choose [their] small hospital." Meanwhile, a different student received an email in which they found out a hospital stopped accepting out-of-state candidates altogether because they became inundated with applications and figured out-of-state students would not come if they received an offer closer to home. While I applaud these sites for their honesty, and I

genuinely encourage more of it, how many other students, without knowing, have been rejected for similar assumptions rather than their ability to actually be successful interns? There may be even more barriers to certification in which students continue to bear the brunt of the harm.

To further put this into perspective, during the past round of applications, I interviewed students who had been rejected from various hospitals and contacted the hospitals about their application numbers. In two instances, the hospitals informed me that they had received "over 100" (the hospital with the highest application numbers) and "66" (the hospital with the lowest number of applications). The "over 100" hospital accepted four students, and the "66" hospital accepted one. That means those two hospitals had rejection rates of 96% and 98%. Even with possibility of duplicate applications to multiple hospitals, that is still a very difficult barrier for a student to overcome!

Continuing the Conversation Together

Please know, I want to be clear, I do not believe any one person is responsible for what this situation has become. Every child life specialist I have ever reached out to for guidance or support has been extraordinarily kind and generous with their time – including members of various ACLP committees. Still, we have a responsibility to publicly acknowledge a field consistently over saturated with overgualified candidates

cannot continue on in this way. We are not operating under the same reality current Certified Child Life Specialists experienced even two years ago when the ACLP initially conducted its Internship Review and Selection Think Tank. We need to know exactly how many qualified students are still in need of a placement, we need to appreciate how hard hospitals are working to parse through applications, and we need to openly discuss the barriers, challenges, and burnout of students and child life specialists alike.

While we are all feeling the effects of the global healthcare crisis, students are shouldering the burdens in different ways. It is only by bringing all stakeholders to the table that we can move forward with new, improved, and more equitable frameworks for success in both the internship process and certification at large. I would encourage folks from all spectrums of the child life field to submit an op-ed and share their perspectives in order to help continue this process. Moreover, I would implore the ACLP Board of Directors to provide space for students to share what they are experiencing. One potential long-term solution is to create a student advisory group and/or student liaison board position. It is long past time to open lines of communication with all members not just the Certified Child Life Specialists.

By working together, and listening to one another, I know we can, and will, get through this; I look forward to continuing these essential conversations alongside you all.

LESSONS LEARNED

In the Community Setting

by Carissa Howard, MS, CCLS, Assistant Professor, Azusa Pacific University

fter spending almost 11 years in a traditional child life setting, 9 of those years in a level one pediatric Emergency Department (ED), I found myself curious about child life outside of the hospital. I knew working in a community setting as a Child Life Specialist (CCLS) would look different, but I was ready for a change. As is true with so many of us, we quickly get comfortable on our unit of choice, and our job becomes routine. We may find ourselves merely going through the motions as we do teachings, provide distraction, support kids through procedures, and even provide bereavement services.

The idea of doing child life outside the world of the hospital was unfamiliar and even intimidating at first, but it was also exciting at the same time. I've had the opportunity to do child life in two different community settings, first in a palliative care setting and then at a transitional living facility for women and children. Both settings seemed so opposite of the fast-paced world of the ED, where my interactions with families were short and to the point - introduce self and services, provide procedural teaching and support, and then say "goodbye" and send them on their way (usually). I had so much to learn in these new settings - they brought me back to the basics of child life.

As I settled into the rhythm of these community settings, I found myself learning and growing as a CCLS. I thought I knew so much after being in the field for so many years already, but I was wrong. The learning curve was steep and feeling

like a new specialist all over again was humbling. As with any new job, I had a lot to learn. I had to figure out how to apply my skills and knowledge in a way that was completely different than I was used to.

Looking back, here are five lessons I learned as a CCLS in a community setting.

1. Keep it Simple

Bigger is not always better. There were days I came in with grandiose interventions and ideas and had a picture in my head of how amazing they would be. It was usually the big, elaborate interventions that fell flat. My patients and their families didn't need big and over the top; they needed simple. They needed small things that would bring them together. Sometimes it was simply reading a story together and then making a family project together that meant the most. My families didn't need fancy interventions - they needed things that would help them connect.

2. Don't be afraid to get messy.

I'm not typically one who loves slime or paint or sensory bins, yet in these new settings, these messy interventions were exactly what my patients needed. They needed sensory stimulation and a safe place to get messy and to try new things. I learned that it's okay to make a mess, and sometimes the messier the intervention is, the more fun the kids would have.



On my first Halloween at the transitional living facility, we made the biggest and messiest sensory bin I had ever seen. We had cooked spaghetti, slime, spiders, cotton candy spider webs, and any other remotely Halloween-related items we could find. To be honest, it was pretty gross. When we brought all the kids into our playroom, the first thing they all went for was the sensory bin. After they'd run their hands through it, they decided they'd dump it all over the floor. It was an absolute disaster, but their laughter and squeals of delight reminded me of how fun it is for kids to get messy!

In my palliative care setting, many patients couldn't play independently, so I quickly had to get over my own dislike of mess and plunge our hands, mine on top of theirs, into the messy

slimy sensory bin. It was often when our hands were buried under the mess, that I got to see the biggest smiles and witness the biggest reactions. The mess was worth it!

3. Relationships matter.

In the hospital setting, my interactions with patients and their families were often limited to a few minutes or hours, or occasionally a few days if I covered a unit on a weekend. In these new community settings, I worked with the same patients week after week. My focus shifted from support and procedures to development and family interventions. In both palliative care and the transitional living facility, I was welcomed into family's homes, into their sacred and safe space. I was invited to get to know the whole family -

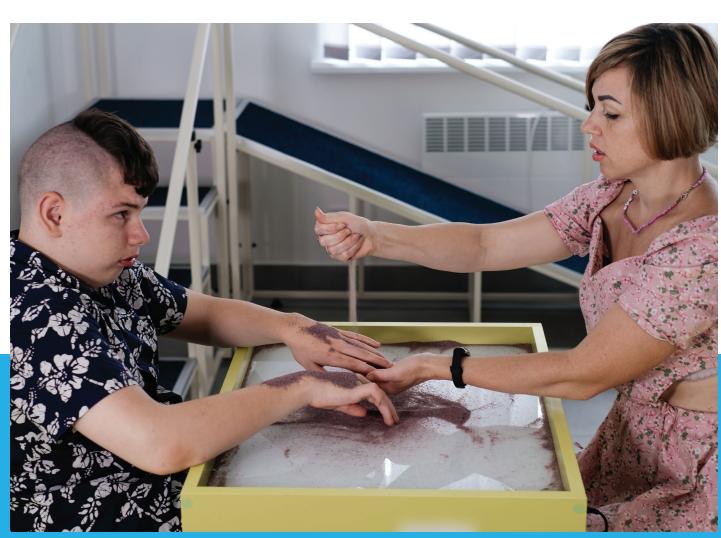
my patient, their siblings, parents, nurses, and more. My goal was no longer to get in and get it done but to create meaningful moments and interventions that would bring the family together and create opportunities for building their family legacy. I worked with some of my patients and their families for over a year. Remembering the small things like birthdays or upcoming events (a sibling's recital, a parent's interview, favorite colors, etc.) meant the world to these families.

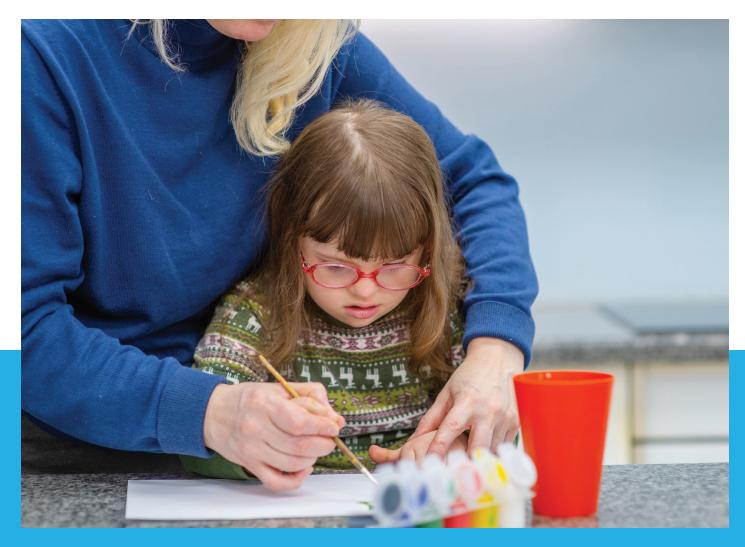
Two of my patients who I looked forward to the most each week were children who could do very little on their own. What I loved most about working with these two little boys was including their siblings in our interventions each week. For those siblings, it was finally a chance to play with their siblings, create art, make music, and

participate in storytime. This was one of the few times each week where they didn't have to be responsible or be the helper for their younger sibling with a chronic illness. For 1 hour each week, they got to play alongside their sibling and just be a kid.

4. Child life comes in all shapes and sizes.

As I welcomed students and interns into these new settings, they often questioned if what we were doing was really child life. These community settings looked very different from what they had envisioned a child life specialist doing. How was pushing a child on a swing for hours, or going on nature walks, or teaching a mom how to play with her child, child life? Child life doesn't just happen within the hospital walls. Child life





happens best when we intentionally engage with a child, meeting them where they are, helping them to feel safe and cared for, in any setting! Even though the setting was different, the goal stayed the same - to provide developmentally appropriate interventions, teachings, and support for children and their families.

One of the most challenging kids I worked with at the transitional living facility ended up being the child I learned the most from. This little guy was only 3 when we first met and was on the spectrum. Prior to meeting him, I had never worked with a child with autism for any length of time, other than a quick interaction in the ED. The first night we met, he screamed the whole time. I remember feeling so overwhelmed and so helpless as nothing I tried worked. As the months went on, I began to understand his needs and got to experience his pure joy when we found something he enjoyed. Over time, instead of screaming when he'd get dropped off for our playgroups, he switched to crying when he had to leave. I learned how to think outside the box, to communicate with things other than words. I learned how to identify developmental deficits and then come up with activities and interventions that would help each child meet their goals and milestones, teaching parents how to do the same.

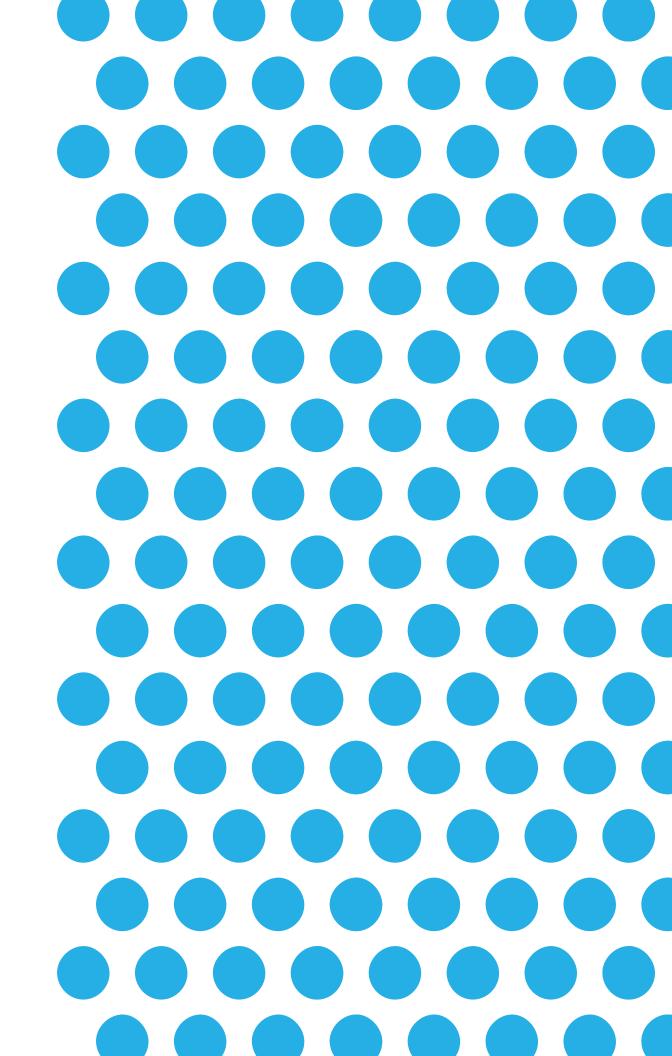
5. Sometimes, change is a really good thing.

I was comfortable in the ED. It was my home for 9 years. I thought I had it all figured out as a CCLS. Prior to working in these community settings, there were nights in the ED when I'd encounter a family with a child who was

differently-abled or developmentally delayed, and I'd make my interactions minimal, often feeling like I didn't know if they would notice I was there or that I didn't have anything to offer. But stepping out of my comfort zone and into these community settings taught me the importance of slowing down, of connecting with each family. I remembered the inherent value and worth of each patient, regardless of their ability or inability to engage.

I became a better specialist after working in palliative care and at the transitional living facility. I learned to be sensitive to my patient's nonverbal cues. My patient's pleasure and discomfort were very rarely expressed with words, but with movements, noises, and body posture. I had to learn to observe, watching for cues as to whether or not my patients enjoyed the activities we were doing. Being in these unique community settings, practicing as a CCLS, reminded me of the absolute value of pure play - laughing, running, jumping, exploring, using your senses - seeing the world through the eyes of my patients was a delight! It wasn't until I left the setting I was most comfortable in, that I grew the most.

If you get the opportunity to try something new as a CCLS, do it! Change units, work outside the hospital walls, think outside the box. Be brave! As our field continues to grow and expand, my hope is that child life will continue to become more common outside of the hospital setting. There are so many settings where children need someone to be their voice. Where else can we provide developmentally appropriate interventions, teachings, and support for children and their families? The possibilities are endless!



CHANGING PERSPECTIVES:

Evidenced-Based NICU Practice

by Emily Martin, MA, CCLS, Cincinnati Children's Hospital Medical Center

"So what exactly do you do in the NICU?", "Do you mostly work with parents?", "Do you just hold babies?", "Why does the NICU need Child Life? They're just babies."

As a child life specialist in a neonatal intensive care unit (NICU), it is not uncommon to get questions rooted in curiosity and misconceptions, often even from other child life specialists. This is understandable given that neither child life training nor education provide much information about the unique needs of infants in the NICU. When it comes to learning about developmental theories and infant development, there is usually not a shortage of either in child life undergraduate and graduate studies. However, I do not recall learning much about the unique needs of premature infants. So when I started working in a NICU, I couldn't help but feel somewhat ill-equipped to fully understand or support the portion of our babies who had been born prematurely.

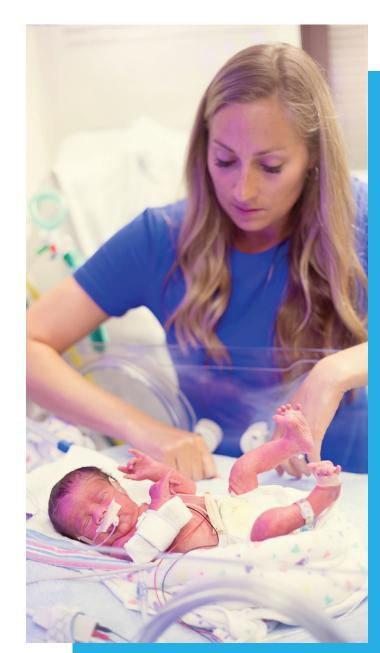
When I started working, child life services in the NICU looked much different than they do now. Services at the time aligned with what most of us are taught in our education and training as child life specialists. In addition to bereavement support, sibling support, and play sessions and procedural support for older babies, we provided normalization for families in the form of monthly birthday baby photos and photos of various milestones. While the work we were doing was certainly appreciated by families, I couldn't help but think we were missing

something. Approximately 25% of our NICU is occupied by premature babies (those born before 37 weeks gestation) at any given time, but we were spending very little time at the bedside supporting this population, even though evidence demonstrates their vulnerability to adverse effects of stress. I made it my mission to learn more about premature infants and their unique needs in order to better support them.

Thanks to advances in medicine, premature and critically ill infants are surviving at much higher rates than they were 20 years ago (Als et al., 2003). Higher survival rates, however, mean more infants are hospitalized and at risk for poor developmental outcomes (Als et al., 2003). According to Mary Coughlin, a nurse and leader in developmental care, infants who experience an extended NICU stay and frequent painful procedures are at risk for problems later in life, including but not limited to learning disorders, behavior challenges, attention deficit disorders, lack of social control, and physical changes in the brain (Coughlin, 2014). A study led by Heidelise Als and her colleagues compared two groups of infants in the NICU: those who received standard NICU care and those who received developmental care (Als et al., 2003). Developmental care includes environmental interventions (cycled lighting, containment during procedures, etc.) as well as those which aim to promote a strong parent-baby bond like kangaroo care. Additionally, developmental care includes staffing models which allow for

babies to have primary nurses and consistency in care. In this study, radiographic imaging of the brains of infants in each group showed better-developed frontal lobes in the infants who received developmental care (Als et al., 2003). Child life specialists can play an important role in helping improve neurodevelopmental outcomes for infants in the NICU; however, many child life specialists have identified this population as one with which they wish they felt more comfortable, supporting the need for more specialized training and orientation for child life specialists working in the NICU (Smith et al., 2014).

In August 2020, I began a year-long training to become NIDCAP-certified in order to enhance the support my team and I were providing to premature babies, and the recommendations I am making in this article come from the training I received. NIDCAP stands for Newborn Individualized Developmental Care and Assessment Program, and it supports NICU babies and their families by individualizing the care each baby receives in order to minimize stress and reduce the long-term effects of a NICU stay. Training involved two classroom days with a NIDCAP trainer followed by biweekly clinical observations to gain practice utilizing the NIDCAP assessment tool. As a NIDCAP professional, I am able to observe an infant using an evidencebased, NIDCAP-specific assessment tool and then take what I observe and compile it into a written report, communicating what the baby has told us through his or her behaviors and then giving





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recommendations regarding interventions to provide. This report is shared with the baby's family and care team to better individualize his or her developmental care.

Through NIDCAP, I learned over 90 different stress cues and behaviors seen in premature infants. This opened my eyes to how even the tiniest infants communicate their needs to us; we just need to know how to interpret and respond to them. For instance, when a premature baby is stressed, he or she will extend his or her arms and legs in search of the walls of the mother's womb. Caregivers can respond to this stress cue by providing containment, or a "hand hug," to mimic the physical boundaries of the womb.

As a NIDCAP professional, I have been able to share much of what I have learned with my NICU

Child Life team, allowing us to reevaluate our practice and services. In order to provide more trauma-informed interventions, we no longer document monthly birthdays and milestones through photos. Instead, we encourage parents to do those things, just as they would if they were at home with their baby. By eliminating this service, we now have more time to be at the bedside providing developmental care to premature infants in order to mitigate the effects of toxic stress. We are present whenever possible at the bedsides of these babies during both routine care as well as medical procedures, providing a second set of hands for containment and a second set of eyes to watch and interpret cues, allowing us to be their advocates and their voices. Additionally, we partner with parents and caregivers, teaching

them how to provide developmental support and ultimately empowering them to be active participants in their babies' care.

Becoming a NIDCAP professional has given me a completely new perspective on infants in the NICU and more specifically, those born prematurely. Since child life specialists work to reduce the effects of stressful experiences, it makes sense to have child life specialists actively and regularly involved in the care of premature infants in order to promote healthy neurodevelopment. Although NIDCAP training is not widely accessible due to a limited number of training sites, my hope in sharing this information is that child life professionals everywhere might look at NICU child life services in a different way and understand the importance of our

profession's involvement in helping give these babies a healthy start. Taking time to learn about the specific cues and behaviors of premature infants can enhance a child life specialist's assessment skills within the NICU, ultimately allowing them to provide support and reciprocal interaction in order to decrease stress in these babies. After all, they are much more than "just babies."

PARENTAL PRESENCE FOR ALL:

When an Absolute Practice Becomes Questionable

by Jenna Read, MS, CCLS, Nemours Children's Hospital, Orlando, Florida



s a newer child life specialist covering my hospital's surgical floor, I was blessed with a heavily utilized policy regarding parental presence in the Operating Room (OR) - caregivers could escort their child to the OR and be present through induction and then were walked back to their preop room by a "parental presence volunteer" to change out of their sterile jumpsuit and head to the waiting area. When I first transitioned to this unit, I felt a little out of place as a surgery CCLS who hardly ever went to the OR, but honestly, I came to feel this policy was highly valuable as it was founded from a family-centered care perspective. Patients could be supported by their primary attachment figure to during one of their scariest moments, and the medical team was on board!

As child life specialists, the principles of family-centered care are pinnacles of our scope of practice, and we utilize them to ensure our families are having their care tailored to their unique needs and preferences. Most of us can easily name multiple reasons why it is beneficial; it improves medical outcomes, enhances patient and family satisfaction, can help reduce healthcare costs, and creates a more supportive workplace and learning environment for healthcare workers (Thompson, 2018). Moreover, the practice of family-centered care not only recognizes, but appreciates, that the family is the constant in a child's life, further promoting that we should empower caregivers to participate and be involved in care at every

opportunity. This includes procedures and difficult medical moments for their children, such as anesthesia induction prior to a sedated procedure or surgery. We know this is likely to be one of the scariest times during a hospitalization for a child due to the fear of the unknown and a limited experience with or understanding of how anesthesia works.

So naturally, when a child must have a procedure or go to the Operating Room (OR), as their child life specialist, we lean toward advocating for parental presence because we know the value of making room for that trusted adult. After all, parents know their kids best, right? They speak their child's unique language when a child is nonverbal and doesn't use words to communicate. They can negate fantasies their child has about being abandoned and provide comfort only a parent can give. They can serve as their child's safety net, pillar of strength and familiarity in a room that is bright, filled with surgical tools and is downright scary.

In child life, we also know the benefit of reducing sedation. When I came to a hospital that had such a strong parental presence policy, I was overjoyed at the thought of reducing need for premedication in my area – and it was clear this was part of why this policy existed. There was this idea that if a child had a parent to go with them to the OR, then they wouldn't require a pre-med or a child life specialist's support during the transition. This became an absolute belief of mine as a new CCLS at this hospital – if I could prepare them and

play with them before surgery and their parents could support them during induction, then they have the best possible outcome.

First Patient Case Study

Enter Henry*, a now 17-year-old patient with developmental delays and a complex medical history requiring botox injections among other procedures every few months. Henry is very experienced with hospital life and the surgical process; I have worked with him before procedures in the preoperative area over a dozen times. Because of his experience, he generally only requires a check-in from me and the opportunity to scent and decorate his anesthesia mask. Henry is well-supported by his mom, Janet*, who knows the value of explaining things step-by-step to Henry. She always escorts him to the OR for induction where she can talk about the sensations of induction with him and hold his hand until he falls asleep. She is a prime example of the value of parental presence. She is an advocate for her son, she knows his interests and dislikes better than anyone, and she already knows what to the expect during the induction process and can focus on providing Henry with the individualized support he needs so that he feels safe and secure. After many years, they have developed the coping plan that works best for Henry, and Janet is the biggest asset to Henry's coping.

Then a global pandemic happened, resulting in mask and social distancing requirements, a national Personal Protective Equipment (PPE) shortage, and a marked decrease in family visitation and parental presence allowances. We were no longer allowing parental presence in the OR at our hospital. Being research-minded and knowing I would need evidence to support advocating for allowing parents back into our OR's eventually post-pandemic (when is that going to be again?), I took to our online medical library to find what support I could for parental presence.

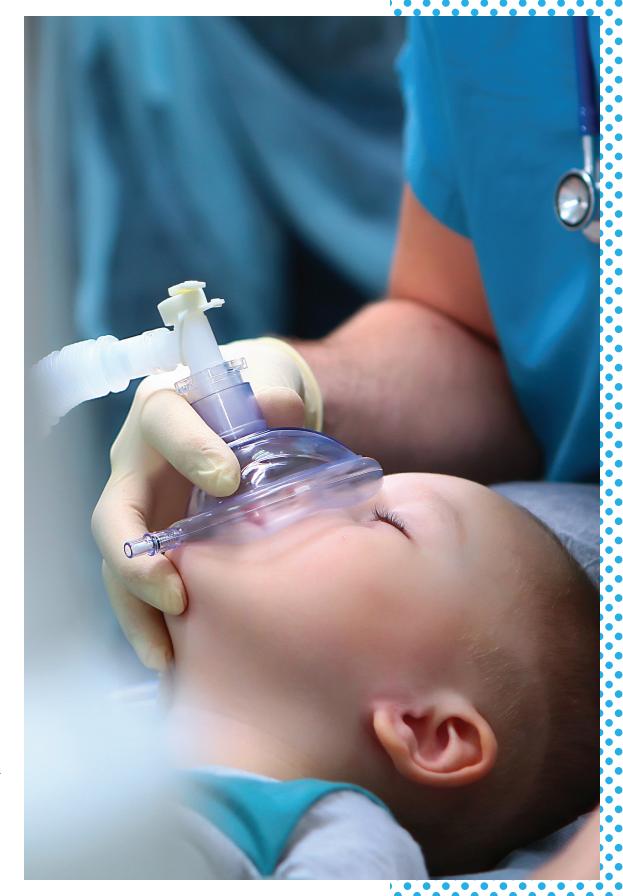
Parent Satisfaction

One important aspect of family-centered care is family presence during care and treatment. Evidence-based recommendations have refuted the misconception that family may interfere during a procedure or that being present will cause great distress to them. In fact, most parents would simply appreciate having the choice to be present (Zhang et al., 2018). Many parents that have been present in the past during inductions, look forward to supporting their child again in the future, now knowing what to expect. Being present during procedures can even increase family members' positive impressions of staff and the care they are receiving (Zhang et al., 2018). If we know that having family presence won't interfere with care, can increase parent satisfaction, and may even make our patients more compliant and our jobs easier, then what's the harm in having them there?

Quality of Induction

When children are more anxious preoperatively, they tend to have more difficult anesthetic inductions which can lead to potential complications. If that preoperative anxiety escalates and carries into their induction, that can lead to breath holding, risk of laryngospasm, and increased post-operative pain (Scully, 2012). We know from our child development backgrounds that children can regress and become more dependent during times of stress, which can lead to low levels of cooperation (like breath holding). One study did support parental presence during anesthesia induction – but with a caveat, the parent present must be calm. Sadeghi et al. (2016) found that the parent present in the operating room during an induction can increase a child's acceptance of their anesthesia induction by helping them to feel safe and protected but only if the parent themselves are calm and at ease

When I began reviewing the literature on parental presence, I was hoping to find research





that supported my absolute belief that parental presence directly reduces anxiety in all patients undergoing anesthesia induction; however, I was unable to find research that supported that hypothesis whole-heartedly. Multiple studies confirmed found that when anxious parents were present during induction, they were less able to respond to their child's need for support, escalating their child's anxiety and further compounding their own parental anxiety, thus rendering the parent increasingly less able to provide the support their child needed (Kain et al., 1996; Sadeghi et al., 2016; Wright et al., 2010). As child life specialists, we are aware how parental trait anxiety can trickle down to patients and increase child anxiety in medical

settings, so to their point I can agree that the anxious parent probably shouldn't be the one in the OR supporting during induction. One study summarized it perfectly, stating that "perhaps more important than the simple presence or absence of parents, the specific characteristics, qualities, and/or behaviors of the parents who choose to be present are critical factors associated with changes in child anxiety" (Wright et al., 2010, p. 755).

Effect on Parents

An interesting perspective I had not considered though, is the effect that seeing your child induced might have on a parent's psychological

well-being. Kain et al. (2003) examined the impact of parental presence during induction of anesthesia in the OR on the physiological and behavioral stress response of the parents. This study found that parents who were present during induction had significantly higher heart rates, blood pressures, and skin conductance levels. These levels were all higher regardless of whether the child received midazolam or not, and parents reported the most stressful moment for them being their moment of separating from their child in the OR (Kain et al., 2003).

Most interestingly, I found a commonality in the literature that parental presence alone to lessen anxiety during induction is not as successful as using a pre-medication like oral midazolam or behavioral distraction; the most successful way to lessen anxiety during induction being to utilize all three methods (Scully, 2012). Very few recent studies have focused on the efficacy of parental presence alone. Another commonality among the literature reviewed is that they all primarily focused on healthy pediatric patients. It can be anticipated that children more experienced with hospitalization and anesthesia would have different needs, reactions, anxieties, and coping behaviors surrounding the induction process. This leads me to my second patient case study.

Second Patient Case Study

Now enter Rachel*, an 11-year-old patient with developmental delays and a complex medical history, having had both neuro and gastrointestinal procedures under anesthesia in the past. Rachel is also on the autism spectrum and has a speech delay, expressive language disorder, and sensory processing disorder. For the last few years, I typically receive a consult to see Rachel prior to a procedure to make sure her preop room receives sensory adaptations and to do mask play with her. Rachel's mom, Susan, always requested a consult for child life, even though Rachel had experienced more than a dozen sedated procedures and usually brought her own sensory toys from home. I've gotten to

know Rachel and Susan* very well over the years and have learned how best to support them. Today was different, though, as there was going to be a big change to Rachel's typical coping plan. Suddenly Susan couldn't go to the OR with her, and this was a hard change – for Susan, especially.

So, we made a new plan. I advocated for the use of oral midazolam as I foresaw the separation from Susan being particularly difficult (for both parties). I got all the handoff from Susan I could possibly receive about how best to support Rachel during the induction and off we went. During the 30 second ride to the OR, Rachel was calm; she popped her dimple popper and held my hand as I talked about my favorite colors on her toy. Another 60 seconds in the OR, and she was easily breathing herself to sleep as she had done many times before, all the while holding my hand and listening to me sing her favorite song as I stroked her hair (just as her mom had instructed). Afterward, I went to find Susan in the waiting room so I could let her know how amazing Rachel had done. Susan was astounded! In her experience with every prior induction, Rachel had tried to push the anesthesia mask away, clung to mom, and had eventually cried herself to sleep.

I took time to debrief with mom about everything that went right for Rachel that day: the decision to use pre-medication, the anticipated decoration and rehearsal with her mask, and the decision for me to accompany her as a known and calm presence. I've made sure to advocate for the same anesthesia plan each induction since, and all have gone just as smoothly. This has not only made things easier and safer for Rachel and the medical team, but has also made Mom feel less anxious and more at peace knowing that, even though she can't physically be there, Rachel is in good hands.

Discussion

One limitation when examining the practice of parental presence is the amount of research available in this area. My literature review through my hospital's digital medical library using the

search terms "[parental presence] + [anesthesia induction]" only produced 22 results, with only six from the last ten years, and only five articles which actually discussed parental presence during pediatric anesthesia induction. Furthermore, within those five articles, each study examined a different age range, revealing extensive gaps in the research due to the variety of techniques and array of groups studied. This certainly indicates that more research is needed on the benefits of parental presence across the developmental stages, the variables that go into preparing and supporting a child through induction (i.e., pharmacologically and non-pharmacologically by way of distraction), and how to assess and support parents for to be present during induction. Furthermore, the existing literature has certain constraints on it having been conducted primarily by anesthesiologists and physicians. It would be interesting to instead see a child life specialist partake in this type of research – I know I would be the first to read it.

Since the pandemic and our change in parental presence at our hospital, I've had to rethink my stance, revisit my absolute beliefs, and weigh the pros and cons of having parental presence during induction. Of course, I will still advocate for parental presence when I know a calm parent can be supportive to their child during a difficult moment –our job is to empower parents to do

something that we simply cannot. However, when it comes to an easily distressed parent, an anxious child who won't be eased without pharmacological support, or even a child who will cope well with behavioral distraction, parental presence alone might not be the best fit. Or even as Sully (2012) found, perhaps the child needs all three to cope their very best!

As times change, so do the practices and the information that we held to be true. This can be startlingly difficult to come to terms with – trust me, I know. Before diving into this topic, I thought "every parent goes, and that's what's best," and that was the very well-intentioned standard of care at this hospital. Yet, I've learned firsthand from cases like Rachel's that just because a practice has always been in place, doesn't mean it should stay the same forever - or for everyone. We learned in our coursework that we needed to be adaptive and flexible to be child life specialists. I always thought this was in regard to patient caseloads and the pace of the hospital, but I'm learning that these traits also need to be applied when revisiting our absolute beliefs about child life and what we think we know is best for a child. The world of child life has changed a lot in the last two years since the beginning of the pandemic, and I'm quite sure that this belief about parental presence isn't the only one worth revisiting.

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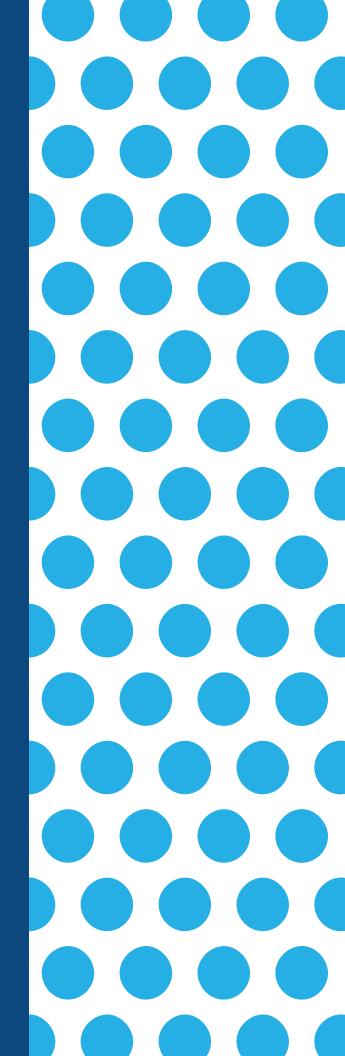
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^{*}Patient and parent names changed for confidentiality.

PEDIATRIC STROKE CODES:

A Two Child Life Specialist Approach

by Lauren Keyes, MA, CCLS, Darcy Dirksen, MS, CCLS, Mount Sinai Kravis Children's Hospital in New York, NY

Resuscitations and codes take priority for child life staff in our Pediatric Emergency Department (PED). We understand how scary these moments can be, for patients and parents alike. The PED itself can be a scary place, with unknown procedures and staff members running in and out of rooms. This stress intensifies during codes as the medical team has to work extremely fast, and things happen at the speed of light with, what can feel like, the bare minimum explanation. Pediatric stroke codes are a unique situation as patients are often awake enough to understand something bad is happening, but potentially not coherent enough to understand at their typical

developmental level. Patients quickly get blood drawn, IVs placed, a CT, and an MRI with multiple teams of staff descending upon the room simultaneously. Parents are often overwhelmed by how quickly these procedures occur and typically have many questions about what is happening to their child. In these situations, we are torn as child life specialists (CCLSs) between meeting the simultaneous needs of the patient and parents.

In a PED staffed with two CCLSs, a common approach is to have one CCLS respond to the emergency situation and one CCLS cover the rest of the unit. We would like to challenge that

practice and make a case for utilizing two child life specialists in pediatric stroke codes due to the unique nature of these types of codes. We believe this helps to alleviate the inherent stress of attempting to juggle the needs of the patient and parents, as well as allows adequate and targeted child life services for both patients and parents. The following case example provides a unique opportunity to compare and contrast our response to a pediatric stroke code with one CCLS versus two CCLSs. The quick turnaround time between this patient's two PED visits allowed for a unique opportunity for us to reflect on the details and emotions of each visit.

Patient G came into the PED on a day with only one CCLS on shift. The patient presented with right sided numbness, headache, nausea, and a significant neurological medical history leading the medical team to activate a pediatric stroke code. The CCLS on shift was initially able to prepare the patient for their IV and CT scan, but as the day went on G became increasingly altered and difficult to calm down. The patient yelled at staff, tried to roll off of the bed, and tried to hit the MRI machine. The only thing they appeared to respond to was the sound of the CCLSs voice redirecting them back to the bed. The CCLS felt that it was important to stay with the patient to



support coping and help them complete the CT and MRI. These scans are emergent in stroke codes and need to be completed in a timely fashion. The patient appeared to relax when they heard single-step instructions and reassurance coming from this CCLS.

At the same time however, the mother was outside of the room crying and praying that her child was going to be okay. The CCLS tried to give her updates as frequently as possible, but felt torn between staying with the patient, as she could see that her interventions were working, or going to comfort the mother. Afterwards, the CCLS felt emotionally drained and, while knowing she had done her best to support the child, felt like she had failed the mother. She wished she could have been in two places at once, so she could have sat with the mother and explained each procedure step by step, while offering validation of the stress that the mother must have been feeling during these unknown moments. She couldn't imagine what that mother had been feeling, hearing her child scream from inside the MRI machine but hoped that she knew the medical team was trying their best to help the patient.

Three days later, patient G came in again with right sided numbness and headache. Again, the medical team activated a pediatric stroke code. G was more altered this visit, yelling and rolling off the bed as they came in. G's mother was agitated and upset about having to return to the PED so soon after the previous incident. On this day there were two CCLSs on shift in the PED. CCLS #1, who had worked with the patient and family on their previous ED visit was able to prepare and support G through their procedures, noting that the patient followed commands and appeared to recognize her voice and presence. This time, CCLS #1 had the ability to call in a second CCLS to provide psychosocial support for G's mother in order to focus her full attention on the patient. When reflecting on the case, CCLS #1 felt calmer and that she hadn't felt pulled in different directions during the procedures. She could focus her full attention on deciding on and

implementing successful interventions for the patient. She also felt that her mental wellbeing was better because she knew the mother was taken care of and she had another CCLS to process with during and after the encounter.

Concurrently, CCLS #2 directed her focus toward the patient's mother. Walking into the room she could tell the mother was angry, as she slammed her hand on an empty stretcher and yelled that the patient's prior discharge had been premature. The mother was also angry that the doctors continued to ask her the same questions repeatedly, expressing her frustration that no one was listening to her answers. CCLS #2 took this opportunity to introduce herself as someone who was there to support her while CCLS #1 helped support her child. She provided water, explanations of the various medical procedures, and a supportive, listening ear. The patient's mother slowly became receptive as she realized that this CCLS was there to solely support her through listening to her concerns and validating her feelings.

When the patient was taken to CT scan, medical staff instructed the mother to stay in the hallway. CCLS #2 offered to either enter the procedure and return frequently to provide medical updates for the mother or to sit in the hallway with her during the CT scan. The mother requested that the CCLS stay with her as she appreciated the supportive presence. While in the hallway, the patient's groaning and yelling could be heard coming from the CT scan. The patient's mother became even more visibly upset, expressing her stress and worry through crying and praying. CCLS #2 was able to provide comfort to the mother through reminding her that CCLS #1 was helping support her child, as well as praying with her. The mother expressed her gratitude for this supportive presence.

When reflecting on the case, CCLS #2 felt satisfied with her ability to focus solely on supporting the mother, knowing that her colleague was supporting the patient. She felt confident that she had been able to build rapport and provide a safe space for the provision of

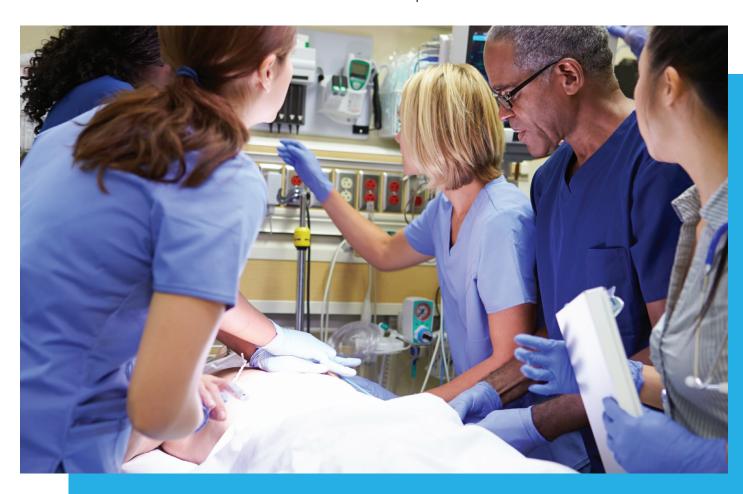
family-centered care. CCLS #2 felt as though the entire case had been much more manageable and put less stress on both her and CCLS #1. This case also helped build CCLS #2's confidence in helping provide sufficient patient and family-centered care to families.

While this article focuses on one particular stroke code, both of these CCLSs have been able to collaborate in this manner on multiple stroke codes. While there are other patients in the emergency department during these stroke codes, the above example shows how stroke codes may need to be prioritized in order to optimize care. When possible, involving two CCLSs during a stressful event in the emergency room is vital in not only caring for the patient, but also caring for the family--a great example of patient and family centered care. During stroke codes, the majority of the medical team is also focusing on these particular patients. Care for all other patients slows for these few minutes, and allows

for the two CCLS approach to work well without sacrificing care for other patients.

If there are other serious patient needs, such as IVs or conscious sedations, with the PED, this two CCLS-approach is not possible within the PED. These situations are up to the individual CCLSs' discretion when assessing patients. If it is not possible to have two CCLSs, a medical team member or social worker should be dedicated to solely support the parent and allow the single CCLS to focus on the patient. Social workers, or even chaplaincy, can be very beneficial in helping support parents alongside CCLSs.

This collaborative approach reduces the stress and tension that one CCLS might feel when having to balance the patient and family alone, thus decreasing the risk of burnout within the field. Ultimately this patient and family centered approach allows each CCLS to fully focus on their designated "patient" to provide comprehensive care.



RESEARCH CORNER:

Coding Qualitative Research into Themes

by Laura Gould, MS, CCLS

Qualitative research is often done through descriptions gained from interviews, questionnaires, or observations. One approach to analyze textual data and identify themes within qualitative research is thematic analysis of semi-structured interviews with open responses (Vaismoradi et. al, 2016). Thematic analysis helps organize and verify qualitative data into patterns (Scharp & Sanders, 2019). Thematic analysis is utilized when there is no right answer and an absence of a hypothesis, allowing researchers to examine both intended and unintended findings (Vaismoradi et. al, 2016). The thematic analysis method is often utilized for psychology and nursing studies (Vaismoradi et. al, 2016). In fields such as child life where research topics may not be as easily defined by quantitative numbers, thematic analysis is one data analysis method researchers may want to consider.

Thematic analysis involves coding interviews into categories and then more abstract themes. Coding data into categories identifies the raw data relevant to the research question and places the information from interviews into smaller, manageable segments. Then, information is sorted into themes representing higher-level insights or abstractions (Vaismoradi et. al, 2016). The researcher has creative liberties when coding, and themes can be organized by concepts, relationships, participant perspective, participant characteristics, or setting (Vaismoradi et. al, 2016). Braun and Clarke (2021) described thematic analysis in six stages which involves the researcher (1) familiarizing self with the data,

(2) coding categories, (3) developing themes, (4) reviewing themes, (5) defining and naming themes, and (6) locating examples in research to support the data collected. The researcher should describe the step-by-step process used so that work can be replicated or expanded upon in the future.

Using Thematic Analysis: A Case Example

While finishing my masters' degree in Organizational Development and Leadership, I utilized thematic analysis for my thesis, "Perceptions of Single Mothers by Choice:
Balancing Careers and Motherhood." Single
mothers by choice (SMC) were identified as
uncoupled women who sought motherhood
through adoption or assistive reproductive
technology. The first step was to identify an area
of interest. When possible, it assists beginning
researchers to model research off of an existing
study for guidance. My thesis was modeled after
2019 study by researchers Trail and Goedeke
in New Zealand. These researchers performed
individual interviews with seven single mothers
by choice who utilized donor insemination and

dissected the open-ended interview responses into six themes (Trail & Goedeke, 2019). This study piqued my interest in collecting information from single mothers by choice in the United States of America and including the impact of being a single mother by choice on career development, especially during the COVID-19 pandemic.

Single mothers by choice were invited to

Single mothers by choice were invited to participate regardless of ethnicity, race, or religious background. Participants were informed that all surveys and interviews would remain confidential and be de-identified. This is an important step in ensuring the confidentiality of participants and gaining their comfort, regardless of the topic of the study. As a single mother through adoption myself, I also needed to identify how I would acknowledge this in my research and to participants to avoid bias and influence within the study. Interpretivism was utilized to collect and reflect on the perspectives shared by participants (Trail & Goedeke, 2019) which means this researcher's subjectivity was not ignored and instead identified with a disclaimer in recruiting participants and written in the thesis itself. To combat potential bias, questions were primarily open-ended to avoid mirroring any unconscious bias I may hold and promote participants sharing their views. For example, a child life specialist conducting research on boundaries in healthcare may hold a conscious or unconscious bias that child life specialists have better boundaries than nurses. This belief may not be true but being a child life specialist and the one conducting the



research, it is important to acknowledge one's role and method to combat potential bias. This is especially important for a subject that is not as straightforward as research may be when quantitative numbers can be found.

Recruitment of participants can also be a challenge. Three days before the university approved my project, an outside researcher posted an announcement seeking participants for their project on single mothers, and this researcher was offering monetary compensation for participating. That was not within the abilities of my research. Participating in my thesis research was voluntary without compensation, and I needed to figure out how to recruit members from a similar pool of potential participants. Identifying myself as a single mother by choice helped tremendously, just like it may be easier for child life specialists to conduct research with child life specialists as participants than it may be for an outsider as it is easier to promote a feeling of comradery and representation. Over just three weeks I was able to interview 22 participants! With a non-flexible deadline to complete my data analysis due to my graduate program deadlines, I was faced with needing to allot more time for data analysis than I had planned, but it was a good problem to have as I had more subjects than I had anticipated.

A thematic analysis process was utilized to characterize the factors contributing to this subset of single mothers and how they maintain careers while being a mother. Putting answers into categories by type of questions allowed me to recognize common themes and a few outliers. When analyzing the interview responses, themes emerged from the 22 interviews including

"desire to mother", "autonomy," "broadening the definition of family," "change in career priorities," and "support networks." In thematic analysis, it is important to recognize that results are not exclusive truths but possible constructs derived from the lens of the researcher and the participants (Trail & Goedke, 2019). Human experience lays the ground work for theorybuilding (Frisby et al., 2009). The final step was relating my research to studies that already exist. These interviews related closely to the research on SMCs while new information emerged about changes in career priorities and the impact of COVID-19 as no known studies could be found on this topic. It is important for a child life specialist doing research to also compare their results to data that has already been collected to analyze for changes or similarities and determine next steps for the researcher or others interested in further exploring the topic.

Thematic Analysis and Child Life Research

There are few examples of this type of analysis in research published by child life professionals. One model is a study which used a mixed-method design to understand CCLSs experiences with working with children with autism spectrum disorder (Jensen et al., 2019). It is within the child life scope of practice to utilize surveys, questionnaires, interviews, focus groups and observations to collect data on questions within child life practice. However, depending on the study especially if children are the subjects, it is important to consult an Institutional Review Board (IRB). Hospitals and colleges must have an IRB in place in order to review all human-subject research.

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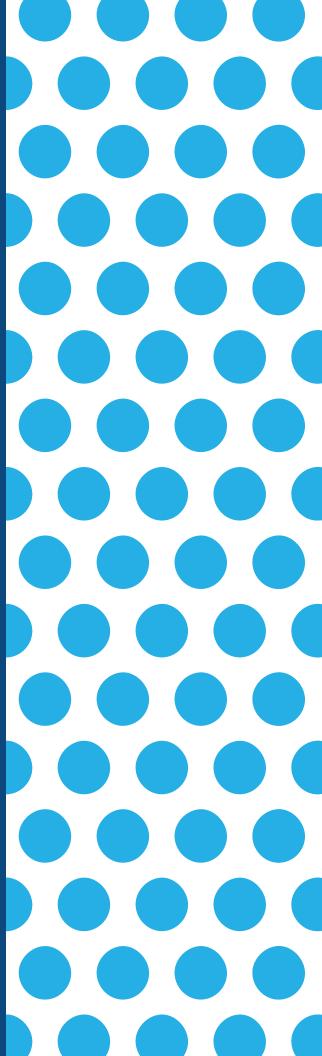
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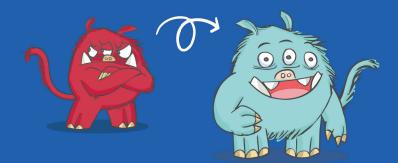
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Nationwide Giveaway To Children's Hospitals

In response to the national "Sound the Alarm for Kids" regarding children's emotional health and the impassioned plea by the Surgeon General and Amy Knight, the President of the Children's Hospital Association, Emotional ABCs is giving all Children's Hospitals across the USA free subscriptions to our Premium program.



Our interactive online program, designed for children ages 4-11, is America's most awarded evidence-based emotional regulation program and we are responding to the nationwide pediatric behavioral health crisis by giving free access to up to 90 patients and 6 Child Life professionals at a time to use our Premium Program at each Children's Hospital across the country.

Children will get free online logins to EmotionalABCs.com so they can enjoy the company of our character, Moody, as they learn to better manage and regulate their emotions.

Click below to go to EmotionalABCs.com/Childrens to learn more about the nationwide giveaway or you can reach out to me, Ross Brodie, CEO of Emotional ABCs at Care@EmotionalABCs.com

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The Forgotten Mourner:
Including Children at
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April 29, 1.0 PDU, Intervention

Supporting Infants
Through End of Life:
Developmental Comfort
Care & Memory Making
May 6, 1.0 PDU, Intervention

Bioethics and Pediatric Trauma

May 11, 1.5 PDUs, Ethics

Breaking Down the
Barriers of Pill Swallowing
Through Behaviour
Modification
June 15, 1.0 PDU, Intervention

Power & Paradoxes in Children's Participation in Decision-Making - The Perspectives of CCLSs in the Netherlands June 22, 1.0 PDU, Ethics

Beyond Burned Out:
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CALENDAR

UPCOMING EVENTS AND IMPORTANT DATES

- APRIL 29: LGBTQIA+ Meet Up.
- APRIL 29: ACLP Webinar, The Forgotten Mourner: Including Children at End-Of-Life (1.0 PDU, Intervention).
- MAY 1: Last day for regular registration rates for the 40th Annual Child Life Conference.
- MAY 2: Initial offer date for Fall 2022 Internships.
- MAY 4: Acceptance date for Fall 2022 Internships.
- MAY 4: ACLP Town Hall, 2022-2024 Strategic Plan
- MAY 5: 2nd offer date for Fall 2022 Internships.
- MAY 6: ACLP Webinar, Supporting Infants Through End of Life: Developmental Comfort Care & Memory Making (1.0 PDU, Intervention).
- MAY 11: ACLP Webinar, Bioethics and Pediatric Trauma (1.5 PDUs, Ethics).
- MAY 12: Applications open for Fall 2022 Diversity Scholarships.
- MAY 16: Registration closes for the 40th Annual Child Life Conference.
- MAY 26-29: 40th Annual Child Life Conference
- JUNE 13: Applications close for the Fall 2022 Diversity Scholarship.
- JUNE 13: ACLP Webinar: Introduction to the Foundations of Racially Conscious Collaboration (3.0 PDUs, Any Domain).
- JUNE 15: ACLP Webinar, Breaking Down the Barriers of Pill Swallowing Through Behaviour Modification (1.0 PDU, Intervention).
- JUNE 22: ACLP Webinar, Power & Paradoxes in Children's Participation in Decision-Making The Perspectives of Child Life Specialists in the Netherlands (1.0 PDU, Ethics).