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ACLPP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

WINTER 2021 | VOL. 39 NO. 1

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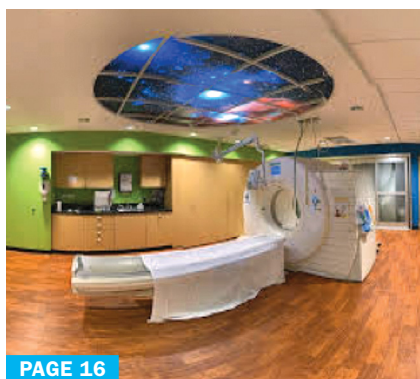
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from the **Executive Editor**
Kathleen McCue, MA, LSW, CCLS

Conflict and Controversy

As you read the title of this column, you may well be wondering what the relationship is between child life and the concepts of conflict and controversy. After all, aren't we usually the "good guys?" We are all taught that at least part of the role of child life is to help settle conflict, enhance communication, and smooth over any controversial words or actions that might occur in our work settings. I clearly remember a student once saying to me, after a discussion about a particularly difficult interaction with a nurse, "Why do I always have to be the one to take the high road, to be calming and understanding? It's not fair!" She was correct, it wasn't really fair, but it is so often what we do in child life. Even when we adamantly disagree about something, or feel slighted professionally, or challenged in our advocacy work, we still have been taught that the best way to resolve a problem and reach a satisfactory outcome is to be accommodating, empathetic, and supportive.

So, is there a place for controversy and even active conflict in child life? I believe that there is. When you read Teresa Schoell's article about anti-racism in the Fall 2020 issue of *ACLP Bulletin*, Teresa states "Being anti-racist means recognizing that my devotion to courtesy, my aversion to conflict, and my pervasive desire to be accepted and liked by those around me so often serve as disguises for complicity, validation, and normalization of the unacceptable." Although this comment was about anti-racism, read the statement with the words "Being a good child life specialist" substituted for "Being an anti-racist." I think many will agree that those words fit our profession. In the second issue of *Journal of Child Life*, there is an article by Donna Koller and Divna Wheelwright titled "Disrupting the Status Quo: A New Theoretical Vision for the Child Life Profession." In this article, the authors challenge "the antiquated views of childhood embedded within established developmental theories." They conclude, "the only way the child life profession can safeguard ethical care is to engage in critical and perhaps difficult examination of the entrenched belief

systems and theoretical orientations." What did you think when you read this? It is a clear challenge to the basic foundations of child life. Did you feel threatened or inspired? Did you question whether all the theories you studied in college, and the certification exams we all took, and the way you apply developmental theory to your practice today, were all invalidated? In this issue of *ACLP Bulletin*, you will read an excellent discussion of the pros and cons of licensure for child life by Colleen Cherry and Lisa Ciarocca. Here are two respected child life professionals discussing the same topic with two very different conclusions. Should they be trying to find a middle ground, or standing strongly in their own positions, in spite of the controversial nature of the topic?

I am certainly not advocating for disrespect or personal insult or out-of-control screaming matches on the part of child life professionals. However, perhaps it is time for people in our field to learn that by tolerating conflict, and speaking up about one's deep beliefs, change is more likely to occur. Fair fighting is a skill to be learned, as are other skills like advocacy and relationship development. We have seen an enormous rise around the world in people refusing to accept systemic racism; rather, they are standing up and embracing their beliefs, in spite of conflict, in spite of controversy. Maybe there is a lesson to be learned for all of us by their example.

When something is really important, it is worth facing a bit of conflict. We talk a lot about respecting the voice of the child and his or her family. What about allowing the voice of child life to be clearly heard, even when addressing controversial or conflictual issues? Your *ACLP Bulletin* editorial team would welcome articles that delve into these sorts of topics. I would even be happy for you to totally disagree with the premise of this column! As long as you can avoid personal attacks and keep your comments reasonably clean, your controversial thoughts and writings are welcome here! ✨



President's Perspective

Kim Stephens, MPA, CCLS

The end of 2020 brought both hope and grief.

Grief as we reflected on the many challenges of 2020: Covid 19, racial reckoning, climate disasters, civil unrest, economic recession, and a once-in-a-lifetime pandemic. In health care, the challenges felt overwhelming. A surge in unemployment resulting in a loss of health insurance leaving millions without access, deep financial losses for hospitals and providers (especially those that were already financially vulnerable, including rural and safety-net providers and primary care practices), substantial racial and ethnic disparities in care, and finally a crisis in public health management of the novel coronavirus all intertwined during 2020 to illuminate the need for future change. Amid these extraordinary times of unprecedented global change, child life professionals around the world continued to serve. And through their service, resilience, and compassion alongside so many others, hope remains as we enter into a new year.

So what can we learn from all of the challenges of 2020 to help us navigate towards a better future? First, I hope we can reflect on the strength and resilience we saw in the children and families we worked with. As child life professionals, we know the impact that health care and significant life experiences can have on the lives of children and families. Yet both in the hospital and in the community, we saw children and youth still engaging in play, learning, and growing. Yes, it looked different, and we still do not know what the long-term impact will be, but despite the challenges, they showed their adaptability and resilience. I remember seeing a story in October about a second grade class using Zoom and their teacher accidentally got disconnected from the call. The following five minutes while the teacher tried to reconnect brought me back to my childhood days when the substitute teacher would step out of the classroom. The students were hilarious, talking about who would get in trouble if they did anything wrong while the teacher was gone. You had the classic “by-the-rules” student telling everyone else to behave in case they were being recorded by the principal, you had the funny classmate trying to tell a really bad knock-knock joke, and you had a variety of students using Zoom as show and tell around their house. It seemed so normal and what you would expect in any second grade classroom. **Resilience. Adaptability. Hope.**

Second, I hope we can reflect on the strength and resilience we saw in our families as they navigated having a loved one work as an essential worker. It is not easy, no matter how old or young you are, to cope with knowing your loved one is going into a situation that might put them at risk. Even our youngest children could sense our anxiety and worry. Our routines became different; sometimes we had to isolate ourselves and struggled with the desire to just hug our loved ones. Yet they found new ways to support us and help us to have the strength to go back to work each day. It might have been a note in our lunch, a quick Facetime call while at lunch, or a sweet card in the mail but our loved ones kept us moving forward and grounded us. **Resilience. Adaptability. Hope.**

Finally, I hope we can reflect on the strength and resilience we saw in each other. Our teams quickly had to adapt our practices to meet the needs of a new and changing landscape. Our clinical institutions had to pivot in the types and ways they provided care. Our academic partners had to shift how to reach and educate our emerging professionals. ACLP had to refocus and shift how to meet the needs of members in many ways including virtual conferences, expanded online educational content, and more opportunities for member connection and networking. We supported each other through the waves and phases of the pandemic and shared our best ideas freely and widely. Colleagues from around the globe reached out to each other on member meet-ups, in the forum, and so many other ways to offer support and encouragement on the hardest days. These very necessary connections have helped and will continue to help us navigate the challenges. We know we still have far to go, but we can take the lessons learned from 2020 and use them as we move forward with changes to improve health care and beyond. **Resilience. Adaptability. Hope.**

I hope you enjoy this issue of the *Bulletin* and use the content to expand your knowledge as we continue to work in this new health care frontier with hope and resilience.

All my best,
Kim ✨



CEO Shares

Jennifer Lipsey, MA

Dear...

...Colleague: In my 12 years with this association, I still have not found a succinct way to define what child life “is.” That’s largely because it isn’t “just” about what child life specialists do but about who they become and how each uses their Self as a tool in their work. Each CCLS and aspiring child life professional brings a wealth of lived experience, academic history, and professional experience that has informed their perspective of how to meaningfully engage individuals through creative means to create trust, security, and the opportunity to adapt, cope, and continue to develop into their best selves.

If I had a magic wand, everyone in the world would understand that the value of child life extends far beyond a profession. To know child life is to understand what it feels like to be cared for in a way that says, “I see you. I hear you. Let’s try...together.” Child life begins as a career ambition and takes hold of the soul. Formal curriculum and instruction gives way to application of principles and values that inform one’s approach to others. Child life requires significant education and training, but not everyone can be a child life specialist just by completing specific courses and training. A person truly becomes a specialist in child life by pushing through the compassion fatigue, sprayed bodily fluids, and chaotic work environment where the only thing predictable is the uncertainty of the day; remaining resourceful and creative day after day when your budget, tools, and workspace seemingly close in around you due to “higher administrative priorities” that dictate how your office space will need to be used and how your staffing structure will be changed; and, only after maintaining hope and optimism despite immersion in an environment where illness, death, grief, anxiety, stress, and fear are inherent. I have seen our members stumble, help each other up, and try the next step together. I have seen the perseverance it takes to thrive despite the physical and emotional tolls of the work; heard the heartbreak of our members processing the heaviness that comes with patient care; and bore witness to the delicate dance of art, skill, and competency necessary to be effective in an emotionally charged, patient care arena. Child life is not for the faint of heart — it requires emotional intelligence, reflection, courage, and insight to form the solid boundaries necessary to prevent projection, transference, and burn out.

... Successor: Congratulations! You have been carefully chosen to care for a membership, staff, and board that helps humanity keep the faith during moments of significant stress, adversity, and loss.

In 2020, our membership numbers continue to remain stable in their climb as has volunteer interest in serving on one of our 38 committees and task forces. It goes without saying that as a leader you have been blessed with an engaged community that presents with enthusiasm and a genuine desire to help their peers and contribute to their industry. You can’t ask for much more in an association community, and I’m certain that, like me, you will do everything in your power to ensure that you show up as your best self to represent each member.

Your role as CEO will require courage, clear communication, and humble servitude. My success in the role was very little of my own doing but instead born out of listening to the members; leaning on the headquarter’s staff and openly inviting different perspectives and concerns to keep each other accountable; and never being afraid to ask questions or confess, “I don’t know.” Yet, if/when responding with, “I don’t know,” I always made sure I followed through to find an answer and circled back with the original inquirer. I listened with curiosity and sincere interest, provided context to staff, and then got out of their way while they led their programs, all the while emphasizing integrity, transparency, and authenticity in all relationships.

Perhaps this is all stuff you know or that is common sense in leadership. When I spell it out, it does seem rather fundamental, but I cannot stress how important it was for me as a CEO. I started with ACLP as an entry-level Program Assistant, moved into Certification, then was promoted to Director of Operations where I was offered the Interim (and eventually permanent, salaried) CEO position. I’ve never held professional ambitions of serving in the C-suite and fought Imposter Syndrome every day (still do). In my capacity as CEO, I had access to a wide network of association executives and the best, most successful were those who took their time to understand their members’ history and values and the association’s operations. The opportunity to have served in so many roles, from entry-level to executive, gave me such valuable insight into the membership, association trends, and my predecessors’ successes and challenges.

I learned to rely on multiple perspectives of all levels of service, competency, and engagement – everyone is a subject matter expert! Acknowledge each as such and recognize each person's value in expanding what you cannot see, hear, feel as a single person. ACLP gifted me with an unbelievable opportunity to finally embrace my Self as CEO, and various members, staff, and board supported my growth every day. I found that as with most things, you get what you give. So give freely, honestly, openly and with kindness. What you will receive in return from this community will leave you speechless.

... ACLP member: With the end of 2020 near, it's hard to leave a community that's provided me with so much security and comfort for the last decade, but I have faith you will take your industry to new heights. I may be leaving ACLP as CEO, but the 12+ years of memories and reflections gained

from your knowledge, skill set, and contributions have left indelible marks on who I am (and aim to be) as mother, peer, and societal influencer. Now, over to you to lead with love.

... ACLP community: Continue to lift each other up and lead the good fight. The world — fraught with suffering, disparities, and loss — is in prime condition for an infusion of child life. Regardless of whether you infuse play, wonder, curiosity, awe, and resiliency at work, home, or local community, please do so knowing that it's vital to keeping our global heart pumping. Each of you is a leader in hope and compassion, which often run scarce, but are vital in keeping a web of hearts beating. May you know your value, feel your worth, and never let anyone diminish your light.

Sincerely,
Jen Lipsey
Outgoing CEO 🌟

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Heather L. Roberts, MSW, CCLS
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Isaac Newton said, "If I have seen further than others, it is by standing on the shoulders of giants." Your legacy in ACLP will certainly be as one of the giants that allowed us to build forward.

SHERWOOD BURNS-NADER

Dear Jen...

Thank you,
Jennifer Lipsey,
from all of us...

You possess a remarkable sensibility, communicate impeccably, and are a highly composed professional... It has been a pleasure getting to know you as CEO of ACLP these past few years.

CARA SISK

Jen's vision, leadership, and fierce advocacy have been a guiding star for the ACLP, and she will be dearly missed!

TERESA A. P. SCHOELL

Thanks, Jen, for all you've done and especially for your support of the Archives!!
Best wishes!

JERRIANN WILSON

...Little did I know the profound impact Jen would have on the organization and on me personally. Over time she developed a comprehensive knowledge of the workings of CLC/ACLP and has demonstrated fierce dedication to our strategic goals...
Best wishes for an excess of happiness, Jen.

AME ENRIGHT

Jen has always been such an inspiration and Child Life cheerleader. I will miss your leadership, encouragement, and even the cloudy days.

BARB JAMES

I have sincerely enjoyed the time that I have spent working with you. I want to thank you for your guidance, support, and encouragement that you have shown me over the years.

MARY BEAN

Your never-ending advocacy, curiosity and professionalism has helped elevate and strengthen the child life profession. I know that you will continue to carry the message of child life in all you do in the future...

JENNIFER SCIOLLA

I will truly miss your amazing spirit, and your ability to make everyone feel heard and respected. You are truly a force and this space will not be the same without you in it.

RAMONA SPENCER

Your insightful wisdom and genuine dedication has brought ACLP to a higher place. You've left your permanent footprint, so thank you for your outstanding service!

SHERI MOSELY

You are one of the most effective (and fun!) leaders I have ever known. Your superpowers are authenticity and accessibility, and I know those qualities will serve you well wherever you land.

BEA WIKANDER

I'm so thankful for the years we worked together. ACLP was lucky to have had you as their CEO. All the best my friend. You are truly one of a kind.

ALEX RODRIGUEZ

ACLP is very fortunate that you stepped up to lead the organization forward with your determination, strength, and leadership. You demonstrated quiet wisdom through challenging times and we are all better off for it. Thank you!

YVONNE KASSIMATIS

Thank you, Jen, for stepping up as a leader when our people most needed you. You led the team and the organization with much grace and enthusiasm and I am so grateful to have been a part of your team.

JANET NELMS CROSS

Thomas A. Edison once said in referring to excellence, "What you are will show in what you do"... When challenges presented themselves, you demonstrated grit, wisdom and grace. We won't be the same without you, and we are stronger because of you.

EILEEN M. CLARK

The members of ACLP are grateful to you for your commitment, your dedication, and your foresight in continuing to propel us forward. Thank you for your years of committed leadership!

ELLEN HOLLON

Jen has generously given of herself to ACLP and has not wavered in her support. Her legacy with ACLP and with the field of child life will be felt for years to come.

QUINN FRANKLIN

It has been a pleasure getting to know you on the Board. Your calm and reflective approach to leadership is a gift. Thank you for your dedication to the CL profession.

TRACY AKITT

You have given so much of your skills, knowledge & time to ACLP... I am grateful for the counsel and support you have offered me both professionally and personally.

SHARON McLEOD

Your vision and strategic thinking combined with compassion and a deep awareness of current issues has launched ACLP into a new generation. You are truly a leader who listens and guides with a quiet intent.

KRISTIN MAIER

I'm grateful to you for your commitment, patience, and willingness to make bold decisions. Thank you for helping shape and strengthen our association.

AMY MORSE

Your passion for helping us excel has been unwavering and you have helped propel us to the next level. Thank you for your loyalty and for ensuring that child life specialists remain on the forefront of pediatric healthcare.

BARBARA ROMITO

Your love and commitment to the cause and the people has always been clear... I have always appreciated your willingness to listen, thoughtfulness when acting and professionalism even in the toughest situations.

MISSI HICKS

Thank you for sharing your many talents... You have provided insightful leadership in moments of challenge and in opportunities for innovation to keep our professional association healthy and moving forward.

SHEILA PALM

Thank you so very much for your years of dedication to ACLP, and your dedication to our field. I am so grateful to you for all of your contributions and wish you the very best as you move on to your next chapter. Much love,

CARLA OLIVER

You are truly child life at heart... You truly understand the work that our members do every day and have been our strongest advocate and champion... we will forever be grateful for your leadership, your passion, your heart, and your friendship.

KIMBERLY STEPHENS

Thank you for your deep care, commitment, passion, advocacy, and leadership with ACLP. We are grateful for all you have done to support the vision and mission of ACLP!

STEPHANIE HOPKINSON

I appreciate the calm, thoughtful way you lead. Your intelligence and passion are admirable. You will be missed!

JENAYA GORDON





X is for Patient eXperience:

THE PATIENT VOICE

Lindsey Watson, CCLS

CHILDREN'S MERCY, KANSAS CITY, MO

Who are the experts on the hospital experience? Who knows how to make a medical procedure less stressful for a child? Is it the doctors... the nurses... the medical team... the child life specialists? While each of these professionals can provide insight and valuable perspective, the true experts are the patients and families who directly experience the hospital and clinic environment. As one patient stated, "Listen when we tell you something." Patients have key insights into how to cope with stressful hospital events and what could make them easier. Our job is to listen to their voice, amplify it, and act.

"Central to any experience effort are the voices of, contributions from and partnerships with those receiving care" (Wolf, 2018, p. 9). It is imperative that hospital systems pursue a culture where patients' feedback, thoughts, questions, concerns, and requests are sought out regularly. The collection of this data is only valuable if the hospital then turns it into actionable steps to influence change. One of the five value drivers of child life services is to "empower children and families to become informed, engaged, and active participants in their healthcare experiences" (Boles et al., 2020, p. 7). A challenge to all child life specialists is to take what they hear and learn from patients and implement changes in care for that patient and future patients. A key question for us all: How can we turn the patient voice into what drives our evidenced-based practice?

Children's Mercy Kansas City has a multidisciplinary group, called the Family-Centered Care Specialty, whose primary mission is to capture the patient voice and utilize this voice to influence positive change. This specialty was developed in 2014 and is a committee that meets on a monthly basis. The committee includes various members of the Patient and Family Support Services section, including section leaders, child life specialists, and patient activity coordinators who are involved in patient care across inpatient, outpatient, and outlying campuses. The committee also includes ad hoc members from the Philanthropy Section, including members of the volunteer and guest services department. The Family-Centered Care Specialty has used various methods

to collect the thoughts, feedback, and ideas of patients who have experienced care via different access points in our hospital system, including inpatient units, outpatient clinics, and emergency departments. The voice of these patients has been gathered through creative avenues, such as play activities, special patient events, one-on-one conversations, and question and answer sessions.

Recently, Children's Mercy accelerated improvement efforts surrounding comfort during needle procedures, including increased emphasis on topical numbing medication usage and comfort positioning. The Family-Centered Care Specialty saw this as an opportunity to explore the patient perspective on comfort during procedures and developed an electronic survey to learn what patients would choose and advocate for when it comes to procedures.

Patient Survey

The electronic survey was conducted with 50 patients, ages 3-18 years, during a five month period. Participants included inpatients and outpatients in various areas of the hospital. Patients were either given an iPad to take the survey on their own or a child life specialist verbally asked the patient the survey questions and documented their responses. Survey responses were gathered and stored via a secure database, REDCap. Questions included:

- If you could have anyone in the room to help you while you are having a procedure, who would it be?
- If you could choose how many people could be in the room while you are having a procedure, what number would you choose?
- Do you like being told about what is going to happen before a procedure?
- Who would you want to tell you about the procedure?
- What do you want to be told?
- Do you like to watch what is happening during a procedure?
- What do you choose to do instead of watching?
- Would you want numbing medication during a needle procedure?

- What is the most helpful thing to you when you have a procedure?
- What is the scariest thing to you about having a procedure?
- What else do you want us to know about helping kids with procedures?

Survey questions aimed to listen to the patient voice and examine patient preferences during procedures as well as desired coping support. In the following paragraphs, we summarize our key findings of the patients' voice, focused on how the hospital's culture can best support patients prior to and during procedures.

Results

According to a recent report from the Association of Child Life Professionals, "research demonstrates that there are benefits of allowing parents/caregivers to be present in medical settings" (Boles et al., 2020, p. 19). In our survey, the patients' voice supported this finding; 86% of patients said having a parent/caregiver with them in the room would be the most beneficial during a procedure. When asked how many people patients would want in the room, 66% of patients stated they would want three or fewer people in the room during a procedure.

It has been previously documented that most patients want to know what is going to happen before a procedure (Breiner, 2009) and are better able to cope with the hospital experience when provided with developmentally appropriate preparation by a CCLS (Boles et al., 2020). In our survey, a patient stated, "it helps to know what will happen." We found that 43% of patients voiced they would want a child life specialist to prepare them, and 50% of patients surveyed would want a nurse to tell them what was going to happen. Similar to our results, Lambert, Glacken, and McCarron (2013) noted "nursing personnel were identified as pivotal, interjecting, assisting, and making it easier for children to understand the medical team" (p. 346). When inquiring what patients would want to know prior to a procedure, our survey revealed that 72.1% of patients wanted to know what they would feel and how long the procedure would take, and 76.7% stated they would want to know what they needed to do during a procedure and if it would hurt.

When asked if patients would want to watch a procedure, the results were variable with 38% of patients stating they would watch, 36% stating they would not watch a procedure, and 26% stating they would sometimes watch a procedure. For those patients that expressed not wanting



to watch the procedure, the two most identified alternative options were looking at something else and closing their eyes. Only one patient chose guided imagery as an alternative focus option during a procedure.

The results supported current hospital efforts to increase pain management and the use of topical numbing medication prior to needle procedures, finding that 100% of patients would want a topical numbing medication to be offered during future needle procedures. When provided choices for coping strategies and asked what would be the most helpful, the survey results indicated that 56% of patients would want to engage in deep breathing along with 60% of patients wanting to hold someone's hand.

Survey results indicated that when patients were asked what the scariest thing about a procedure would be, 58% said pain was the scariest thing, 34% stated not knowing what would happen would be the scariest thing, and 30% said being held down would be the scariest thing. One patient stated: "be as gentle as you can and go through the steps with [the patient]."

Sharing the Patient Voice

The Family-Centered Care Specialty reviewed the data collected and created a document titled "Top 10 Things Patients Want YOU to Know about Procedures!" The document was shared with all 8,000+ hospital staff via an internal hospital website. This summary document put the patient voice into an easily digestible format for all staff to understand what patients would advocate for regarding procedures. It served as a call to medical staff, caregivers, and

[continued on page 10](#)

X is for Patient eXperience: The Patient Voice

Child Life Specialists surveyed 50 patients ranging in age from three to 18 years old on what helps them cope with procedures!

Patients were surveyed on inpatient units, in outpatient areas, and in the emergency department.

Top 10 things patients want YOU to know about procedures!

1. Of the patients that had a poke, **100%** said yes or maybe they would want the numbing topical used again!
“It’s not always used, even when I ask. It should always be offered.” — In response to what else do you want us to know about numbing agents.
2. **58%** of the patients said the scariest thing was PAIN.
Followed by 34% not knowing what will happen and 30% said being held down is the scariest thing.
3. **77.6%** said YES when asked if they want to know what’s going to happen before a procedure.
4. **60%** of patients said holding someone’s hand during a procedure is what helps the most!
What else helps? **56%** said taking deep breaths.
5. **86%** of patients said a parent/caregiver when asked if they could have anyone in the room with them. **44%** said a Child Life Specialist, **28%** said their nurse, and **12%** said other.
6. **38%** said YES, they like to watch what’s happening during a procedure, **36%** said no, and **26%** said sometimes. A reminder that every patient is unique!
7. How many is too many? We asked patients how many people they want in the room!
One person: **6%** Two people: **32%** Three people: **28%** Four people: **16%** Five people: **18%**
8. **50%** of patients want their NURSE to tell them about their procedure! **43%** said the Child Life Specialist, **40%** said parent/caregiver, and **15%** said other.
“Whoever’s going to do the procedure,” one patient requested.
9. **76.7%** of patients want to know what THEY need to do during a procedure and if it will hurt.
10. **72.1%** of patients want to know what they will feel and how long the procedure will take.

For more information on ways to help patients cope with procedures, ask a Child Life Specialist!

hospital administrators to take note, which many did. The medical team at Children’s Mercy posted numerous comments on the internal website supporting how important this patient voice is to the culture of Children’s Mercy. One staff nurse shared, “This is such a great reminder of who is really in charge of our cares....It’s all about the kids!” A psychologist commented, “It is fantastic to hear the voices of kids weighing in on this topic. Pain prevention is always important, individualizing the care for each child will help them feel the most comfortable during these routine procedures!” Another nurse stated, “This survey is such a meaningful look into what truly adds value to the care we deliver to young children and adolescents.” After reading the survey summary, one medical provider consulted the Family-Centered Care Specialty to assess how they could further gather the patient voice to improve care and hospital processes centered around a specific procedure.

The results of our survey, the patient voice, supported core values and evidenced-based practice of child life professionals. The daily work of child life specialists involves asking patients about their experiences, preferences, and ideas. We hope that our small sample survey gives others the inspiration to take this daily work a step further, to create surveys or other methods to formally gather and amplify the voice of our patients. Conducting this sort of investigation continues to uphold our commitment to the primary values of the child life profession, and our simple survey provided valuable feedback that impacted the care provided to the patients. We plan to continue using our survey results to expand education to other medical staff to make positive change throughout the hospital system. We will continue to learn from the most valuable resource in the hospital, the patients, and we encourage you to do the same. ✨

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FULLY LOADED ELECTRONICS

Video Game Slang for the Child Life Professional

Few things reduce fear, anxiety, and pain in humans more than humor does. Few people are better at connecting with a fearful or anxious child than a Child Life Professional. While it may be hilarious for a kiddo to listen to their specialist be a total n00b when it comes to the video gaming devices they love so much, this list will help you level up your gaming slang. Dropping these bits of knowledge on your video game obsessed kiddo will either draw laughter or will help you pwn (that's not a typo) the room — we call it a win-win.

- 1 **N00b or Noob** — derived from the word newbie, noob refers to a new player who is not skilled in playing video games.
- 2 **Pwn or pwned** — derived from a typo of the word own, this means “domination,” and used most of the time to describe the humiliating defeat to the opposing team.
- 3 **Poggers** — amazing — usually used in a chat when a gamer pulls off a sick move or does something that is hype-worthy.
- 4 **Scrub** — a player who does not have the proper skills but believes that they are the best player.
- 5 **Smurf or Smurfing** — “smurfing” is used when an experienced player creates a new account for the purpose of disguising themselves as a noob and use their skills to defeat inexperienced opponents with ease.
- 6 **Grinding** — explains the amount of time needed to build character experience, power, strength, and items in a game.
- 7 **Easter Eggs** — features, often useless, hidden within a game that you can either find or unlock. Oftentimes they are nods to other games, films, or general gaming culture.
- 8 **Farming** — gathering items and supplies necessary to progress in the game.



9 **Mats** — materials — usually referring to in-game resources for building items like weapons or shelter.

10 **Gank** — a gang of players team up and attack one solitary opponent.

While the list could go on, these top 10 will help interpret the language of, and engage with, the children in your care.

Like video game heroes, Child Life Professionals spend their time supporting allies, restoring health, and removing harmful or otherwise negative stressors in their area of effect (AoE for you gamers out there). Unfortunately, Child Life Professionals can't hit the reset button or rage quit (another bit of slang there) when times get tough and must rely on a full arsenal of communication, distraction, and entertainment tools in order to effectively perform their jobs.

Video game devices have been a staple in bedside entertainment for years. Loaded with age-appropriate games and patient centered activities, gaming consoles provide essential distraction

and entertainment for patients. Hospitals with gaming systems report a significant increase in patient satisfaction scores, and those who partner with Fully Loaded Electronics do so with the backing of superior tech support and worry-free device guarantees.

Fully Loaded Electronics makes it easy for Child Life Specialists to provide entertainment to their patients. We deeply appreciate the important work of hospital staff and our mission is to make video games simple, fun, and worry-free so you can get back to pnwng the care of your patients. While child life specialists may not get a badge at the end of each shift, partnering with Fully Loaded Electronics will get you the gold star of approval from kids of all ages.

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The Common Thread of Language

Christy C. French, MS, CCLS

NORTHWELL HEALTH, MANHASSET, NY
ELIZABETH SETON CHILDREN'S HOSPITAL, YONKERS, NY

Language has intrigued me for years. Growing up I desperately wanted to be multilingual. I yearned to understand what was being said in other languages, to be privy to the many stories told, and to belong to something greater. In grade school, I jumped at the opportunity to take a foreign language and my undergraduate degree is in French. At the same time, I also had an interest in teaching and eventually pursued a master's in early childhood/elementary education. As chance would have it, my first year teaching I was asked to develop a preschool-kindergarten French program, allowing me to combine my early childhood knowledge with my French skills. It seemed meant to be, but several years later in a twist of fate, I discovered child life, a profession that demonstrates the importance of language when working with children and families. Language interfaces with the practice of child life in many ways, from how we give our “elevator speeches” when defining our role, to explaining a complex procedure to a preschool child, to the connections we make with patients and families, but it is *proficiency* in

the languages of child development, play, ethical responsibility, and leadership that unequivocally ensures the child life specialist will have a positive and profound impact. Language clearly represents a common thread in the fabric of my existence, but veritably language connects us all.

I was introduced to child life when my youngest was admitted to the hospital for an emergency appendectomy. Shortly after arriving, an individual came into the room who transformed our experience. It was unclear who this person was at first – he wasn't dressed in scrubs, he didn't have a badge – but he quickly demonstrated his valuable role. Later he told us his name and official title, Certified Child Life Specialist (CCLS). My husband and I were equally impressed by the compassionate, creative ways he interacted with my son, in addition to how he calmed the room. Thankfully my son's surgery went well, and we were only in the hospital for a few days. During that time, I began to do some research on child life and came across the Association of Child Life Professionals (ACLP) website. It was there I uncovered the mission, values, vision, operating principles, codes, and guidelines for professional conduct (ACLP, 2011). As I gathered more information, it became clear that child life represented much of what I stood for and hoped to achieve; it spoke my lan-

guage. Today I feel extremely grateful and privileged to say I am a Certified Child Life Specialist, where I see the power of our practices and the many languages we speak. The different languages of child life, including the applied languages of child development, play, and ethical responsibility, as well as the inclusive language of leadership, are integral to the relationships we build and the outcomes we create.

Just as my husband and I recognized how much child life supported our child during a stressful medical experience, nurses and doctors also take note. The nurse who placed my son's IV said, "We love child life!" and recently a doctor said to me, "The way you speak and interact with the children before surgery makes a huge difference." In witnessing our work, the multidisciplinary team can help validate theory put to practice, highlight the significance of language, and champion the role of child life.

In 2017, I enrolled in a child life master's program. Several of the classes focused on the language of child development, more specifically cognitive theories, social learning theories, and system theories, as well as theories about attachment, temperament, psychosocial development, stress, and coping. "As child life practitioners we draw from a collective source of formal theories to shape and drive our contemporary practice" (Thompson, 2009, p.23). Articulated by different theorists, the language of child development guides, informs, and supports our practices. It provides a framework in which to see and relate to the whole child and scaffolds our interventions. The goal in selecting specific language is to account for a child's developmental level, incorporate familiar terms, and make choices that reflect "the softest, most honest language" (2009, p.182). When preparing preschool to school-age children for surgery, child life specialists often describe anesthesia as "sleep medicine" or an IV as a "tiny straw" that gives your body the medicine it needs; such language choices are non-threatening and promote coping and understanding. Equally important, a CCLS must model

and convey to the multidisciplinary team the importance of developmentally appropriate words and actions. Just as my husband and I recognized how much child life supported our child during a stressful medical experience, nurses and doctors also take note. The nurse who placed my son's IV said, "We love child life!" and recently a doctor said to me, "The way you speak and interact with the children before surgery makes a huge difference." In witnessing our work, the multidisciplinary team can help validate theory put to practice, highlight the significance of language, and champion the role of child life.

Play represents another powerful instrument in terms of understanding children and nurturing growth. Several theorists, such as Axline, Erikson, Piaget, and Vygotsky, have highlighted the link between child development and play (Howard & McInnes, 2013). Play therapist Gary Landreth defines play as "the language of children," a language that "provides a developmentally responsive means for expressing thoughts and feelings, exploring relationships, making sense of experiences, disclosing wishes, and developing coping strategies" (2012, p.12). Play represents an infinite resource that "provides the child life specialist the rare opportunity to understand the child's world and allows a flow of communication when other forms of interpersonal connection are difficult" (Thompson, 2009, p.156). As a specialist working in an outpatient ambulatory surgery center, I use medical play to help support children going into surgery. This form of play allows children to be in control of their situation (e.g., child states their doll wants the IV in the right arm or their stuffed animal to count to 10 before taking medicine), to express themselves (e.g., child might share their toy feels scared), to process information (e.g., playing out the day of surgery), and to clear up any misconceptions (e.g., the child life specialist might help explain to child's doll that an incision is a small opening, they will be asleep, and they will put special band-aids on it to allow it to get better). It enables each child to be seen and heard, provides a sense of freedom and familiarity, and builds trust. Play is a powerful, universal language.

Concurrently, understanding the language of child development and embracing the language of play falls under the code of ethical responsibility (ACLP, 2011). As child life professionals, we strive to maximize the physical and emotional health as well as the social, cognitive, and developmental abilities of children and minimize the potential stress and trauma that children and families may face. We have "an

[*continued on page 14*](#)

The Common Thread of Language

(ethical) obligation to serve children and families, regardless of race, gender, religion, sexual orientation, economic status, values, national origin, or disability” (ACLP, 2011, p. 3). We must respect the multitude of human experiences, continually examine our biases, listen carefully to each patient and family, and communicate mindfully. Careful attention should be demonstrated when working with our most vulnerable populations; this includes articulating culturally sensitive language when interacting with LGBTQ+ youth and implementing culturally competent care for *all* (Keo-Meier & Ehrensaft, 2018). When introducing myself, I state my pronouns (she/her/hers), am intentional about creating open-ended conversations, deliberate with my inquiry, and avoid making assumptions. My goal is to create a safe space where I can identify the individual needs of the patient and family. It is our moral duty to honor the language that best describes each experience in order to promote resilience, coping, and wellness.

Child development, play, and ethical considerations provide the foundation for our practices as child life specialists, but it is the language of leadership that provides a compass to navigate us through all of our experiences, both personal and professional. I was introduced to the language of leadership during my final semester of my child life master’s program by an insightful, discerning professor and CCLS; together we explored what it means to be true leaders in our practice as child life specialists and beyond. My definition of leadership changed dramatically. Initially I defined leadership as a person guiding or directing a group toward a common goal, but I soon learned that a leader can be “anyone who takes responsibility for finding the potential in people and processes, and who has the courage to develop that potential” (Brown, 2018, p.4). The language of leadership focuses on the collective experience, and a successful leader knows the discourse will be incomplete without the contributions of

every person. As child life specialists, we may be called upon to be leaders in a variety of situations; therefore, we must be erudite in the language of leadership. We must understand the importance of giving everyone a voice, enabling ideas to be shared in all forms. Additionally, the language of leadership embraces universal humanity, making diversity a priority and creating cultural synergy (Molinari & Shanderson, 2012). Ultimately, it boils down to awareness of self and others; looking at who you are, what you can learn, and how you can move forward together. The language of leadership points us toward our true north, towards a conscious and cohesive existence. With such awareness comes shared insights (Eurich, 2017), knowledge that informs us in obvious and subtle ways, and knowledge that promotes growth. The language of leadership is an invaluable tool. As child life specialists and global citizens, I urge you to take advantage of not only the foundation of child life, but also this golden compass. I encourage you to recognize the nuances within your partnerships; this is where validity exists, where optimal results will ensue. Missing the obscurities obscures the truth. Legitimacy lies in the shared experiences, tied together by the common thread of language, where everyone counts.

Everybody counts.
When the spider
Weaves the web
No connecting point
Is missed.
If you are missing
From our midst
We are the lesser
For that loss,
And incomplete.

— J.BROWN, 2008 ✨

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Rebecca Gordon, MA, CCLS

NORTON CHILDREN'S HOSPITAL, LOUISVILLE, KY

In the constantly changing world of health care, new ideas and ways of thinking contribute to continuous progression in serving patients and families as they encounter the stressors sourced from new people, places, and experiences. As child life specialists, psychosocial professionals, and advocates for best practice, considerations are to be made for moving beyond what has always been done and transition to opportunities for a new standard of care. Over the past several years, new audio-visual technology has allowed for alternative approaches to many educational and interventional services. Specifically, virtual reality has become an innovative tool in the health care setting for education, distraction, and play for diversion as a way for users to be immersed into a world beyond their own. However, what if a tool used to submerge a child into a world of star-gazing, marine life-viewing, and dinosaur-hunting could be used to allow children to be transported into a room that will soon become familiar for medical procedures such as MRI's, CT scans, surgical procedures, and more, all from the comfort of their own hospital bed?

When evaluating the ways in which we as child life specialists support the psychosocial well-being of patients and families prior to procedures, the question is how to adapt to

the needs of children raised in a world of technology while being fiscally mindful to one's own institution. Through use of virtual reality goggles donated by outside organizations, cost-free applications, and coordination with hospital departments, 360-degree preparation materials were created by the child life team at Norton Children's Hospital to allow patients a greater understanding and viewpoint of rooms they will encounter during their hospital stay. According to Bray (2019), "If children understand and can develop realistic expectations about what will happen when they come to hospital, they can become more active in healthcare encounters and more engaged in making choices" (p. 627). While this mindset is both valued and practiced in the field of child life, moving beyond photo, video, and auditory preparations by utilizing 360-degree photo preparations within and outside of virtual reality allows this perspective to be broadened.

Street View, an application by Google, allows users to view landmarks, city streets, and geographical areas by transforming multiple photo sets into a 360-degree view. Users can move their screen to view at varying vantage points while being visually integrated into the location-based photo-sets, which can be accessed later on compatible mobile, desktop, and virtual reality headset devices. By use of the Street View application at Norton Children's Hospital, hospital-specific 360-degree preparations were created to further support

patients and families prior to procedures, inpatient stays, and potential stressors related to hospitalization with no cost to the department. Coordination with various departments including risk management, security, public relations, child life, surgery, inpatient units, and radiology was necessary when publicly posting photos through this outlet. Once gaining appropriate permissions within their establishment, institutions can follow the instructions below to create individualized 360-degree preparation tools for their patients and families. The instructions are fairly intuitive but are described here to assist the specialist in the development of the tool.

Immersive Preparation Tool Creation Steps:

1. Download Street View app onto mobile device such as cell phone or tablet.
2. In the lower right-hand corner, select the orange camera button and then choose "Photo Sphere."
3. Point the device's camera at the room to include orange dots.
 - a. Stay in one spot until dot disappears and new ones appear.
 - b. Photos will overlap; use the undo arrow in the lower left-hand corner to undo a photo if it needs to be redone.
4. When the 360-degree photo is finished, the checkmark below the photo will light up green. Press the checkmark to complete the photo.
5. Your photo will show up as "Ready to publish." Click select and choose the 360-degree photo you have made.
 - a. Click on "..." in upper right-hand corner of photo, and select "Edit Location."
 - Move location dot to your hospital (ex: Norton Children's Hospital).
 - b. Click "pick a maps listing."
 - Click or enter appropriate address (ex: Norton Children's Hospital).
6. Click the upload arrow in upper right-hand corner of the photo and then select "Publish."
 - a. Within a few minutes, Google will approve your photo. Once approved, you will be able to view on your VR goggles on the Street View app by searching for the institution's name or street address.

When creating these preparation materials, multiple attempts may be needed when taking 360-degree photos while using a mobile device. Child life specialists taking these photos may benefit from practicing this process prior to arriving in areas that may be time sensitive due to patient



Compare this two-dimensional photo to the 360-degree perspective in the photo at the beginning of the article.

care. Practicing in a room without time constraints will allow child life specialists to practice aligning image sets and to gain familiarity with the system prior to completing preparations. Standing in one place while rotating your entire body, or sitting in a rotating chair, ensures that the photo becomes consistent and lines up evenly. Additionally, finding an area to take photos at the center of the room

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A Familiar Room: Creating 360° Photo Preparation Tools through Street View by Google



Patient using virtual reality and 360-degree preparation tools to prepare for a CT scan.

provides effective results in maintaining even distribution of multiple overlapped images. Child life specialists working to create these preparations should keep in mind vantage points applicable to a child and consider including potential machines, materials, and staff members that patients may encounter during their procedure to adequately prepare for as well as address any potential stressors or questions arising during preparation.

Child life specialists should utilize assessment skills in determining proper patient populations for virtual reality preparation using 360-degree photos. Among child life specialists at Norton Children's Hospital, virtual reality preparation has been deemed an effective preparation tool when used with patients assessed to have an ability to regulate and connect their understanding of the virtual world to the actuality of their upcoming procedure. For children who face motion sickness or have a history of seizures, immersive preparation may not be appropriate. However, 360-degree photo preparations on a desktop or mobile device can serve an alternative for institutions without virtual reality tools and for patients who may benefit from alternative forms of preparation.

Since trialing the use of 360-degree preparation tools both inside and outside of virtual reality, patients and families have expressed that this means of preparation has effectively lessened pre-procedural and pre-admission anxiety, while

also offering a unique sense of familiarity when entering rooms experienced with virtual reality. During a recent encounter, child life was called to prepare a school-age patient with no previous hospital experience for a CT scan. Prior to preparation, the patient expressed strong anxiety and fear in regard to the upcoming procedure. When presented with virtual reality as a preparation tool, the patient brightened immediately and was conversational throughout. Occasionally, the patient would ask questions about different medical equipment in the virtual reality preparation and expand the conversation about the items she already recognized. After several minutes, the patient removed the headset and simply stated "well that's not scary at all." While patients and families continue to verbalize positive implications of virtual reality and 360-degree preparation tools, in the future empirical research would provide an opportunity to gain greater insight into the effectiveness of these tools in contrast to traditional preparation approaches.

At Norton Children's Hospital, conversations surrounding the use of both 360-degree preparation and virtual reality have been expanded further due to the impact of COVID-19. During the early months of the pandemic, child life staff members were limited to direct patient care with patients in non-isolation rooms. By using the patient's room phone and available devices, preparation was able to be completed using the 360-degree photos in a non-direct capacity until

our restrictions were ultimately lifted. For institutions using Zoom, screen-sharing features are an additional opportunity to expand preparing patients when face-to-face preparation is not an option. Due to changes in visitation policies, child life specialists within the pediatric intensive care unit and cardiac intensive care unit have discussed possible opportunities for sibling support through use of virtual reality. This could offer siblings a view into the patient's life at the hospital without going directly onto an inpatient unit and provide an opportunity for sibling education and dialogue. Additional conversations have occurred when discussing department-wide alternatives for pre-operative tours. Both of these alternatives could theoretically take place in a lobby setting when siblings and outside guests are allowed.

Within the Association of Child Life Professionals's value statements, it is emphasized that we as child life professionals value "the commitment to excellence and integrity in our professional practices [which] involves lifelong learning, adherence to our code of ethics, and the development and support of educational and training programs based upon defined clinical competencies" (ACLP, 2011). As child life professionals, we are obligated to not only provide the services with which we are familiar—but also to explore new ways of thinking to better serve our patients and families. Each day patients step into a world of health care that proves to be an intimidating reality. Through virtual reality and 360-degree preparation, child life specialists can work to transform a room that was once unfamiliar, intimidating, and distant to become simply just another room. ✨

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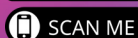
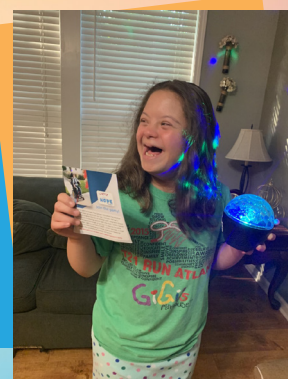
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SUPPORTING TRAUMA-INFORMED CARE THROUGH A PATIENT-DIRECTED INTERVENTION

Sarah Braukman, CCLS, TRCC, CTP

CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER, CINCINNATI, OH

For child life professionals, the six guiding principles of trauma-informed care (Center for Disease Control and Prevention, 2020), as are presented below, are familiar and congruent with a long-held philosophy of care. The goals of child life specialists organically support trauma-informed practice as they are inherently flexible in nature and routinely center on choice and control, felt safety, therapeutic relationships, skill-building, strengths, and resilience as a means to help mitigate stress and trauma from health care. It is an exciting time for the profession to become more intentionally involved in creating processes that align with trauma-informed care and reinforce the work that is already known to be so imperative to patients and families. Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, awareness, sensitivity, and cultural change at an organizational level (SAMHSA, 2019).

Developing a Trauma-Informed Quality Improvement Project

At Cincinnati Children's Hospital Medical Center (CCHMC), an interdisciplinary working group with representation including leadership, integrative care, music therapy, and child life, has been engaging with intentional work founded in the principles of trauma-informed care. One goal was to invest in a project that enhances the work that is already being done by Child Life and Integrative Care's (CLIC) collective professions. CLIC at CCHMC is well positioned in trauma-informed practice and is not looking to recreate professional practice, but instead to provide a more intentional trauma-informed foundation to back up the work already being done. The second goal was to choose a project that was pediatric patient centered. Much of the trauma-informed work in this institution and in the literature thus far has been parent or adult focused, and this was an excellent opportunity to use dedicated expertise related to children and adolescents. The final goal intended to foster

6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:



Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

division collaboration by choosing a project that encompassed the various professional strengths, commonalities, and differences of each discipline.

Narrowing down initial lofty goals to one specific, actionable goal required a thorough and lengthy process. There were many brainstorming sessions and restarts before the group settled on creating a patient-centered goal process. As a collective group of professionals, the CLIC division excels at assessment, goal setting, and involving patients and families in the daily work. It was an intriguing idea to ask what would happen if the patient was approached as a blank slate and first asked for their perspective, and then not only listened to, but encouraged to set the action steps. This idea balanced the clinician assessment with the patient perspective, which aligned well with the guiding principles of trauma-informed care through collaboration, choice, and empowerment, and may foster a sense of self-efficacy, the belief that one has the ability to produce desired outcomes (Bandura, 1977).

The Pediatric Intensive Care Unit (PICU) was chosen for this quality improvement study due to the best overall access of patients to the three disciplines participating in the study: child life, music therapy, and holistic health. A note of consideration throughout this project was staffing. The CLIC division at CCHMC is significantly weighted in child life clinicians; therefore, in spite of wholehearted endorsement and support for the services of the other disciplines within the division, there was a need to maintain a reasonable rate of demand on their services. The acuity of the PICU assisted with keeping the number of “goal-eligible” participants at a reasonable level while the tool was tested. Cognitive functioning played a role in determining eligibility for the study, as did acuity and appropriateness of patient condition. For example, if a family received distressing news that day or had just arrived on the unit, it was very quickly determined to be inappropriate to introduce this patient-directed intervention, even if the other admission criteria for the study were met.

Designing the “I Can” Tool

The next step was fleshing out what the patient-directed goal would look like both visually and in practice. It was through a suggestion by one of the PICU physicians that the idea of an “I Can” goal began to be explored. Recreational therapy colleagues were able to share that a similar approach

to goal setting was often utilized with their mental health patient population with success. The research group gravitated towards the simplicity of this concept and appreciated that it took a positive approach towards goal-setting, was empowering, and allowed the participant to see and own their progress.

The first version of the “I Can” tool offered both suggestions for goal-setting as well as an open-ended option for the patient to drive their own goals (see Figure 1). The tool was equipped with prompts to help the patient decide which disciplines would be the most helpful for them to accomplish their designated goal. The hope was to not only allow the patient to set the goal, but to empower them to choose who they felt should help them. To do this effectively, the patient needed to understand what supports were available to them and grasp, at least on some level, what that support might look like. Finally, the tool needed a component to help the patients visualize and track progress. Color was important, as was the visual cue presented on the tracking tool. After referencing existing tracking tools, such as the FLACC Behavioral Pain Scale and the Stress Thermometer, the group decided to incorporate a visual that did not present extremes, therefore allowing more room for individual interpretation.

After trialing the tool a handful of times and using feedback from the patients themselves, a second version was created with the intention of providing a tool more appealing to older patients. The visual faces were removed from the measurement scale and wording was updated on the goal descriptions to reflect a more developmentally advanced age (see Figure 2). Moving forward, patients would be permitted to choose the tool with which they wanted to engage.

Data Collection

Once the group felt the “I Can” tool was ready, the PICU child life specialists began to explore opportunities to introduce this tool to as many study-appropriate patients as possible. Of note, the child life specialist was selected as the clinician designated to introduce the tool, again due to the greater overall availability of child life staff within the division. For those who chose a goal, the PICU specialist would then provide some general information about the three disciplines available for referral and the patient would choose

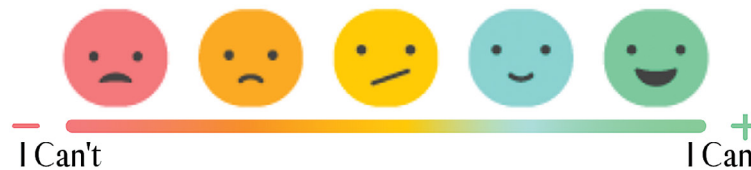
[continued on page 22](#)

I CAN ask questions
 I CAN be calm
 I CAN have choices
 I CAN make my room comfortable
 I CAN _____

To make progress, I CAN use:

Child Life	Music Therapy	Holistic Health
<ul style="list-style-type: none"> • help during procedures • understand diagnosis/treatment • have someone to talk to • play • learn coping strategies 	<ul style="list-style-type: none"> • listen to relaxing music • learn/play an instrument • write/record a song • talk about music • learn coping strategies 	<ul style="list-style-type: none"> • use guided imagery • use meditation • get a massage • use energy work • learn coping strategies

Where are you today?



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Figure 1.
"I Can" Tool, Version 1

I CAN ask questions about my care and treatment
 I CAN find ways to feel calm when I am worried or stressed
 I CAN ask for things that make me more comfortable during my stay
 I CAN learn and practice skills I feel remind me of my own strength
 I CAN _____

To make progress, I CAN use:

Child Life	Music Therapy	Holistic Health
<ul style="list-style-type: none"> • help during procedures • understand diagnosis/treatment • have someone to talk to • play • learn coping strategies 	<ul style="list-style-type: none"> • listen to relaxing music • learn/play an instrument • write/record a song • talk about music • learn coping strategies 	<ul style="list-style-type: none"> • use guided imagery • use meditation • get a massage • use energy work • learn coping strategies

Where are you today?



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Figure 2.
"I Can" Tool, Version 2

I Can: Supporting Trauma-Informed Care through a Patient-Directed Intervention

if they felt child life, holistic health, music therapy, or a combination of support would best help them move towards the “I Can” end of the line. Additionally, a Smart Phrase was created for the EPIC charting system to allow the creation of a goal in the patient’s Plan of Care related to the “I Can” statement, which could then be charted collectively by the various disciplines selected by the patient to help them work towards their goal.

Basic data collection was maintained to help the research group determine patient interest and engagement, including notation of which services were selected by the patient as well as the dates of admission, introduction, and follow up. Additionally, the PICU CCLS kept a narrative regarding patient interactions so the research group would be able to learn from both the introduction of the tool from a professional perspective as well as how patients and families responded to the tool.

Over the course of this four-month quality improvement study, 33 patients were identified as meeting the study criteria: non-sedated, developmentally appropriate, English-speaking, and between 6-21 years of age. Of these, 13 patients received information about the “I Can” tool and were able to make a decision to decline or to set a goal (see Table 1). The child life specialists in the PICU were unable to connect with the remaining 20 patients due to a variety of variables including patient acuity, transfer from PICU, and high alternate unit needs.

Lessons Learned

The goal of any quality improvement study is to learn. As families were asked for feedback, many noted an appreciation for the sense of control and autonomy that the “I Can” tool provided. The first patient to engage with the “I Can” tool was awake and intubated. She chose the goal to “make my room more comfortable” and the CCLS followed her lead in decorating her room. Her caregiver remarked specifically on the positivity that came from giving her something she could control in a medical situation where she could easily feel less autonomous.

It should come as no surprise that each participant engaged with the tool in their own unique way. Some chose their own goals, while others selected from the provided list. One patient decided that her goal should be to “eat Doritos,” and she quickly marked her goal as completed on the “I Can” line as she happily munched her chips. One patient was able to articulate that his goals were already being met by a number of resources, which he readily identified. Some used the tool as a way to enhance access to a relationship they already enjoyed

Table 1.
Summary of Study Participants

For the purpose of this article, the data below gives a general overview out of respect for participant’s confidentiality.

RESEARCH NUMBER	ENROLLED YES/NO	CHILD LIFE YES/NO	MUSIC THERAPY YES/NO	HOLISTIC HEALTH YES/NO	MOST RECENT PRAP SCORE	NOTES
1	Yes	Yes	No	No	5	Patient intubated & awake
2	Yes	No	No	No	5	Adapted tool to select self to support goal achievement
3	No	–	–	–	–	
4	Yes	No	Yes	No	4	
5	No	–	–	–	4	Patient asked for time to consider, but follow up was unable to occur
6	Yes	No	No	Yes	5	Patient was unaware of holistic health supports prior to study
7	No	–	–	–	6	
8	Yes	Yes	No	No	–	
9	Yes	Yes	Yes	Yes	5	Patient chose to further identify specific pieces from the tool (from the itemized bullets under the disciplines) to help target chosen goal
10	Yes	Yes	Yes		3	
11	No	–	–	–	3	Patient identified all goals on tool, but declined participating as identified self to support goal achievement
12	Yes	No	Yes	No	–	
13	Yes	Yes	Yes	Yes	–	Tool utilized in interdisciplinary conversation

and perceived as valuable, which aligns with the guiding principles of trustworthiness and safety. And, of course, some declined, which can also be an empowering choice.

The biggest takeaway from all of these encounters was the reinforcement that incredible things can happen when one asks a question and then listens. There is tremendous potential to create collaboration both with the patient and family as well as with the various disciplines with whom they inter-

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I Can: Supporting Trauma-Informed Care through a Patient-Directed Intervention

face. When clinicians allow the patients to come alongside them in intentional collaboration, a trauma-informed foundation begins to form, creating a practice in which one can readily identify the presence of the six guiding principles.

The “I Can” tool created gateways to communication, not just between division disciplines and the patients and families, but also between other health care providers and the patient and family. The final participant in the quality improvement study was a seven year old boy. His chosen goal was to “be super happy.” This patient had previously expressed thoughts of self-harm and emotional distress and already had a referral to see behavioral medicine during his admission. The patient engaged very thoughtfully, not only with the tool, but also in how he chose to fill it out. He and the child life specialist were able to have an honest conversation in which he reflected that all of the disciplines on the tool helped him to feel happy “sometimes,” but nothing worked all the time. By itself, this was an insightful reflection from someone so young; however, the child life specialist was also able to connect with the behavioral medicine clinician and let her know about this goal and conversation, as well as where the patient had chosen to hang the goal in his room. It is unknown if behavioral medicine referenced the “I Can” goal with the patient, but it was an open door for her to use as desired during their interaction. It was interactions like these that led the research team to feel encouraged about the potential for the patient-directed goal process to connect the patient’s treatment team in a way that is not only cohesive, but that originates with the patient themselves. How incredible would it be if health care evolved to where patients and families owned and drove their own health care team and experience?

Despite positive takeaways, the team uncovered some challenges to implementing the “I Can” tool in the PICU. The

biggest challenge was staffing and access to services. Access to the support of integrative care and music therapy was an anticipated challenge, but child life services are also often stretched on this high-needs unit. To engage patients with the tool, the PICU colleagues were being asked to specifically target these patients, and this was an interruption to what would have been their normal, organic work flow and prioritization. Acuity was also a factor. Often when patients were alert enough and ready to engage, they were preparing to transfer to a step-down unit and often discharged before follow up was possible.

This quality improvement project was an educational journey during which a new concept was introduced into clinical practice. At the conclusion of the project, there was evidence of potential for this tool to benefit patients and families, and there were also remaining unanswered questions. Primarily, this initial project was unable to effectively test long-term impact from subsequent interactions, both related to referrals to the selected disciplines and the patient’s own self-assessment on progress towards their identified goal. The group felt strongly, however, that the tool was worth continued exploration. An Institutional Review Board (IRB) proposal is currently undergoing revision with plans to implement a small pilot study of the “I Can” tool. Division clinicians have self-identified whether this patient-directed goal intervention might be a useful addition to their professional toolbox. The intention is to continue to learn from the use of the “I Can” tool with an inpatient population which may allow for assessing the long-term benefit of the intervention. This includes the recognition that even when a patient declines to set a goal or identifies other supports for the chosen goals, the patient is still communicating something to the care team about their needs and resilience. This realization, and the positive stories, make this a process worth continuing to explore. ✨

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Background Information: An Introduction to Licensure

The following Point/Counterpoint article is intended to familiarize the reader with the current connection between the profession of child life and the process of licensure. It is important to state first that at this point, in the United States, there is no licensure for child life. If there is licensure in any other country, a letter to the editor from a child life representative in that country discussing their licensing status would be welcome. This article will only be examining licensure from the perspective of the United States.

Across professions, licensure is always a function of the individual state. Although certification can occur on a national level, and professional standards are often established by national groups representing a profession, licensing of a profession is done at the state level. Usually, the process of licensure involves several steps. First, a new profession is established and develops standards of practice. The profession then expands geographically, and there is an increase in demand for the number of qualified practitioners. Educational standards are created, and educational programs are developed at the appropriate level for the profession. The next step is the formation of a national group representing the profession. This group typically takes the lead in finalizing the competencies, standards, ethical practices, and scope of practice of the profession. The national group will often take on the responsibility of creating a certification process to continue to standardize the core components of the profession. All these steps have occurred in child life, leading to the existence of the Association of Child Life Professionals and of the Certified Child Life Specialist credential.

At this point, the process to licensure becomes more complex. A variety of paths may be followed to move from certification credentialing to licensure. Typically, there is some sort of significant demand in a state to begin the process of establishing a new licensure status for a profession. The demand may come from the members of the profession, the national professional organization, members of the state legislature, another individual in power in the state, or the public. A state will consider the number of individuals practicing in their state, the cost of establishing a licensure credential, the impact on other already-licensed professions, and the risk to the public if licensure is not established. This process can be lengthy, expensive, and political. At the very least, to begin the process of state licensure, a bill must be introduced and passed by the state legislature to begin investigation of the possibility of licensure of the profession. Once licensure is established, it applies to all practicing members of a profession in that state.

In the following two discussions, the reader will hear about the risks, benefits, and challenges of seeking child life licensure in any state in the United States. The two authors in this article are experienced in traditional hospital-based child life, community-based child life, and private practice, and they will provide an overview of the pros and cons related to the establishment of child life licensure. The goal of this article is to bring forth discussion that will provide the child life professional with a more comprehensive understanding of the advantages and disadvantages of seeking to develop licensure processes.



POINT/COUNTERPOINT



Point: Child Life Licensure

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Licensure is not an easy process, nor does it address all obstacles in continuing to develop the profession of child life. So why continue to pursue it? What does licensure afford a profession over certification? Are the probable changes in requirements worth the effort to individual Certified Child Life Specialists (CCLS) and the child life profession? Is this profession living up to the vision and ingenuity Emma Plank showed when child life first began? Here is what my experiences have taught me in my recent years as a CCLS in private practice.

Consistency in Skills and Knowledge

The current child life certification does not provide any distinction between a bachelor's and master's level specialist, and because of this, there is a wide variation of skills and knowledge a Certified Child Life Specialist might have. Licensure would ensure that the level of education, practicum and internship requirements, and post-graduate professional hours would be more stringently defined and regulated.

The process of licensing distinguishes between a range of academic levels from bachelor, master, and doctoral degrees. At each level, each degree increases the scope of practice defined in the licensing documents. This ensures a standard of care consistent throughout the state. Professionals we work with equate being licensed as a higher measure of reliability in the knowledge and training needed to consistently administer to patients and families. For example, in the field of psychology, there are three levels of licensing: bachelor, master, and doctoral. In the case of child life, licensing boards could distinguish scope of practice as: a child life assistant, a bachelor's in child life, and a master's in child life. Different licenses for various levels of academic achievement could then be used to define the responsibilities of each level of licensure, support a defined clinical ladder, and create a benchmark for differentiated wages. Additional compensation could then become more structured and less arbitrary by looking at years of experience, involvement in specialized programs, additional certifications, or added responsibilities.

Expanding Employment Opportunities & Care

State licensed professionals are also afforded employment opportunities in other settings such as state programs and

community care facilities, as well as inclusion in insurance preferred provider listings. Being a listed provider with insurance companies could increase referrals for child life services. This opens career opportunities to the many who currently have achieved certification but are unable to find employment as a child life specialist. Application of child life skills is greatly needed in community facilities, private practice pediatrician offices, schools, and so much more. Owners and managers of these entities recognize what comes with a professional license, and they want the security of knowing the person serving their clients has met a substantial level of scrutiny and that each hire can consistently provide the described level of care.

By establishing licensure for the profession, insurance providers would be more willing to list child life which would improve funding for programs, leading to an expansion of programs, increased care for patients, and further providing evidence for the reputation of child life as a profession.

Becoming Essential

To some hospital administrators, child life specialists do not always meet compulsory conditions to qualify as essential staff. This lack of an essential designation could in turn lead to a decline in their necessity. This is often compounded by the fact that child life specialists' hours are a non-billable service. A hospital's budget may only cover part of child life services or even just a specific child life program, which limits the number of units and clinics that can offer child life services. Due to this, in many hospitals, child life departments must look elsewhere for additional funding from a foundation, grant, donations, or other external sources. If hospitals could recoup child life costs through insurance reimbursements, funding would no longer be as big of an issue, and child life programs would be able to expand.

However, in most cases, to be listed with insurance providers, a profession needs to be licensed.

In my experience, I have contacted several insurance carriers over multiple years and have always been denied listing due to lack of professional licensure. When a service is billable to insurance, it offers the opportunity for families and medical staff to request child life services in environments where it is not available and yet so needed. In my practice, families seeking support for medical, palliative, hospice, or bereavement have been unable to engage in my services due to 'fee-for-service' costs, even with a sliding scale option. Directors of in-hospital palliative and hospice programs have asked for my support, but I was unable to engage because of funding. Despite inquiries from families and facilities valuing the benefits of child life, their inability to pay or bill their insurance providers becomes the deciding factor in engagement. Without full insurance coverage for all child life services, the financial burden rests fully with the family. Child life should be available to all, not just for those who can pay.

On January 1, 2014, it became possible for privately contracted Certified Child Life Specialists to provide pediatric palliative services with an in-home provider under the Affordable Care Act Pediatric Palliative Care Waiver (PPCW). This was the first time a federal agency listed child life services and deemed them reimbursable by insurance. The services were limited to those diagnoses listed in the PPCW and must be administered under supervision of a licensed provider, but it gave child life noted stature in pediatric palliative care, a billing code, and an opportunity the discipline never previously had to be reimbursed.

Many child life specialists fear hospitals will use insurance billing to reduce their numbers. However, this fear is unwar-

ranted as hospitals already have licensed entities within their employment whose numbers have not been reduced. Occupational, physical, speech therapists, marriage and family therapists, social workers, and more are all state licensed and have a significant presence in the hospital. Child life would have a greater voice to expand if the hospital could bill for services and recoup the cost. Families would still receive child life services, but the hospital will be able to negotiate with insurance companies and receive reimbursement as they currently do with other licensed providers.

Lack of Legal Ramifications

To be a Certified Child Life Specialist means that the individual has met specific academic and clinical experience requirements in addition to passing the Child Life Certification Exam. The certification is issued by the Child Life Certification Commission (CLCC) which is independent of but aligned with the Association of Child Life Professionals (ACLP). Recertification occurs every five years in the individual's certification cycle. It is up to the individual to choose to keep their certification current, which entails renewals, annual maintenance, and more. When someone makes the choice to call themselves a Certified Child Life Specialist without pursuing or maintaining certification, a complaint must be filed with CLCC in order to pursue any legal action. There is no other legal recourse to prevent someone from using the CCLS credential. Practicing as a child life specialist without certification could not only jeopardize a child's well-being but it can also misrepresent the profession's credibility. If child life were a licensed profession, there would not be a choice for licensure if someone wanted to practice as a child life specialist. This level of uniformity across the profession would not only ensure consistency of care, but it would also provide legal consequences for non-compliance of maintaining licensure while practicing.

The Case for Licensure

What child life provides is unique and impactful on a child and their family. We are strangling our profession by not moving forward on becoming a licensed profession. Licensure would ensure consistent academic knowledge at the various degree levels, increase the overall reputation of the profession, and provide hospitals and programs with the option to bill insurance companies for child life services, which would not only increase the number of patients served but also employment opportunities for child life specialists. We have come so far. We need to continue to grow, not just in numbers, but in stature. ✨

Licensure would ensure consistent academic knowledge at the various degree levels, increase the overall reputation of the profession, and provide hospitals and programs with the option to bill insurance companies for child life services, which would not only increase the number of patients served but also employment opportunities for child life specialists.



POINT/COUNTERPOINT

Counterpoint: Risks and Challenges of Licensure for Child Life Specialists

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COUNTERPOINT

The reader has now been presented with several salient points regarding the benefits of licensure for child life. The most compelling point relates to the possibility of insurance reimbursement and ease of fee collection by child life professionals. However, this only impacts a very small percentage of individuals within our field, especially those in private practice. For most of us, there are as many risks to establishing licensure as there are benefits. The remainder of this article will present those areas of concern, including increased costs to child life specialists and their employers, the possibility of negatively impacting our relationships with other professions, the difficulties inherent in the long and challenging process of gaining licensure, and the ultimate question about whether the benefit to a few child life specialists outweighs the potential negative impact to many others in our profession.

Costs

Even though there is usually a legacy clause when new licensure is established, eventually all practicing child life professionals in any state which has established licensure would have to comply with whatever requirements were approved to continue working in their field. This includes those working in a hospital as well as those in the community or in private practice. These costs may include, but are not limited to, paying fees, taking an exam, and maintaining licensure through continuing education. Some newly licensed individuals are required to obtain additional training, additional college courses, approved work experience, and ongoing supervision, all which may entail further costs to the practitioner. Each state has the potential to establish different requirements for licensure, so the costs may not be standardized from state to state, which may be perceived as unfair by those in states with the highest costs.

The cost to a state for establishing licensure is based on administrative expenses, licensure board costs, and the ongoing maintenance of the licensure process, including new licenses, license renewals, ethical monitoring, and enforcement. This cost can be significant, is different for every state, and may be a prohibitive factor for many states, especially for those states with a low population of child life professionals. Even if a state is willing to invest in the cost of establishing licensure for child life, that cost will always be passed on to practitioners through fees.

Employers may also be impacted since they will be required to hire only licensed child life specialists. If salaries are standardized or even increased for some, that may mean that employers will have to make very difficult decisions about the number of child life professionals each institution can afford to employ.

Finally, increased costs may negatively impact our current initiative to achieve greater diversity in our profession. We know that the cost of child life education and clinical training is already prohibitive to those of lower income. This is not the time to make it more difficult for individuals from all backgrounds to enter child life.

Professional Relationships

Other professionals, especially those in psychosocial fields, may resent, disagree with, or attempt to prevent licensure of child life professionals. They may see such licensure as a threat to their professional domains. Currently, we successfully negotiate role responsibilities with other professionals. Working in an interdisciplinary mode is a hallmark of child life. However, that flexibility may be lessened by strict licensing standards, and “turf” conflicts could be the result.

At the present time, child life often looks to physicians, nurses, and other health care professionals for support in establishing child life programs, increasing personnel, being part of hospital leadership teams, and even providing appropriate services. If those individuals begin to see conflicts

arising around role definition because of attempted child life licensure, they may be less likely to step forward and continue their advocacy for the profession. These conflicts can emerge because of a confrontational licensure process as described above or even occur after licensure is established. If licensure occurs in any state, then that state will form a state licensing board, which will be responsible for continuing to update licensure credentials. Board members will include child life professionals but also other health care professionals, lawyers, financial experts, and even political appointees. There is the potential for some of these members to have their own agendas and not endorse the standards developed by child life organizations. Thus, conflicts may occur, and those conflicts can filter down to those who have previously supported child life.

Challenges Inherent in the Licensure Process

Practitioners in states with licensure may choose not to maintain their CCLS credential any longer since they will be required to maintain their licensure. The Certified Child Life Specialist credential may become obsolete in that state, which not only reduces the control that our professional membership group has over our profession, but also devalues the CCLS credential for those in states in which licensure is not available.

There are only two states in the United States that currently have more than 500 Certified Child Life Specialists, and only six additional states that have more than 200. This may not be a high enough population of child life professionals to even consider application for licensure. For example, the state of Ohio, which established licensure for social workers about 25 years ago, has 28,129 licensed social workers, as compared to a total of 301 Certified Child Life Specialists. Even if approved in those few states with higher numbers, it is unlikely that licensure of child life professionals would become national. If this process does not have the potential to become national, then a significant imbalance could occur in the profession. Essentially, states with licensure would have “different” child life standards than

those without licensure, leading to a potential schism in the profession.

Is Licensure Really What Our Profession Needs?

Some might argue that licensure would bring more credibility to our profession. Our work and research, combined with patient and medical team testimonials, are a strong reflection of our current credibility. By focusing on promoting the benefits of our profession to insurance companies, school systems, and the public in general, we can achieve similar goals. By engaging in research that demonstrates the value of child life, both psychosocially and financially, we will continue to increase our identity and worth. A good example of advocacy for our profession is the work done with companies that provide liability insurance to those in health care. A major insurer did not offer “child life specialist” as a professional option for insurance applicants. However, when ACLP reached out to share our concerns and present our qualifications and credentials, the insurer added child life specialist as a choice on their list of acknowledged professions. This was accomplished without the benefit of licensure.

While licenses may limit who is legally allowed to perform certain duties, a license does not eliminate unethical or harmful practice. We have come a long way in establishing child life as a viable, definable, predictable profession. However, every year our national organization and our certification commission take further steps to make sure our child life practice meets the actual needs of the children and families we serve. Protecting the public is the first order of business, and no state license will improve on the practice for which we are already holding ourselves accountable.

Over the years our profession has had to move forward with some difficult decisions. Those decisions were not easy but were made while keeping the future of the profession always uppermost in mind. Perhaps at some point in time, licensure for child life will clearly be in the profession’s best interest. Right now, to seek licensure while we are still defining ourselves and examining our roles, especially in the community and in private practice, seems premature. ✧

ADDITIONAL REFERENCES RELATED TO LICENSURE FOR CHILD LIFE

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Grow, Release, Identify, Empower, and Fulfill (G.R.I.E.F.) Program:

AN EDUCATIONAL PROGRAM ABOUT GRIEF AND LOSS

Michelle Cumber, MA, CCLS, CEIM

Introduction

Health care workers confront grief and loss often. Whether working with a chronic patient who is at end of life or a patient who was brought to the hospital after a traumatic incident occurred, grief and loss are an inevitable part of a health care worker's job. Staff who feel comfortable providing end of life support for families are often limited, though, due to the lack of educational opportunities provided during academic coursework and workplace training. This paper will describe a year-long educational program developed by child life specialists for staff that explored different aspects related to grief and loss and included suggestions for implementation into daily practice.

The Development of the G.R.I.E.F. Program

In May 2015, two child life specialists who work in the pediatric intensive care unit (PICU) and pediatric emergency department (ED) attended a training in grief and bereavement offered through the Grief Recovery Institute®. This training made them acutely aware of the need to support other staff in gaining knowledge and comfort in this area. Upon returning to work after the training, many members of the interdisciplinary team expressed a lack of comfort when working with grieving families. The two child life specialists saw this as a prime educational opportunity to combine some aspects from the Grief Recovery® training with information learned from academic coursework and clinical work

to create the Grow, Release, Identify, Empower, and Fulfill (G.R.I.E.F.) Program, a year-long educational program for PICU and pediatric ED staff, in hopes of increasing staff's knowledge and comfort level about this important topic.

Program Implementation

In January 2016, child life specialists distributed introductory letters to all staff who work in the PICU and pediatric ED, outlining the program and discussing the requirements for participation. Those requirements included completing a pre-questionnaire, reading seven newsletters distributed throughout the course of the program, completing a post-questionnaire, and finally taking a survey of an overall evaluation of the program. The child life specialists collaborated with a pediatric nurse educator to ensure all participants received two continuing education units upon completion of the program in December 2016.

Staff had two weeks to review the program's introductory letter and indicate if they were interested in participating. After this two-week period, there were 39 registered participants in the program, including one PICU nurse practitioner, 11 PICU nurses, one PICU patient care tech, three PICU transport nurses, 16 pediatric ED nurses, one pediatric ED patient care tech, four float nurses, one nurse/family teaching program coordinator, and one art therapist. Registered participants then received a pre-questionnaire to assess their baseline knowledge about grief and loss as well as their comfort level when working with families during end of life situations. The pre-questionnaire utilized a five-point Likert Scale to measure the extent to which participants agreed or disagreed with specific statements. In addition, the pre-questionnaire inquired about the type of content staff felt would be helpful to include in the newsletters. In response, the newsletters were specifically tailored to include information and topic areas with which staff had identified they were particularly uncomfortable.

Delivery of the program consisted of a series of seven newsletters sent via email to participants every two months, each focusing on a different aspect related to grief and loss. The child life specialists provided examples of how the topics pertained to each unit and made suggestions for incorporating the information into staff's daily practice.

About the Newsletters

Each newsletter was designed with a specific focus or theme that incorporated information from a myriad of resources, both academic and clinical in nature. Each touched upon aspects that patients, families, caregivers, and staff all experience when there is a loss of any kind, both in the hospital and personally. Each newsletter also provided additional recommendations and tools to help staff understand what grief

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Newsletters 1-4

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Grow, Release, Identify, Empower, and Fulfill (G.R.I.E.F.) Program: An Educational Program about Grief and Loss

is, how to process it, how to help families navigate through their journeys in the health care setting, and a discussion on how to return to patient care needs following the death of a pediatric patient.

The *Introduction Newsletter* was sent in February 2016 and included a brief introduction to the importance of recognizing that individuals should be cognizant of their own needs before helping others and emphasized how our bodies are meant to process information and not store it. In addition, it also touched on how society has taught us how to obtain information, friendships, and material possessions, though it doesn't always teach us what to do if we lose something valuable in our lives (James & Friedman, 2009).

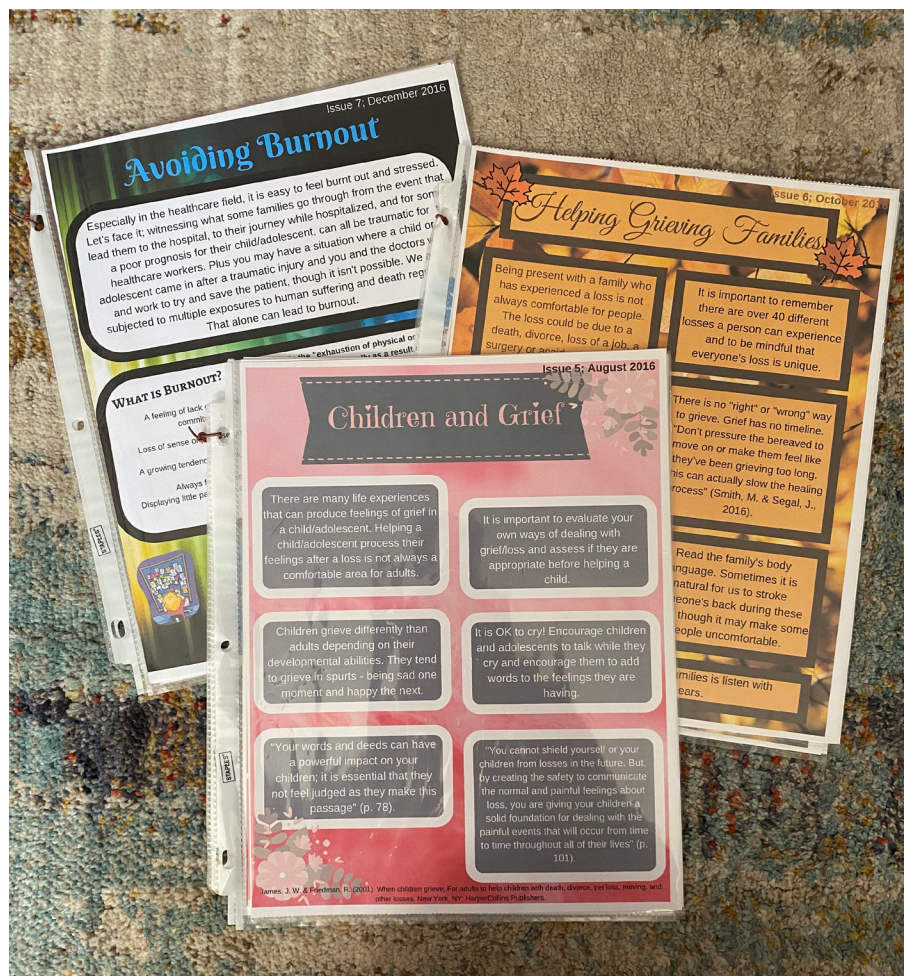
The second newsletter, *What is Grief and What Constitutes a Loss*, was sent two weeks following the *Introduction Newsletter*. This newsletter discussed over 40 types of losses a person

may experience and how grief is the most powerful and misunderstood emotion (James & Friedman, 2009). Further, it explored how grief is emotional, not intellectual, and how often it is misdiagnosed as depression (James & Friedman, 2009).

The third newsletter, *6 Myths About Dealing with Grief*, was distributed in April 2016 and addressed myths related to a loss (James & Friedman, 2009; The Grief Recovery Institute®, 2017). It also included information about how to listen to grieving families, the importance of being present with them in the moment, and how to create a safe place for griever to express their emotions.

The fourth newsletter, *Short Term Energy Relieving Behaviors (STERBS)*, was sent in June 2016. According to James and Friedman (2009), STERBS are behaviors individuals may engage in to release stress, tension, or use as a coping mechanism, such as drinking too much alcohol, using drugs, obsessively eating, not eating at all, working too much, or excessive use of video games or exercising. While some of these may not seem harmful, they serve to distract an individual from the loss and don't allow them to process properly what has occurred which can cause more challenges (James & Friedman, 2009). Lastly, this newsletter discussed the thought process and information related to changing a habit.

The fifth newsletter, *Children and Grief*, was sent in August 2016 and discussed how children and adolescents process grief and loss. It included information about symptoms of grief children and adolescents may experience, their developmental stages (for those who are typically developing), their cognitive ability to understand what has occurred, and tips for speaking with them about their experiences. In addition, the child life specialists included some activities and resources that can be used to help children and adolescents process a loss.



Newsletters 5-7

The sixth newsletter, *Helping Grieving Families*, was sent in October 2016 and focused on the importance of meeting families where they are emotionally. It also provided suggestions about what is helpful to say and what to avoid saying during these challenging times. In addition, the child life specialists discussed various types of legacy-building activities and included helpful resources for children, adolescents, and adults.

The final newsletter, *Avoiding Burnout*, was distributed in December 2016. Self-care is an important facet of an individual's health, though it isn't typically the focus of anyone's day. This newsletter discussed burnout and compassion fatigue and identified symptoms and signs of each. It also provided suggestions for enjoyable activities and tips for maintaining work-life balance.

Program Evaluation

Following the final newsletter, child life specialists provided a post-questionnaire to evaluate the overall effectiveness of the program, which was structured the same as the pre-questionnaire. Based on these responses, the child life specialists analyzed the data collected from both the pre- and post-questionnaires to evaluate the effectiveness of this educational program.

The data revealed an increase in staff's knowledge surrounding grief and loss, an increase in staff's comfort level within their personal and professional life regarding bereavement, and an increase in confidence when working with families at end of life. In addition, staff's ability to cope with bereavement situations within their personal life increased, as well as their ability to cope with bereavement situations at work. Likewise, staff's confidence in providing end of life support for patients increased, as well as their comfort levels with remaining in the room with family members following a patient's death.

Conclusion

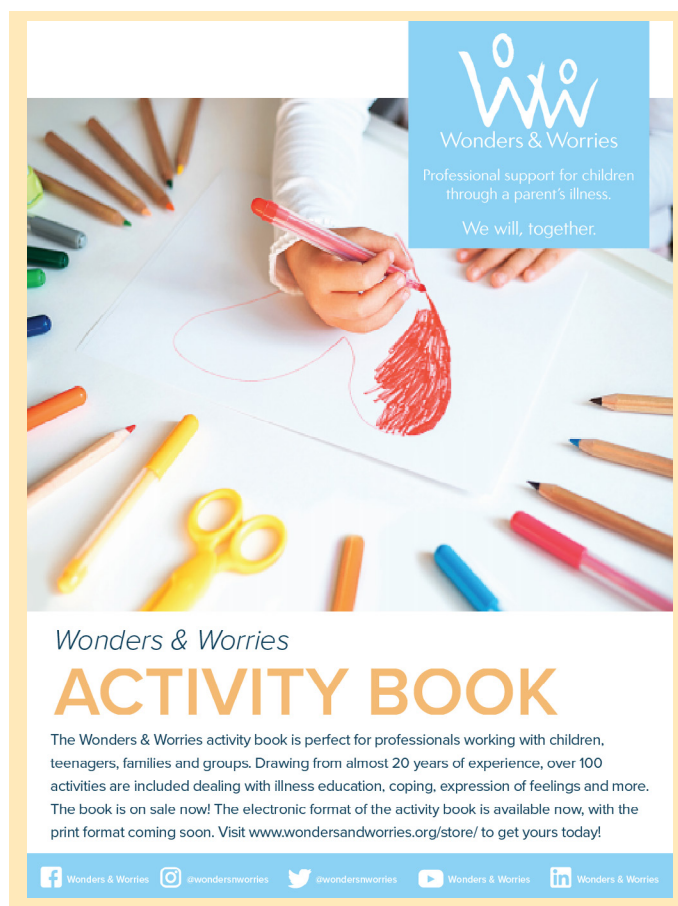
Overall, working in the PICU and pediatric ED is stressful; health care workers are meeting children and families during high anxiety-producing and vulnerable times of their lives. Medical professionals seek to extend a patient's life at all costs and are also taught what to do medically in situations where interventions will no longer help a patient heal. However, limited educational opportunities are available to help medical professionals mentally and emotionally prepare themselves and patient's families (Jackson, 2017).

The G.R.I.E.F. Program was designed to incorporate information about grief and loss from child life practice and

other training to help address this gap in staff's knowledge base. Results from the evaluation of the program indicate that this training was well received by staff and did help to increase their overall knowledge and comfort level when working with families during end of life situations. This is an important topic that often is overlooked during educational and workforce training, though it is vital information that should be addressed more frequently and thoroughly. Proper training and knowledge is imperative to help staff members navigate this topic and child life can be a valuable resource for doing just that. ✨

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Child Life in Extreme Circumstances

Kizzy Marco, CCLS

CHILDREN'S HOSPITAL COLORADO, AURORA, CO

Child life specialists are often called upon to be the fix-it people on their teams. Does a child exhibit signs of poor coping? Child life specialists can fix it. Is a sibling regressing at home due to a new diagnosis in the family? Child life specialists can fix it. Deep breathing, visual schedules, incentives, and support — child life specialists are the go-to fixers. But what happens when we are faced with something that quite simply cannot be fixed? What do we do, how do we feel, and where do we turn when we find ourselves in the middle of situations that are ongoing, systemic, and beyond truly fixing?

It seems reasonable to say that each of us, right in this moment, are dealing with unparalleled experiences, both personally and professionally. Here in Colorado, we are facing the largest and most destructive wildfires in state history. Our state is hurting. And it has been such a strange, eerie experience to struggle to even get the latest updates on the fires when so much of what is being reported is about the several other enormous, life-altering events and trends: political divide, a worldwide pandemic taking hundreds

of thousands of lives, systemic racism and oppression of minorities, and the list goes on. The reality of 2020 has been heartbreaking, overwhelming, frustrating, and sometimes even lonely. None of us have true expertise in facing (or fixing) the many vast challenges in front of us each day because we are experiencing them in real-time, as they unfold. I find myself struggling more now with feelings of sadness and helplessness than any other time in my life, and I suspect I am not alone in that.

In early March 2020, I landed in my home city of Denver, Colorado, after traveling for 27 hours. I had been in Ireland on a long-anticipated family trip celebrating my parents' 40th wedding anniversary. On the first official night of the trip, we were awakened in the middle of the night and directed to get back to the United States as quickly as possible due to the outbreak of COVID-19 and associated border closures and travel restrictions. Trying to look on the bright side, I told myself when I landed that I would return to my job earlier than planned and get back to work. If only I had known the chaos that lay ahead.

By the time I returned to the hospital for my first shift back, temperatures were being taken at the door, along with surveys about symptoms and mandatory masks in patient care areas. Within a week of my return, masks were always required, along with face shields in patient care areas. At

first, I felt a sense of importance; I knew all the changes would be hard, but I felt ready to serve the patients and families that found themselves in the hospital during a pandemic. I hate to admit it, but those feelings eventually waned as my energy level dropped and feelings of frustration and exhaustion began to seep in. I could see in kids' eyes that I looked strange in my PPE, and I was tired of scaring kids. I was tired of not always being able to see clearly through the bleach streaks in my plastic face shield. One day, I provided child life support at our COVID-19 testing site, and I saw 125 kids in eight hours. Despite my best attempt at support, each one of them cried. Most of them screamed. Some of them bled. I felt an overwhelming sense of hopelessness at the end of the day. It reminded me of another time of intense stress and unpredictability a couple of years ago when I provided child life support at a detention shelter for children who had been separated from their parents at the border...

A look at the past

For several years now, the world has watched as a crisis has unfolded at the United States-Mexico border. At my earliest opportunity, I made arrangements to volunteer at a shelter for children who had been separated from their parents while attempting to enter America. All I really knew then was I felt a deep sense of hopelessness and concern about what I was reading and hearing in the news and desperately wanted to do whatever I could to help. I reached out to the shelter, which was privately funded and not directly associated with any branch of the federal government. I explained that I was a child life specialist and that I also worked with a trained facility dog who brought incredible comfort to children. They warmly accepted my offer and asked how soon I was available. I arrived a few days later feeling ready and willing to do whatever I could to provide support to the kids. However, just like the COVID-19 pandemic, there was no possible way of knowing or preparing for the depth and breadth of the devastation that lay ahead.

According to data published by the American Civil Liberties Union (ACLU), at least 2,654 children have been separated from their parents at the border under the current United States administration, and more than one thousand of those children were under ten years old at the time of their detention (2019). Many, if not most, children detained at the border do not speak English, nor do they have a clear understanding of where they are and what will happen next. When I arrived in the shelter, I found each child, no matter their age or sex, wearing identical shoes. They were glittery and much too large on almost every tiny set of feet. When I inquired about the shoes, a staff member at the shelter informed me that

almost every child arrived at the border without shoes on their feet. Many of them, she said, had only the clothes on their back. I felt sick to my stomach when I thought about that harsh reality. In a world where I have never had to go without shoes or food or safety, I realized how deeply privileged I am. I suddenly felt ill-equipped to support children who had experienced more trauma in a handful of years than most people will face in their lifetime.

As any child life specialist does, I did my best to keep my emotions in check, trying not to allow myself to think about all that brought them to this exact moment; what it would be like as a small child to be in such danger that you have to flee your home and all you have ever known, walking hundreds of miles, navigating treacherous waters in a makeshift raft or hiding in the back of a hot, unmarked truck and risking death to try for a better future. Each of the children in my presence at the shelter had fled Central America and been detained and separated from their families at the United States-Mexico border. None of them knew where their caregivers were nor had a family reunification plan.

I first entered a room of young school-age boys. My expertly trained (and very gentle) working dog was by my side. I was stunned when several of the boys immediately recoiled with looks of terror on their faces. I stepped back, simultaneously trying to give the boys space and process what was happening. One boy asked quietly, "policía?" My heart sank. I assured the boys in Spanish that I was not affiliated with the police and that my dog was safe and only here to play with them (Later, a shelter employee informed me that many of these children were

[*continued on page 36*](#)

Child Life in Extreme Circumstances

exposed to law enforcement dogs used to guard and deter immigrants on their journey to asylum. Again, I felt a familiar sense of sadness and hopelessness. The cruelty against these innocent children was overwhelming. Though slow to warm, each child eventually gave me and my dog their trust, even trying to convince me to leave my dog for them “to keep.” They posed for Polaroid photos with their new canine buddy and showed them off proudly. I felt joyful and excited to be helping them find something to smile about. And then I realized the photo with my dog was one of their only possessions on earth, and sadness washed over me again.

Time and again it has been shown that experiencing fear or trauma for an extended period can lead to toxic stress, impacting virtually all aspects of a child’s health and development (Griffin, 2015). Children are, of course, highly vulnerable at baseline simply based on their lack of life experience, skills, resources to cope and, in these cases, inability to fend for themselves. Based on what we

know scientifically and anecdotally about development, we can be certain that traumatic early separation will cause irreparable damage to the children and families at the center of the crisis. The results of one biomedical study on the effects of early separation from parents suggest that “data on forced detention... reveal high incidence of post-traumatic stress, anxiety disorders, depression, aggression, and suicidal ideation. These consequences will be magnified in youths forcibly separated from their parents, particularly younger children who depend on attachment bonds for self-regulation and resilience” (Teicher, 2018). Though in some cases, reunification between children and caregivers has happened, or efforts are made for families to stay together during detention, the psychological trauma of the circumstances undoubtedly far outlasts the situations themselves. There is not a simple “all better” solution once children have been inexplicably and forcibly removed from their parents or caged and left to rest on concrete floors.

Back to the present

This is inarguably a unique and heart-wrenching time to care for and connect honestly with children. The 24-hour news cycle puts adults in positions to be asked questions by children and teenagers about what is happening at our southern border and why. This is also true for the recent worldwide unrest around the topics of systemic racism, the Black Lives Matter movement, police brutality, and political divide. All of this is in simultaneous existence with a pandemic that poses questions that even the most brilliant scientists and physicians cannot answer.

Child life specialists have the capacity to nurture and empower children impacted by trauma; their expertise in child development and clinical experience makes them poised to intervene and support children at a moment’s notice, in a shelter or during a global pandemic. For me,

to say the work is emotionally charged would be an understatement. On one hand, showing up in times of disaster or intensity has deepened my child life practice and knowledge of children’s response to trauma. The opportunities to serve were personally and professionally fulfilling during times that were distressing for the world. On the other hand, the work is not without hardships. It is physically and emotionally tiring, and I have often felt overwhelmed by the depth of trauma, loss, and uncertainty within the children I met and served. Although wonderful training for disaster response does exist, including the Red Cross, Child Life Disaster Relief (CLDR), and Children’s Disaster Services (CDS), it is impossible to be fully prepared to witness the suffering of children living through the unimaginable. I am forever changed by the turn of events over the last few years, as we all are. The commitment I make now is that I will stay vigilant, informed, and ready to help as long as this time of worldwide chaos continues. ✨

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LOOSE PARTS

Creating and Constructing

Creating and Constructing Burn Debridement, Layer by Layer

Elyse Mahoney

GRADUATE STUDENT, BANK STREET COLLEGE OF EDUCATION, NEW YORK, NY

Burns are a global health problem which impact both children and adults. In both the home and community setting, children can sustain serious second-and third-degree burns from a variety of circumstances including a kitchen accident, house fire, chemical spill, electrical accident, or other factors. In order for healthy tissue to heal and new skin to grow, the burned area must be removed by conducting a procedure called debridement.

Ideally, debridement is started as soon as the burn is sustained. Decreased length of hospitalization and faster healing times are directly linked to early debridement procedures (Browning & Cindass, 2020). Depending on the severity of the burn, the physician will determine which method of debridement (surgical, mechanical, chemical, or autolytic tissue removal) to utilize. In addition, debridement may need to be conducted multiple times over the course of several weeks or even months (Browning & Cindass, 2020).

This medical play activity illustrates debridement of second- and third-degree burns, ideally directed towards school-age children seven and older. It is composed of loose parts commonly found in both the hospital and at home. While this activity can also be implemented with younger children, ages five to six, it should be presented to them pre-assembled. Caregivers can participate in this activity alongside their children or can facilitate the use of this activity to teach children what will be happening to a loved one undergoing debridement. Whether the patient is the child, a sibling, or an adult with a burn injury, this 30-45 minute medical play activity can provide beneficial opportunities for education and coping.

Materials Needed:

- 10-15 squares of 1-ply toilet paper
- 1 sandwich size sealable plastic bag
- 1 black permanent marker
- 1 black washable marker
- 1 red washable marker
- 1 pair of scissors
- 1 pair of tweezers
- 5-6 paper towels
- 1/4 cup of water
- 1 bottle of dish soap-only 1-2 drops will be used
- 1 roll/dispenser of clear tape

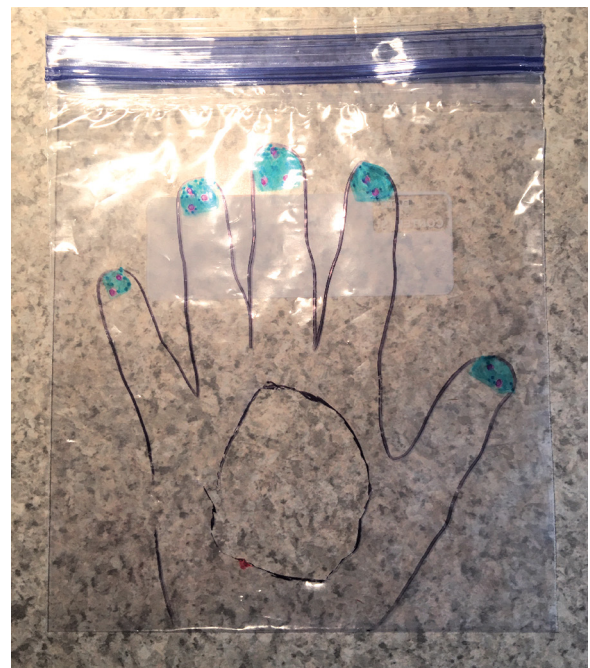


Figure 1.
Outline of burned body part, with hole cut out for debridement

Instructions:

1. Using the black permanent marker, have the child draw the body part that was burned onto a sandwich size sealable plastic bag. If the body part is small, like a hand, it can be traced to scale. A larger body part, like a belly or thigh, can be illustrated by a circle or general shape. Allow the child to customize the body part with birth marks, scars, etc. Using a pair of scissors, help the child cut a hole in the front of the plastic bag to represent the area of burned skin that needs debridement. The hole should be proportional to the part of the body on which it is located. *See Figure 1*
2. Take 2 squares of toilet paper, that are still attached, and have the child completely color the squares red by using the red washable marker. The red colored toilet paper will represent the healthy layer of tissue, from which the new skins grows.
3. Fold the red colored toilet paper squares in half. Insert the folded red colored toilet paper into the sandwich size sealable plastic bag. Push the red colored toilet paper down, so it is directly centered underneath the hole in the plastic bag. Using the clear tape, adhere the toilet paper to the back of the

plastic bag (the side without the hole) so that it is in the center of the hole in the bag.

See Figure 2

4. Using a black washable marker, have the child completely color one square of toilet paper. This will serve as the top outermost layer of burnt skin.
 - a. Discuss with the child that the burn caused their skin to stop growing. To prevent infection and for new tissue and skin to grow, the burned skin and tissue has to be removed, which is called debridement (Mayo, 2018).
5. Have the child remove five pieces of toilet paper to represent a second-degree burn or seven pieces of toilet paper to represent a third-degree burn. The difference in the number of pieces will serve as a visual representation, teaching the child the differences in depth between second-and third-degree burns. (Mayo, 2018).
6. On each square of toilet paper, have the child draw a black shape that represents their burn. The black shape should cover less area on each successive piece of toilet paper.

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Figure 2.
Red layer of healthy tissue, bottom-most layer, that's taped to the plastic bag

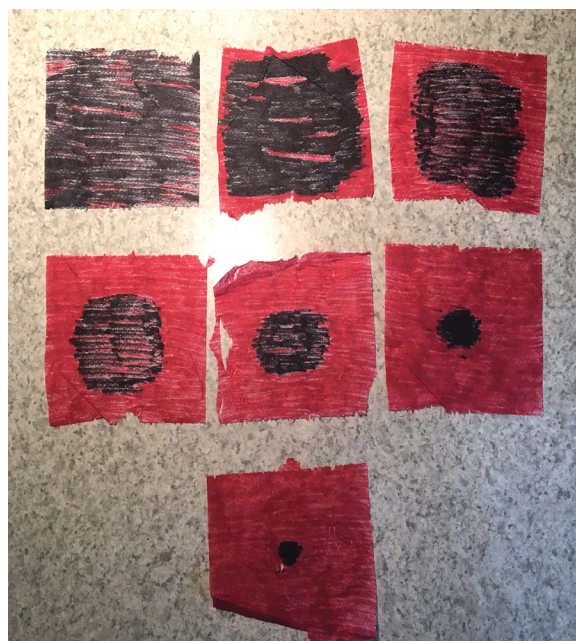


Figure 3.
Layers of burnt skin and tissue that will be removed during debridement

Loose Parts: Creating and Constructing Burn Debridement, Layer by Layer

- a. Depending on the child's age, take the opportunity to discuss the anatomy of the skin. There are 3 primary layers of the skin; the epidermis (top layer), the dermis (middle layer), and subcutaneous tissue (bottom layer; Mayo, 2018). *See Figure 3*
7. When all the toilet paper squares are colored, stack them from largest to smallest covered area so the squares with the largest areas are towards the top.
8. Insert the stack of toilet paper squares into the sandwich size sealable plastic bag, so that they are on top of the red square of toilet paper taped to the inside of the sandwich size sealable plastic bag. Seal the bag. The activity is now fully assembled. *See Figure 4*



Figure 4.
Fully assembled activity, ready for debridement

9. Have the child wash and dry their hands, just like the provider performing the debridement will do. If you have access to gloves or other personal protective equipment that will be used during debridement, provide the child with the choice to dress up like the medical staff.
10. Using a paper towel, have the child lightly dab it in the 1/4 cup of water. The paper towel only needs to be damp. Have the child apply a small amount of dish soap (1-2 drops) onto the paper towel.

11. Have the child gently clean the burn by lightly dabbing it with the damp paper towel.
- a. Depending on the child's age, take the opportunity to tell the child that the individual performing the debridement will use a special kind of soap (anti-microbial soap) to clean their burn so as to prevent infection. The soap will feel cool against their skin and may be colored; red, orange, or brown (Mayo, 2018).
12. Using a dry paper towel, have the child gently dab the skin dry.
13. Have the child use the tweezers to carefully and gently remove each square of toilet paper/"layer of burned skin." The child will continue cleaning and removing "layers of skin" until they reach the completely red square, which represents the "healthy tissue" underneath. *See Figure 5*
14. Once the child has reached the red square, they should re-clean the "healthy skin" using a new damp paper towel and small amount (1-2 drops) of dish soap.
15. Using a dry paper towel, have the child pat the "skin" dry.



Figure 5.
Skin and tissue removed during debridement

16. The child can fold a new dry piece of paper towel to serve as gauze, which will cover the “healthy skin.” Using the clear tape, the child will secure the paper towel in place so as to keep the burn covered and dry. The gauze and clear tape should be loose, so as to allow the skin to breathe. Breathing allows the skin to heal. See *Figure 6*

By providing children with the opportunity to engage in play about burn debridement, they will be better prepared and know what to expect during the procedure. In addition, this loose parts activity will help them make meaning of their situation or that of their loved one. While this activity was created to educate and discuss second- and third-degree burns, it also offers an opportunity to provide information about treating more commonly occurring first degree burns. As always, this type of medical play activity should be ended by asking the child for additional questions, addressing misconceptions, and obtaining feedback on the child’s reactions to the play session. 🧡

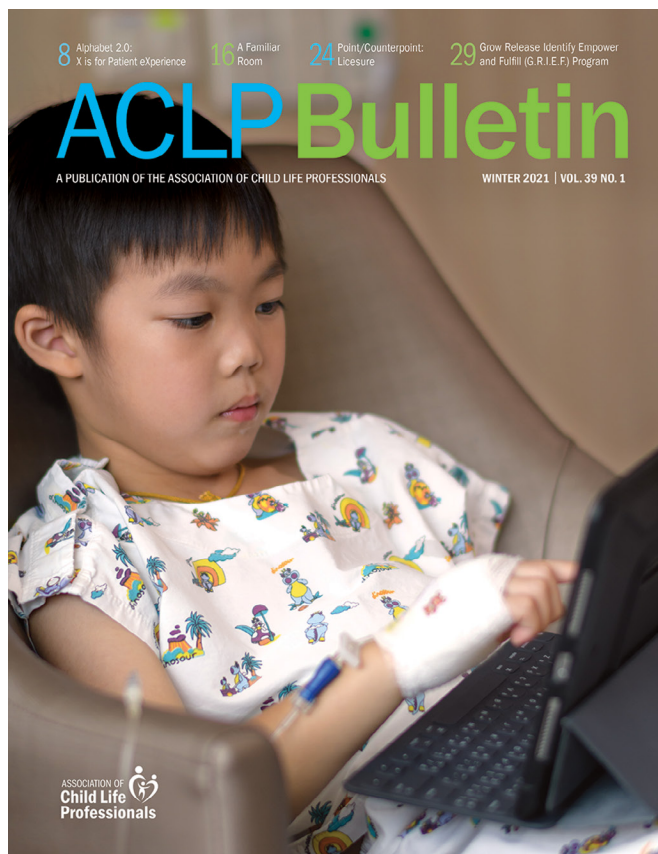
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Figure 6.
Bandaged hand, post debridement

Mayo Clinic. (2018, Jan. 30). *Burns: First aid*. <https://www.mayoclinic.org/first-aid/first-aid-burns/basics/art-20056649>



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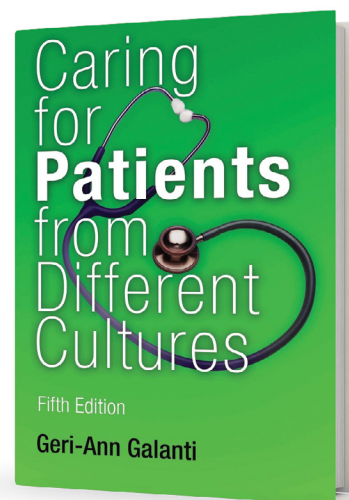
BOOK REVIEW

Kayla Rueter, BS, CCLS

DELL CHILDREN'S MEDICAL CENTER, AUSTIN, TX

Caring for Patients from Different Cultures

By Geri-Ann Galanti (2014). University of Pennsylvania Press



As strong advocates for patient- and family-centered care, child life specialists are trained to take into account all aspects of a patient and their family, including their culture. *Caring for Patients from Different Cultures* (Galanti, 2014) may be a helpful resource for child life specialists looking to further develop their understanding of how culture interacts with a patient or family's coping. The author, Geri-Ann Galanti, is a medical anthropologist and professor who wrote this book to help clinicians better understand the importance of cultural competence when aiming to achieve patient and family-centered care. In her initial discussion of cultural competence, Galanti outlines the four C's of culturally competent care, basic concepts which set the tone for the book and act as mnemonic for providers of questions to consider when working with a family from another culture.

THE FOUR C'S OF CULTURAL COMPETENCE

Call	What do you call your problem?
Cause	What do you think caused your problem?
Cope	What have you done to cope with your problem?
Concerns	What concerns do you have about your problem?

Throughout the rest of the book, the author breaks culture down into a plethora of topics and focuses on one per chapter. Topics covered include: communication and time orientation; pain; religion, and spirituality; activities of daily living and the body; family; men and women; staff relations; birth; end of life; mental health; traditional medicine-practices and perspectives; improving adherence; and making a difference.

Within each chapter, the writer discusses different sub-topics of that theme and includes relevant case studies in order to help the reader have an in-depth look at how culture influences the family system. At the end of each chapter, the reader will find summaries and key takeaways.

As a child life specialist, I found the chapter on pain to be relevant to my practice. This chapter is broken down into subtopics such as expression of pain, pediatrics, requesting pain medication, attitudes towards pain medication, drug-seeking, forms of medication, instructions on use of pain medications, terminology, and the influence of the health care provider. One of the case studies focuses on a 16-year-old Hmong girl with Ewing's Sarcoma. The author discusses how the patient would never report pain or request pain medication but would have tears streaming down her face. She explains that Hmong patients typically do not report pain or ask for pain medications due to being part of a culture that is usually stoic. Knowing this information, the patient's bedside nurse was able to incorporate the patient's culture and views on reporting pain to help in how she treated her pain.

Understanding the culture of a patient and family can help child life specialists to advocate on their behalf to other members of the healthcare team. In my own practice, I worked with a Pakistani patient whose parents needed to train on how to catheterize their adolescent daughter but were refusing. Once I researched Pakistani culture, and assessed this patient's particular family, I was able to relate to our team that what we saw as a disinterest or refusal to train may have a cultural basis. Due to being a culture that values privacy and tends to prioritize the needs of male children,

my patient had never received any personal hygiene help from her mother; she always completed it by herself. Recognizing the mother may not have performed such tasks on her daughter before, we were able to shift how we looked at the situation and provide additional support.

Each chapter is accompanied by multiple case studies which show how a patient and family's experience with health care was made difficult by misunderstandings due to culture. The case studies also vary between cultures, regions, ages, religions, and languages, and some result in ideal resolutions while others do not. A few of the case studies are linked within multiple chapters, which shows how multifaceted these cultural misunderstandings can be. Even though the case studies are not all pediatric, they remain relevant to child life specialists because learning about adult experiences aids in understanding what contributes to their positive or negative experiences with the health care system. The intensity of some of the case studies, however, may be a weakness of the book. A large portion of them have drastic endings, such as a death or a surgery that cannot be performed. In my practice, I tend to see cultural misunderstandings that are not life altering, so having more patient scenarios that reflect those situations would have been helpful to the reader.

The appendix of the book lists cultural profiles. It is noted by the author that the cultural profiles listed are broad and do not encompass all components of one culture. She also reminds the reader that these are generalizations, meant to be used as starting points, not as something to stereotype individuals. Each cultural profile is broken down into categories, such as values, world views, and communication; time orientation; pain; family/gender issues; pregnancy and birth; end of life; and health beliefs and practices. These profiles are helpful to child life specialists who are trying to gain an understanding of a culture in regards to how a patient or family is coping. As a profession who strongly values

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family-centered, culturally competent care, having readily available research on different cultures, across a variety of topics, can be beneficial for child life specialists in advocating for patients and families. Reading this book, I was able to reflect on my own practice and patient cases I have experienced through a cultural lens, and I was able to gain a better understanding of how a family from a culture different than my own was coping with an end-of-life diagnosis.

This book is relevant to child life specialists in many ways. Being culturally competent is another aspect of our practice that helps us to engage with patients and families. Taking into account a patient and family's culture aids in our assessment of the family system, how they may cope, how they may perceive the impact of their illness/injury, and their overall experience with the health care system. This book is a welcome resource to keep on hand for quick reference, along with being another tool for child life specialists to use as we try to make the hospital experience less traumatic and as positive as possible for all families. ✨

REFERENCE

Galanti, G. (2014). *Caring for patients from different cultures* (5th ed.). University of Pennsylvania Press.



ACLP Calendar

JANUARY

- 1-31 Start planning your Child Life Month events and activities for March!
 - 1 Submission deadline for [ACLP Bulletin](#) for consideration in the Spring 2021 issue
 - 5 Application deadline for the [2021 Summer Internship](#)
 - 31 Deadline to pay [2021 certification maintenance fees](#)

FEBRUARY

- 1-28 Continue planning your Child Life Month events and activities for March
- 18 Applications available for the Summer 2021 [Diversity Scholarship](#)
- 25 Bulletin Open House

MARCH*

- 1-31 Celebrate Child Life Month!
- 18 Deadline to submit a [Diversity Scholarship](#) application
- 10 Deadline to apply for the March 2021 administration of the [Child Life Professional Certification Exam](#)
- 15 Deadline to submit [internship applications](#) for Fall 2021
- 15-30 [Child Life Professional Certification Exam](#) administration testing window

APRIL

- 1 [CLPDC data entry](#) for 2021 annual data and 2020 Q1 data begins
- 1 Deadline to submit articles for consideration for the [Summer 2021 issue of the ACLP Bulletin](#)

*ACLP is looking forward to hosting the annual conference.
Stay tuned for registration information that should become available in March 2021.

Here's how you can get started

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- Take a poll

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Moving Beyond Theories that Guide Child Life

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Playroom? Solutions for Programming During
COVID-19

February 15:

Ethical Focus on Academic Programs &
Clinical Internships: Increasing Diversity in
the Profession

February 26:

A Robotic Internship: One Program's
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