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A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

SPRING 2021 | VOL. 39 NO. 2

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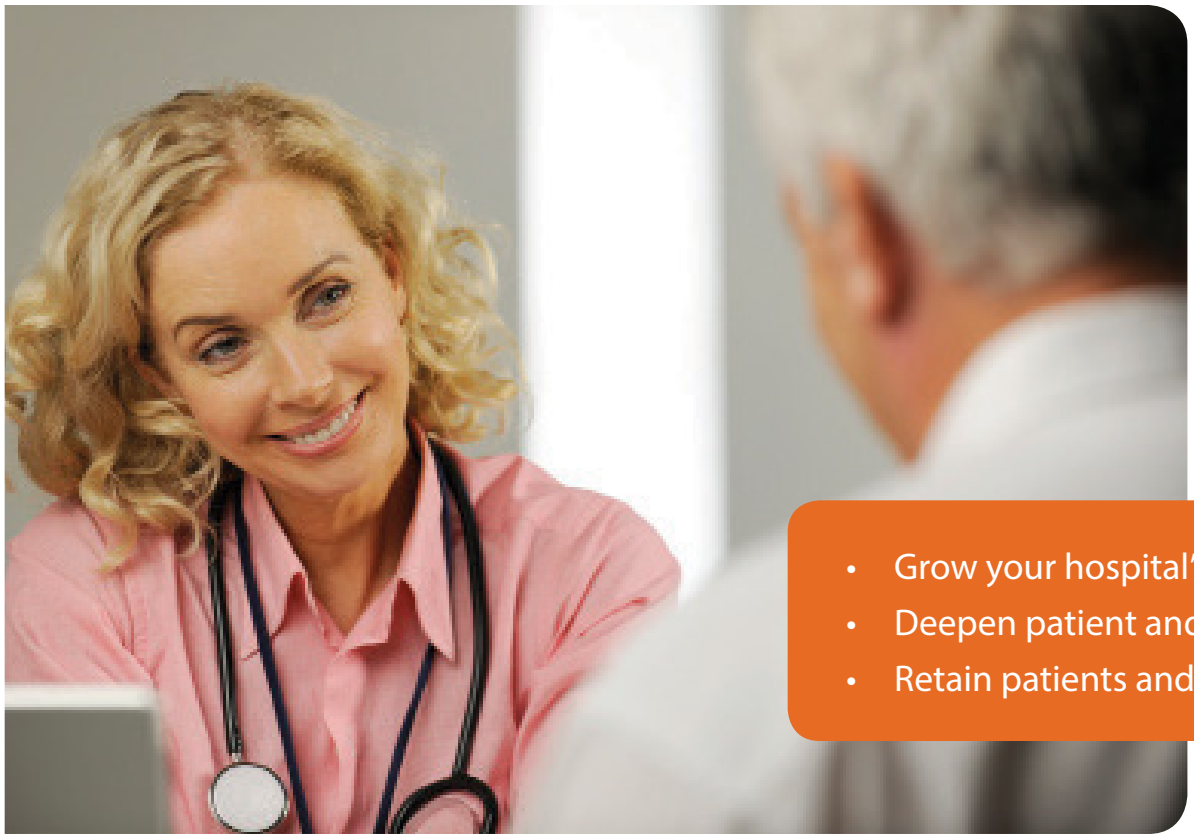

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For information on advertising in *ACLP Bulletin*, please refer to the *Advertising page* on the ACLP website.

ASSOCIATION OF Child Life Professionals

CONNECT WITH US

from the Executive Editor

Kathleen McCue, MA, LSW, CCLS

Hope

I'm sitting at my computer on an apocalyptic weather day in central Texas. There is more ice, snow, and colder temperatures here than ever before in recorded history. Texas is also one of the states with increasing COVID-19 rates and very limited vaccine opportunities. I am still processing the horror of the January attack on the United States Capitol and continue to be confused about the responses and aftermath. Sometimes it feels like we are just extending the challenges and stressors of 2020 right into 2021. You might now be wondering why this column has the title "Hope."

I guess it's because I do feel hopeful. I know this bad weather will pass, and I will survive it. I know we have multiple vaccines slowly making their way into citizens' arms, and several more on the horizon. I believe that it is possible for Americans and individuals around the world to come together and tackle some of the difficult problems of our time, with compassion and integrity. And, as I look at the article lineup for this issue of *ACLP Bulletin*, I see optimism, creative thinking, and plenty of reason for hope.

Over the past year, we have published multiple articles on the current international issues of COVID-19 and diversity, equity, and inclusion (DEI). In this issue, Cara Sisk and Brittany Wittenberg examine the broad-spectrum impact of COVID-19, not only on students but on the profession overall. They challenge us to consider the empirical validity of the current expectations and requirements for individuals seeking to enter the profession of child life. Rather than being discouraged by the events of the past year, these authors embrace the reality that this challenge may result in a new way of looking at child life training. The global topics of DEI have also been regularly addressed in *ACLP Bulletin*. Katy Tenhulzen provides an overview of the establishment of implicit bias, based on developmental, neurologic, and behavioral principles. She adds specific suggestions for both examining our own biases as well as altering beliefs that are well ingrained in each of our psyches. It is very hopeful to read that even well-hidden biases can be recognized and altered if we are all open enough to make the attempt.

On a continuing reflective note, Alexis Plumb describes the efforts made by Child Life Council and ACLP toward inclusion. In her article, "Moments from the past: Reflecting on our history to make a more inclusive future," Alexis identifies two "moments" in our organization's history that represent efforts to minimize barriers to entry into the profession. She acknowledges the limited nature of this information, and encourages all members to submit artifacts and contributions to the Child Life Archives Committee. Finally, Cara Sisk and Kathryn Cantrell, in "How Far Have We Come?", ask us to honestly examine the progress made in the last 13 years in moving the profession of child life toward an identity as a field of inquiry, based on scientific research. Both of these articles affirm that even though we still have work to do, we are continuing to think, self-examine, and progress. There is nothing more hopeful than that!

I believe that we can all find hope in some parts of both our personal and professional lives. All of us in child life spend much of our clinical time helping children find resilience, coping, and strength in difficult situations. Can't we use the same skills to help ourselves and our colleagues also tap into personal resilience? After this past tough year, hope may be seen by some as unrealistic or perhaps a little too "Mary Poppins-like." But if there is any group of people who can embrace the concept of hope, it is people in child life.

President's Perspective

Kim Stephens, MPA, CCLS

A Time for Renewal, Rejuvenation, and Regrowth

Spring in south central Texas is always a bit of an adventure and drastically different than my Mid-Atlantic East Coast upbringing in South Jersey. Where I live on the northern edge of the South Texas Plains, our weather can swing between beautiful, sunny days to crazy downpour nights. Both the sun and the rain are necessary to bring on the spectacular shows of wildflowers from March into June. The wildflowers are such a beautiful visual of the season. However, here "springtime" does not only refer to the season, but also to ideas of rebirth, rejuvenation, renewal, and regrowth. Springtime this year feels especially meaningful, as we continue through the challenging times in our nation and our world.

Springtime also feels very meaningful for our profession this year. Child life professionals around the world have come through the hard winter of this pandemic and are starting to see renewal and regrowth with the distribution of the COVID-19 vaccine and the recovery plans now in place in most medical facilities. While many of our institutions are and still will have to make hard choices during the financial recovery from the pandemic, glimmers of renewal are appearing as the public regains trust that it is safe to seek health care. Some of this health care is in person, but some of this growth is in the expansion of telemedicine beyond the forced need of the pandemic. All of health care has been required to look at how we can better provide care that is affordable, accessible, and equitable to all. Child life is no exception to this.

ACLP is on a strong path forward through the springtime of renewal, rejuvenation, and regrowth. We too have had to look at how we better provide services to all members that are affordable, accessible, and equitable to all. We are amid groundbreaking work on emotional safety with the publication of the emotional safety framework and the creation of a new website dedicated to promoting this important concept to external stakeholders. This work will continue to highlight the essential role that child life professionals have in any setting where children undergo challenging events, enabling our members to advocate for necessary positions. We are continuing forward progress on our DEI action plan, having embarked in January on a new, year-long diversity, equity, and inclusion (DEI) training program as an organization. Tony Hudson will facilitate this training program to center racial consciousness and intersectional equity, to assess racial challenges, and to develop effective and enduring systemic change. This will lead into our DEI summit planned for June of 2021. We have hired our first Coordinator of Member Inclusion to focus on the inclusion and belonging of **all** members of the organization. We have successfully launched our first class of Research Fellows led by Chief Fellow Dr. Jessika Boles, which is doing important work to strengthen and expand the focus on necessary research by and with our members. All of this has been accomplished while maintaining the financial health of the organization through these challenging financial times due to the extraordinary work of the ACLP staff in reducing expenses and continuing to seek out new opportunities for funding to best support our members.

My hope is that this springtime brings a renewed sense of hope, excitement, and growth for each one of you as you continue to support the well-being of all the infants, children, youth, and families you serve. Your work is essential to their renewal and rejuvenation every day.

In your service,
Kim

CEO Shares

Bailey Kasten, CAE, Chief Operating Officer & Interim CEO

The Launch of Emotional Safety

All children and families deserve emotional safety.

We know this to be true. It is a cornerstone of the profession and a critical component to the work that you do every day. As you read through this issue of *ACLP Bulletin*, you will see the concept of emotional safety shine through in every article. One that characterizes emotional safety succinctly is "It's Okay Not to be Okay" by author Kristin Brown. The article describes the importance of encouraging children to release their emotions through crying. This physical act of crying helps them be able to identify and name their feelings to improve their emotional intelligence and well-being. On page 36, Jessica Westbrooks outlines resources for creating a personalized pain scale in her article "Non-pharmacological Pain Management for Children with Sickle Cell Disease and Other Sources of Pain." This personalized pain scale speaks to the need for assessments that prioritize, respect, and protect the emotional well-being of patients.

With the global pandemic, social unrest, and climate catastrophes, the need to minimize stress in a medical setting is more critical now than ever before. This is why we are proud to launch the new Emotional Safety Initiative. This initiative is a new way of presenting what you have always known: that children and families deserve a level of care that is cognizant of their emotional and psychosocial needs from the moment they step foot into your institution to the second they leave.

A high-level overview of the new Emotional Safety Framework can be found in this issue. Page 6 describes how the framework came to be and page 7 dives deeper into the four pillars of emotional safety. You can also learn more about this framework by visiting *emotional-safety.org*, watching and sharing the educational videos on the website, *attending the webinar series*, and reading the full *Emotional Safety Initiative white paper*.

What does this new framework mean for you? We hope it will be a catalyst to bring together our health care partners, families, and patients to promote patient and family-centered care and atraumatic care experiences, along with highlighting the important role of child life specialists in this work. The framework provides you with the tools to talk about the importance of emotional safety and the work that you do with other health care allies. This conversation will help others learn about child life and how we fit into the bigger picture of comprehensive health care. Having health care systems that value and prioritize emotional safety will have a profound impact on the care that children and families receive. Now is the time for change. We hope you will join us in advancing emotional safety for pediatric patients and families.

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ACLP Emotional Safety Initiative

The ACLP Board of Directors first discussed emotional safety in 2016. In 2018, the board made emotional safety a priority and ACLP began to seek funding to host a meeting. In November 2019, ACLP hosted a multidisciplinary meeting including child life specialists, physicians, nurses, other health care professionals, and parent representatives. The meeting was led by ACLP's Patient Experience Committee and explored emotional safety of pediatric patients and their families as a priority of equal importance with patient safety initiatives, as well as established that emotional safety is the priority of all health care team members, not just child life and other psychosocial professionals. This meeting resulted in the creation of the Emotional Safety Framework, the cornerstone of the Emotional Safety Initiative.

Emotional Safety Initiative promotes resiliency, healing, and trust for pediatric patients and their families during all medical experiences. For too long, hospitals and medical institutions have prioritized physical safety efforts at the expense of emotional safety, leading to potentially traumatic long-term effects. By incorporating evidence-based methods, open and age-appropriate communication with patients and families, reliable environments, and individualized intervention plans into all areas of pediatric care, we can minimize stress and foster a healthier lifelong relationship to the medical care.

The Emotional Safety Framework has been evaluated by numerous health care professionals, parent advisory groups, and patient/teen advisory groups. It consists of four pillars: screening and assessment, intervention, environment, and staff communication, education, and training.

ACLP is excited to share this work with the child life community and the public to promote child-friendly health care, atraumatic care practices, and encourage both health care administrators and parents/caregivers to prioritize emotionally safe care for pediatrics and educate them on the important role of child life specialists in this work.

WAYS TO ENGAGE

- Visit emotional-safety.org
- Read the full white paper
- Share the framework with colleagues & administrators
- Attend the emotional safety webinar series
- Encourage parents & caregivers to become advocates for emotional safety

emotional SAFETY INITIATIVE

EMOTIONAL SAFETY FRAMEWORK

EMOTIONAL SAFETY is the intentional multidisciplinary practice to promote resiliency, healing, and trust for pediatric patients and their families during medical experiences.

SCREENING AND ASSESSMENT

GOAL: Healthcare treatment plans should be informed by and catered to the individual needs and strengths of each patient and their family. Our goal is to better identify those needs, effectively communicate them to all appropriate healthcare staff, and implement interventions that prioritize, respect, and protect the emotional well-being of all patients throughout the healthcare experience.

INTERVENTION

GOAL: Ensure children feel comfortable and understand all medical encounters and procedures. Use emotionally safe, evidence-based best practices with each patient or family encounter.

ENVIRONMENT

GOAL: Use evidence-based practices to build safe and reliable environments that minimize stress and promote emotional safety for patients, families, and staff.

STAFF COMMUNICATION, EDUCATION, AND TRAINING

GOAL: Educate all teams about emotionally safe standards. Prioritize collaboration and effective communication among the interdisciplinary team, patient, and their support systems. Use open dialog and understanding to better advocate for children and families within the hospital environment.

CHILD LIFE'S STUDENT-TO-PROFESSIONAL PIPELINE AND THE COVID-19 PANDEMIC:

A Call to Reconsider Student Selection Practices

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Having spent the majority of 2020 living with the disruptions of the COVID-19 pandemic, the child life profession has begun to rebound. Assessment of the academic and clinical preparation of students pursuing child life includes not only the immediate effects of this pandemic, but also anticipated long-term effects. All stakeholders in child life's student-to-professional pipeline have been impacted by the pandemic in ways none of us could ever have imagined. Students' practicums and internships were terminated, disrupted, or delayed. Academic programs quickly modified instructional modalities to ensure the provision of ongoing quality higher education. Clinical sites resolutely protected patients' health, requiring supervisors to dismiss students from child life volunteer, practicum, and internship experiences. While the entire child life community was impacted, the students, our newest and most vulnerable members, were left feeling devastated when their career pursuit of child life was snatched from them. Whether interacting with children in the hospital, children in other stressful situations, or with healthy children, the student's child life education and clinical training was impacted by the COVID-19 pandemic.

Student Impact

The first step in long-term assessment of the pandemic's impact on child life students was to determine the timeline of student cohorts whose requisite experiences with children for internship application were affected, which concomitantly affects their eligibility for Child Life Certification (Figure 1). Beginning in March 2020 with the COVID-19 shutdown, students in internship, practicum, or volunteer roles were affected with the majority of these experiences halted for unspecified time periods [unpublished survey data on child life student programs impacted by COVID-19, 2020]. With each clinical site developing their own policies regarding students and volunteers in order to mitigate the spread of COVID-19, what has happened to students varies greatly. In this section, we will provide information on the cohorts of child life students who were impacted. Not including child life interns whose internship experiences were halted during the shutdown (and presumably resumed and completed in 2020), there are four cohorts of child life students impacted by the COVID-19 pandemic at different stages in their career preparation: students seeking internships, students seeking practicums, students seeking volunteer hours, and students seeking hours with healthy children. Each of these student cohorts will be considered.

Students Seeking Internships

Child life students seeking internships have confronted the additional challenge of determining which hospitals continue to offer child life internships amidst the pandemic. Complicated by the reality that some hospitals are unable to offer internships, this cohort is facing a reduction in the total amount of internship positions available. Therefore, this cohort may take additional internship application cycles to successfully receive an internship. However, this cohort is nearing the end of the student-to-professional pipeline and may not be as affected by the pandemic as future cohorts.

Students Seeking Practicums

Similar to students seeking internships, students seeking practicums have a reduced number of hospitals to consider. This has led some students to pursue virtual child life practicum opportunities, which has raised many unanswered questions for students and child life educators, as they begin to see virtual practicum hours on students' resumes: Will virtual practicums be considered equal to traditional practicums when viewing

Figure 1.
COVID-19 Impact on Student-to-Professional Timeline

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internship applications? Are all virtual practicums treated equally? Will virtual child life practicums become the new norm in a student-to-professional pipeline that only takes top-tier students? These students (and their loved ones) are appropriately concerned about the feasibility of successfully becoming a child life specialist due to the pandemic.

Students Seeking Health Care Volunteer Hours

The next student cohort impacted by the pandemic are students seeking hospital volunteer hours. This cohort faces many uncertainties and have asked their academic mentors, "Will I be considered for a practicum or internship if I have no hospital volunteer hours?" Before the pandemic, child life academics would have resolutely told students they would not be considered for practicums and internships without hospital volunteer hours; however, the pandemic has led child life educators to reconsider the criteria needed to be a successful child life intern or practicum student.

In a nonprobability sample (n = 45), clinical sites offering child life internships varied greatly and ranged from 60 to 600 hours in required experience hours with a mean of 165 hours (*Mdn* = 150 hours, *Mode* = 100 hours) [unpublished work on child life internship opportunities during COVID-19, Sisk, 2020]. However, the minimum number of health care and well-child experience hours for students applying to Accredited Clinical Internship Sites is 100 hours in each category (ACLP Clinical Internship Accreditation Application, 2014). Student qualifications for a practicum or internship varies depending on each clinical internship and whether the site is willing to change the number of experience hours compared with pre-pandemic requirements. This cohort's practicum applications will appear at clinical sites later in 2021 and child life internships in 2022 and beyond.

Students Seeking Hours with Well Children

The remaining student cohort impacted by the pandemic are students beginning experiential hours with healthy children. Because most universities delivered courses virtually since the March 2020 shutdown, students' hours with children were cut short due to the closure of laboratory schools and child care centers across the nation (Bipartisan Policy Center, 2020). When child care centers were allowed to safely re-open, the U.S. Centers for Disease Control and Prevention (2020) did not allow parents to enter the center, much less a revolving door of students needing experience hours with children. Instead, academics offered students foundational child development knowledge and observation skills through textbook platforms and videos of children at each developmental stage. While these learning methods demonstrate best practice during the COVID-19 pandemic, in-person interactions with children and families are irreplaceable. This continued reduction in foundational experiential hours will impact child life practicum and internship applicant pools in the coming years.

Child life professionals know that foundational experiences with well children are necessary to understand child development before helping students learn to work with children in stressful situations. If a cohort of students missed foundational learning opportunities, how will that impact child life service delivery? Although we do not have answers, over the next few years it is important to reflect on how the pandemic has impacted students' knowledge and experiences. Hopefully, with the recent vaccine rollout in the United States (The New York Times, 2021), COVID-19 will be well-controlled so students can resume internships, practicums, and volunteer hours later in 2021.

Impacts on Students from Underrepresented Groups

It is important to recognize the additional impact of COVID-19 on students from underrepresented groups. Similar to disparities that existed between students before the pandemic, students from high socioeconomic status (SES) backgrounds may have the resources available to dedicate time to returning to their volunteer hours at hospitals whereas students from low SES backgrounds may need to focus their time on paid experiences. In addition, because the pandemic has led to poorer health outcomes for individuals who are Black or Hispanic (Golestaneh et al., 2020; Laurencin & McClinton, 2020), the lack of diversity in child life student cohorts may remain due to the financial resources needed to care for family who have lost a wage earner due to COVID-19. Therefore, this pandemic may disproportionately impact child life students of color more so than students who are White when it comes to experiences with children, which is a deciding factor for internship attainment. Additional examination of the minimum experience necessary for child life internship positions is needed so that students from marginalized backgrounds have an equitable opportunity to successfully enter the child life profession (ACLP, 2020a).

Child Life Professionals' Responsibilities: A Call to Reconsider Student Selection Practices

Preparation of child life students is a shared responsibility between child life academic programs and clinical sites.

As stated in the Association of Child Life Professional's (ACLP, 2019) Standards for Academic and Clinical Preparation Programs: "It is the responsibility of the academic and clinical preparation programs to put forth competent individuals who are prepared to establish their eligibility to sit for (and pass) the Child Life Professional Certification Exam." Child life professionals should be encouraged by discussions on the ACLP Academic and Clinical Internship Coordinators forums expressing the willingness of these stakeholders to work collaboratively for solutions while demonstrating creative problem-solving to address the challenges students face. Although long-term ramifications for each stakeholder group are not yet fully actualized, current ramifications are outlined in Figure 2.

The COVID-19 pandemic has called child life professionals to consider the minimum requirements necessary to be a successful child life intern. Valuing flexibility, evidence-based practice, and dedication to diversity, equity, and inclusion, now is the time for child life professionals to demonstrate these qualities to support students. With the competitive reality in internship applications, there is likely a pool of students who gained the required number of health care and well-child hours prior to COVID-19 but did not receive internships. Thus, it may appear as if the student-to-professional pipeline was not affected because these students continue to apply. However, the pipeline continues to be propagated with students in academic programs whose experience hours were negatively affected by COVID-19. Being child life professionals, we must ask ourselves: Is it equitable to consider only applicants who have the number of experience hours set in times of pre-pandemic stability when current students are deprived of experience hours? After all, principle 12 of the Child Life Code of Ethics states that child life specialists will "assume responsibility for…providing optimal learning experiences" for students (ACLP, 2020b).

This is a time for child life stakeholders in the student-to-professional pipeline to consider: What are the essentials for becoming a Certified Child Life Specialist? Internship experience hour requirements need to be established on empirical evidence to eliminate arbitrarily set standards based on program preferences that change when exacerbated by the amount of applications received. As the competition rises, students feel the pressure to go beyond posted requirements for internships, while the system incorporates increasingly stringent standards to handle the number of applications received. This leads to increasing competition between students and the phasing

Figure 2: *COVID-19 Impact and Stakeholder Ramifications*

STUDENTS

Fewer experience hours acquired
Uncertainty about certification eligibility
Impacted financial aid and graduation deadlines
Increased competition for unaffiliated internships
Seek other career opportunities

CLINICAL INTERNSHIP SITES

Lack of volunteers for patient care and program goals
Interruption in responsibility to train students
Break from students to prevent burnout
Time to reflect on student programs

ACADEMIC PROGRAMS

Unable to facilitate volunteer & clinical experience goals
Uncertain of receptiveness to virtual volunteer & clinical experiences
Upperclassman unsuccessful in attaining internships
Lack of hands-on experiential learning with children will impact students' child life competency
Enrollment concerns correlate with an economic impact on programs

ASSOCIATION OF CHILD LIFE PROFESSIONALS

Revenue loss with fewer students taking the Certification Exam
Membership loss as fewer students pursue child life

CHILD LIFE PROFESSION

The profession will see multiple cohorts of qualified students who are passionate about child life yet unable to meet pre-pandemic experience hours

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Child Life's Student-to-Professional Pipeline and the COVID-19 Pandemic: A Call to Reconsider Student Selection Practices

out of students who cannot dedicate hours of unpaid work to a profession that may disregard the student's application for not following program preferences in the application process.

Students often hear that there were more qualified candidates who have more experiences with children of all ages and in varied contexts when receiving feedback of why they did not receive an internship. This implies that having more experiences is the system's ultimate measure of internship readiness. To disqualify this rationale, we must determine if the number of hours required is a proportional determinant of an internship applicant's goodness-of-fit with the child life profession: Does having more hours unquestionably create a higher-quality applicant, or does having more hours only amplify inequities among students who are able to dedicate hours to volunteer work versus students who must pursue paid work to survive? Ideally, students' academic preparation and knowledge are being evaluated in the same manner to assess that more child life-specific education, beyond the one required course taught by a Certified Child Life Specialist, is becoming a predominant indicator of internship readiness.

Child life's internship selection system has an escalating scale which is set by the elite, top percentage of students accepted for internships who push the parameters of what an intern is expected to possess and increasingly achieve each application cycle. The litmus test of this is that internship sites do not continue making offers to students beyond a line of demarcation considered to be below program standards. Thus, internship positions go unfilled while students, who meet internship application requirements, are left without internships each cycle. Evidence to consider if subjectivity is involved: Why do some internship sites turn down a student, yet another internship site makes the same student an offer? Standardizing experience hour requirements would allow students to have a more equitable internship application and review process, because they would be evaluated on child life knowledge, skills, and abilities that readied them for an internship versus more hours accumulated.

If child life specialists are to have a diverse, equitable, and inclusive profession, the ideal of a *superstar* internship candidate must be replaced with the priority that Certified Child Life Specialist preceptors are confidently equipped to teach, train, and mentor each student, transforming their child life academic knowledge into a clinical experience where students learn from child life professionals in practice how to become a *superstar* child life specialist.

Modifications to Requisite Experiential Hours

A testament to the child life community's support and collaboration was that adjustments were quickly made to ensure students immediately caught in the COVID-19 crisis were able to complete practicums and internships. While beneficial short-term adjustments were made to educational programming in 2020, there are modifications for child life professionals and the ACLP to consider for current and future student cohorts:

- Create a common definition of virtual volunteer hours that is recognized among child life professionals and consider allowing students to submit virtual hours for volunteer, practicum, and other experiences with children;
- Temporarily reduce the number of hours required for each type of required experience. This would provide an opportunity to assess why the number of hours required was chosen and explore if less hours impacts interns' clinical training;
- Require either a child life practicum or health care volunteer hours versus both;
- Facilitate student cohorts for practicums as observational experiences while working with child life academic programs to develop placements versus the competitive practicum application process;
- Without considering the complications of reviewing large numbers of internship applications when establishing internship requirements, determine the essential knowledge, skills, and abilities for internship and practicum applicants to demonstrate;
- Assess individual program preferences for internship applicants and establish the child life profession's requirements for experience hours based on evidence, instead of considering the ACLP Accredited Internship minimum requirement of 100 hours as inferior. This removes the pressure for students to compete and attain up to 600 hours in experience, which equals the time they are expected to commit to the clinical internship; and
- Carefully consider how applications are reviewed or removed from the review pile and if these practices are equitable to students from underrepresented racial, ethnic, and SES backgrounds who do not have the same resources or opportunities as students from the majority culture. However, as both authors are former practicing child life specialists now teaching in academia, we recognize that in

order for clinical sites to receive applications from students from diverse backgrounds, the recruitment of diverse child life students must start in academia. Similar to how clinical sites review internship applications, child life academics must carefully consider how to recruit and support child life students from diverse and underrepresented groups and make sure these practices are equitable.

In this unique time, the child life professional community may learn invaluable insights regarding current site-specific internship application requirements, realizing that some aspects may be modified temporarily to help cohorts of student impacted by the pandemic and other aspects may need to be adapted for long-term improvements to the system.

Conclusion

This pivotal time in our world's history has the potential to profoundly shape the child life profession. Decisions made during this COVID-19 pandemic and the manner in which child life students are treated will define our profession for years to come. To support child life students and the profession's future, child life's collective professional goal must be to model adaptability and to reconsider the pre-pandemic student selection process so that the child life profession emerges through the pandemic more supportive of student equity within the internship application and Certification Eligibility processes and more keenly aware of the knowledge, skills, and experiences ultimately necessary for learning to become a Certified Child Life Specialist.

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2021 DISTINGUISHED SERVICE AWARD RECIPIENT

A Catalyst for Change

The *Distinguished Service Award* is given each year to an outstanding ACLP member for their contributions to the field of child life. They are recognized for their exceptional leadership, integrity, and vision. ACLP is pleased to present the 2021 Distinguished Service Award to Carla (Oliver) Barrentine.

Carla's career accomplishments in each of these areas has been exemplarily, helping her to stand out as this year's recipient for the *Distinguished Service Award*. Carla is Director of Operations at Children's Hospital Colorado (CHCO). In this role, she oversees the Child Life, Creative Arts Therapy, Seacrest Studio, and Spiritual Care Departments. Carla exemplifies determination, ingenuity, and commitment to the advancement and growth of the field of child life in all she does. From the moment Carla's career began, her drive, passion, and commitment to the field was evident.

After completing her internship under Mary Barkey at Rainbow Babies and Children's Hospital, Carla began her career at Texas Children's Hospital as an outpatient child life specialist for three years. From there, Carla found her niche in supporting patients with burn injuries at Shriner's Hospital for Children in Galveston. She became a Survivors Offering Assistance in Recovery (SOAR) instructor and trainer for the Phoenix Society. She was a contributing author on the Phoenix Society's *The Journey Back-Resources to Assist School Reentry after Burn Injury*, which is used around the world for helping patients transition back to school. She began to present regularly at the American Burn Association, Child Life Annual Conference, and the World Burn Congress. She published manuscripts on working with burn survivors in *Burn Support News* as well as several other peer-reviewed journals. Quickly, Carla became a leading expert on providing psychosocial support to pediatric burn survivors and their families. After an impressive clinical record, Carla moved into a leadership role as the Child Life Manager at Shriner's Hospital for Children in Galveston in 2004. In 2009, Carla took the Child Life Manager position at Children's Hospital Colorado and has continued to excel, moving into a Director role in 2015 and Director of Operations in 2019.

A Vision for the Growth of Child Life

In 2013, child life programs across the country were experiencing significant barriers to growth. Carla saw a need to strengthen and grow her department, but new position requests were unlikely to get approved due to the financial

2021 Distinguished Service Award Winner Carla (Oliver) Barrentine

uncertainty many health care institutions were facing. Carla was not deterred. She first conducted a department-wide needs assessment to identify the gaps in service and priorities for the department. Without obtaining any new positions, she took a creative approach to use existing FTEs to add two new leadership roles including an Associate Clinical Manager and a Research and Quality Improvement Specialist. Giving the Certified Child Life Specialists (CCLS) in these roles dedicated time to devote to clinical management, process improvement, program evaluation, and research garnered evidence to demonstrate programmatic outcomes, effectiveness, and cost-savings.

Carla's vision was the foundation for the evolution and growth of the department. Carla began networking with hospital leadership, which resulted in executives rounding with and shadowing the child life specialists. Carla is a strong proponent of diversifying the roles in child life and strategically focusing on projects that can help promote and increase the credibility and visibility of child life. Through

her strategic planning and relationship building, Carla built and grew the Child Life Department at CHCO from a 12-person department, composed solely of child life specialists, to 65 staff who serve a variety of support roles including child life specialists, child life assistants, medical dog coordinator, education coordinator, supervisors, managers, and gaming technology specialist. She has set forth an exemplary model for structuring and staffing a child life department. Child life leaders from across the country regularly reach out to her for guidance and mentorship on how to grow a child life program. Carla dreamed of an ideal structure for a child life department and has worked tirelessly to see that dream come to fruition.

> *"One of Carla's great gifts is seeing what's special in others and elevating them. Our department is now cohesive, strong, and innovative because of her leadership."*

Carla's greatest strength is relationship building and engineering strong, unified, and productive teams. She sees the strengths in each individual and builds on them. She fortifies people by connecting them with one another, creating a synergetic team. One of her colleagues wrote in a letter of support for the nomination, "One of Carla's great gifts is seeing what's special in others and elevating them. Our department is now cohesive, strong, and innovative because of her leadership." One of the most shining examples of Carla's strength in relationship building is her securement of an endowed chair, *The Beekuizen Directorship for Child Life*, in 2017. Her strong relationship with the donor helped safeguard the position to ensure there is always a child life director at CHCO.

Her ability to creatively problem solve allows her to develop innovative positions to strengthen her department and expand the depth and breadth of the services provided. With technology rapidly evolving, Carla was interested in seeing how child life could leverage technologies such as virtual reality (VR) and augmented reality (AR) to provide complementary, nonpharmacological pain management and other innovative services for patients and families. After receiving a grant to support one year of funding for a gaming technology specialist, Carla was one of the first leaders to successfully incorporate AR, VR, and other technologies to support patients. She formed the Extended Reality Program at CHCO, an interdisciplinary steering committee, comprised of nursing, child life, physicians, and the new gaming technology specialist to help advance the integration of technology at CHCO to improve the patient and family experience. After just one year, Carla was able to operationalize the position and secure its sustainability at CHCO. Gaming and technology are now intricately woven into the interventions and services her department provides hospital wide. Thanks to Carla's vision and resourcefulness, preparing patients for their MRI's using VR simulation, supporting patients for their burn dressing changes using AR, connecting a child's voice to their legacy item using QR codes, and joining siblings together virtually using robots have all been integrated into the standard of care at CHCO. The gaming technology specialist role has since been replicated across the country at over 25 other health care institutions. CHCO now plays a prominent role as a training ground for gaming technology specialists across the country to help facilitate networking and brainstorming opportunities.

Carla is passionate about aligning with the Association of Child Life Professionals (ACLP) to focus the efforts of her department on strengthening the perceived value and credibility of the child life profession. She sees engaging in research and creating interdisciplinary alignments as two of the most critical strategies for meeting this goal. Carla believes that achieving a high standard of patient care involves interdisciplinary communication and multi-organizational cooperation. To this end, Carla developed roles and secured funding for a research coordinator and a medical director of child life that would be dedicated to advancing this strategic vision for her department and the field. The Child Life Department at CHCO is now leading research and quality improvement initiatives that do not just impact the care at CHCO but help to promote best practice and quality care throughout health care.

Carla's accomplishments reach far beyond the walls of CHCO. Carla has contributed to the broader child life field through mentorship, publications, presentations, and volunteering for the ACLP in various roles. She has served the ACLP as a member of the Conference Planning Committee, board director, and president, and she has chaired the Patient and Family Experience Task Force and Committee for the past several years. As part of this work, Carla contributed to the Beryl Institute's white paper on improving patient experience published in 2018 and played a pivotal role in the Emotional Safety Summit that was hosted by the ACLP last year.

Over her career, Carla has supported countless patients and families both directly and indirectly and has served as a leader with ACLP, a mentor to many, and a change-agent in the field. Her contributions to child life are deep and far reaching. Please join us in congratulating Carla on her outstanding service and the great honor of being recognized as this year's Distinguished Service Award winner!

Don't Follow That Gut Instinct: Debiasing for Equitable Care in Child Life

By Katy Tenhulzen, MS, CCLS
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By now, we all should be aware of the ongoing fight for social justice and the dire need for systemic change. Accordingly, the ACLP has encouraged us all to engage in this work within our child life teams, academic programs, and hospitals. Each of us has a responsibility to actively engage in self-reflection about our role in combating — *as well as our role in inadvertently contributing to* — inequity and injustice. Most people who provide support to children and families of diverse backgrounds would be unlikely to view themselves as overtly racist, sexist, or intolerant of certain groups of people. However, each of us has developed biases which impact our view of the world and the people in it. Some people may be aware of negative beliefs and perceptions they have about a group of people based on certain characteristics. Many of our biases, however, are implicit, meaning we have internalized and unconscious beliefs, attitudes, and perceptions that impact the way we behave around others. It is only with intention that we can identify and shift implicit biases (Amodio & Swencionis, 2018). In this paper, we will examine how biases develop, how these biases can impact patient care, and what strategies can be implemented to overcome implicit bias.

Schemas and Bias

Think back to Piaget's concept of schemas: the way we organize information to understand the world around us. Schemas can be understood as metaphorical file folders in which we store and add bits of information as we encounter things in our environment. Much of the information we store is implicit — understood without necessarily being linked to conscious thought. The contents of these folders include facts (gathered through direct and indirect methods and which may or may not be objectively accurate), sensory information, and emotions (experienced personally or observed in others). Implicit memory works by linking our sensory and emotional experiences. For example, as an adult, the smell of warm chocolate chip cookies may stimulate feelings of comfort and joy because baking cookies with a loved one was a positive experience of connection as a child. Alternately, hearing a dog barking may elicit a fear response if one was bitten by a dog as a child. As our schemas become more complex, they help us filter through the vast sensory input we experience throughout a given day. This helps our brain to quickly decide:

- what to pay attention to
- how to respond to things or people we encounter, and
- whether we should approach or avoid them based on unconscious threat assessment (Soon, 2019).

Automatic positive or negative feelings, assumptions, and responses to someone based on these unconscious assessments and schemas are called biases (Perception Institute, n.d.). According to Eberhardt (2019), "implicit bias is not a new way of calling someone a racist…implicit bias is a kind of distorting lens that's a product of both the architecture of the brain and the disparities in our society" (p. 6). Since childhood, we have been developing schemas and perceptions of people based on many social categories, such as race, ethnicity, ability, body size, age, gender, sexuality, and political affiliation. Over time and with repeated exposure, the brain will link positive or negative emotional responses and intrinsic beliefs about people with certain characteristics. This happens through direct experience, such as seeing or hearing the way parents or teachers talk about, or to, people who look a certain way. This also happens through indirect experience, such as media exposure (Payne & Dal Cin, 2015). Consider the typical appearance of the hero, the love interest, the incarcerated, the ideal parent, the abusive parent, or the drug dealer. The biases we develop from recurring media exposure are particularly powerful when it comes to groups we don't have much interaction with in real life.

Schemas are refined over time, but once they have been developed it takes a lot of new and different information to alter them. The human brain resists the discomfort of disequilibrium, so we easily accept new information if it integrates with what we already believe to be true. In contrast, if we encounter something that contradicts an existing schema, we tend to consider it an anomaly rather than evidence that we might be wrong. Accommodation generally requires multiple experiences that contradict a schema. The human brain also has a negativity bias, which means we tend to notice, focus on, and retain memories of negative stimuli over positive stimuli (Vaish, Grossmann, & Woodward, 2008). This is an adaptive function of the human brain because it increases the likelihood of survival, but it can lead to harmful consequences for us emotionally and socially. Even without our conscious awareness, negative biases can trigger emotional responses such as fear or anger. Our attitude, body language, behavior, desire, and ability to engage and connect with others can be altered by even a slightly elevated stress response. This, in turn, can alter their perceptions, behavior, desire, and ability to engage and connect with us.

The identification of negative biases can be quite uncomfortable because they often do not line up with the values we consciously align with, such as kindness, equity, and inclusion (Sukhera et al., 2018). But we will continue to inadvertently cause harm to patients, families, colleagues, and students if we do not identify and actively work to change our negative biases. Our negative biases inhibit others' ability to feel safe with us and impair our ability to provide equitable care.

Impact on Patient Care

In-Group/Out-Group Bias

In less than one second, our brain processes an initial impression of someone using existing schemas and biases (Pichon, Rieger, & Vuilleumier, 2012). Existing schemas increase our efficiency in determining an appropriate response, including whether this is someone we should avoid or approach. If that person is deemed "safe" we receive an unconscious "green light" to approach and engage with them. This sense of safety and comfort may be influenced by how similar they are to us, how similar they are to other people we have engaged with who have made us feel at ease (or not), and/or how the media we consume generally portrays people who look like them. "In-group biases" refer to

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the underlying preferences humans tend to have for people who are like us (Tropp & Molina, 2012). Several factors influence whether someone fits into a person's in-group or out-group including race, ethnicity, ability, body size, age, gender, religion, socioeconomic factors, etc. When we feel safe and comfortable approaching someone, they are more likely to feel at ease with us. This feeling of mutual safety and comfort increases the likelihood the interaction will be positive. This feels rewarding and can perpetuate a cycle where we tend to spend more of our time and energy with people from our in-group(s).

We may prioritize seeing or spend more time with patients and families who are in our in-group. Patients and families who do not provoke an underlying feeling of comfort and ease for us will likely feel the same way with us. Studies suggest that interactions with people from out-groups tend to increase anxiety. Provider bias and anxiety often leads to inequitable care, shorter visits, less eye contact, less time spent building rapport, and less collaborative decision-making (Powell, Tropp, Goff, & Godsill, 2014). In-group/out-group bias can also significantly impact students who desire to enter this field. We must consider how bias and other systemic barriers have thwarted us from creating teams that represent the populations we serve.

Reflect on your own in- and out-groups.

How might they impact your interactions with patients and families?

How might they influence who you choose to hire and which students you tend to select to mentor?

Bias and Nonverbal Communication

Implicit bias impacts non-verbal communication in both directions. Our perception of whether someone is approachable, or not, is influenced by facial expressions, eye contact, and the amount of physical distance (current COVID precautions excluded) we put between us. This is a bidirectional process, with the provider and patient/family assessing the safety and approachability of the other. The nonverbal cues we present to patients and family members, and the perceptions we have about their nonverbal cues, impact our ability to build rapport and develop therapeutic relationships. We may not even be aware of the subtle nonverbal cues we are giving to families, and our biases influence our interpretation of their cues. For example, White people who have stronger implicit racial bias are more likely to interpret neutral facial expressions as neutral or happy if the person is White, but to interpret neutral expressions as angry if the person is Black (Hugenberg & Bodenhausen, 2003). These kinds of misperceptions may lead a child life specialist to wrongly assume the family is not interested in child life support or to misinterpret the needs of a child or family during assessment. Further, having even a subtle defensive reaction to a patient or family may lead them to feel a sense of unease or, worse, may confirm existing negative schemas they have developed based on previous experiences with racism in health care.

How might biases impact relationships and communication with pediatric patients and families who fall into one's out-groups?

Bias and Empathy

Researchers such as Forgiarini, Gallucci, and Maravita (2011) highlight MRI studies that suggest people tend to have more empathy for others who are in their in-group. This is significant for child life specialists since our ability to empathize is critical to our ability to provide psychosocial support. White providers are more likely to have a stronger emotional reaction when observing a White patient in pain than when observing a Black patient experiencing pain — even when the patients are subject to the exact same procedure. Many people, including health care providers, believe that Black people have a higher pain tolerance or fewer nerve receptors (Hoffman et al., 2016). Zestcott, Blair and Stone (2016) describe health care discrimination as a significant problem, and patients of marginalized groups feel this impact on many levels: from experiencing microaggressions, mistrust in their health care team, and even higher mortality rates in various contexts. Healthcare workers may be more likely to perceive a patient of color as being uncooperative, defiant, or as displaying more behavior problems. This may reduce the patience extended to certain patients, lead to harsher verbal interactions, and increase the probability of using physical restraint.

How might a child life specialist's ability to provide equitable procedural and pain management support to certain patients be impacted by reduced empathy, an underlying expectation of "toughness," and/or perceptions of defiance?

Bias Interventions

Clearly, bias impacts the experience of patients and their families in health care settings. The good news is that we can shift our biases and behavior, which can have immediate positive consequences in our provision of care.

Identifying biases is the first step. Take the Harvard Implicit Bias tests: *https://implicit.harvard.edu/implicit/takeatest.html*

Learn more about implicit bias: *UCLA Equity, Diversity and Inclusion*

Take action to *debias*:

- **Acknowledge without shame**. People who are drawn to child life are kind and empathic, and it can be difficult to acknowledge we have biases that impact the care we provide. Shame is not motivating and is more likely to make us shut down or become trapped in denial. If we allow ourselves to believe that our inherent kindness means we are immune to bias, we will continue to cause harm while missing out on opportunities to learn, grow, and provide more equitable care.
- **Focus on equity**. If a person's desire to "not appear biased" is top of mind when interacting with a person from a marginalized group, this heightens anxiety and leads to hypervigilant monitoring of what we are communicating and how it is being received (Powell, Tropp, Goff, & Godsill, 2014). Focus your motivation on being an equitable provider rather than on avoiding external judgments. Act with purpose and intention rather than reacting or avoiding situations out of fear, by using the following recommendations.
- **Replace stereotypes**. Notice your negative reactions to others. Does this reaction stem from a stereotype you have integrated into a schema? Replace the stereotype with self-talk and by intentionally noting what makes the individual unique rather than making assumptions based on one dimension of who they are.
- **Conscious consumption**. What stereotypes are being perpetuated in your social circles and in your media consumption? Whose faces and voices are represented? How are they represented? Be intentional in avoiding media that reinforces negative stereotypes and seek out sources that elevate people who are typically marginalized. Diversify your social media feed, read books written by authors of color, and listen to podcasts from people who have different lived experiences as you. Adjusting negative biases requires repeated exposure to things that don't line up with your existing schemas.
- **Empathy and perspective-taking**. Connect with people who are different from you. Put yourself in the shoes of people who experience marginalization and bias and consider the toll it would take on you. Sit in discomfort as you acknowledge the privilege you have had to not have to think about these things until now.
- **Override your "gut instinct."** Our biases inform our gut responses which drive us to behave and communicate in certain ways. Pay attention to what happens internally when you interact with certain people from your out-groups. Is there tension somewhere in your body? Does your heart rate change? Do you find yourself tempted to wrap-up an intervention more quickly? What can you do in these moments to regulate and feel a sense of neurological safety so you can be fully present with this patient and family?
- **Integrate mindfulness**. In addition to myriad other benefits of mindfulness practices, experts suggest this can also reduce anxiety related to implicit bias and increase positive interactions with clients from a practitioner's out-groups (Kanter, 2020). Specific recommendations include 10 minutes of mindfulness/meditation per day and engaging in a brief practice (even just 30 seconds) of mindfulness before entering a patient's room. Pair this with mindful breathing: our nervous system calms when the count of our out-breaths are longer than the count of our in-breaths (e.g., breathe in for 3 seconds, out for 5 seconds.)
- **Collect and analyze data**. Collect demographic data within your department to track the distribution of time, services, and resources. This can be a great way to track

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whether patients and families are receiving equitable care and a chance to evaluate why this may not be happening. Is the diversity of your patient population reflected in your team and the students you select to work with? If it's not, why is that? What systemic barriers and biases need to be addressed?

- **Continued education**. How can your department continue to learn and grow together? Be intentional in integrating diversity, equity, and inclusion into you work through book clubs, trainings, and setting specific goals and objectives for improvement.

"Neither our evolutionary path nor our present culture dooms us to be held hostage by bias. Change requires a kind of open-minded attention that is well within our reach" (Eberhardt, 2019, p. 7). Please join me and many other leaders in the field in committing to this work with open minds and hearts so we can demand change and equity in the child life profession and within our respective institutions.

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It's Okay Not to be Okay

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It was during my undergraduate training that I first learned about the complexity of crying. I was taught that crying can emerge from a myriad of emotions, that emotions are often a reflection of chemical changes in the brain, and that a human body is constantly attempting to maintain those chemicals in a state of equilibrium. It was like a lightbulb of understanding went off: that when one of those emotions' skyrockets, our bodies need a release for that chemical, which is why human beings can cry when we are happy, sad, mad, scared and so on. As a student, I knew this information would be vital in my practice as a child life specialist to support patients and families during a variety of situations that can raise any number of emotions to new heights. However, it was not until I became an adult patient preparing for my first surgical experience that it truly hit home how the release that crying provides is necessary and sacred in one's coping process.

It was a quick but defining moment in pre-op when the anesthesiologist placed the nerve block. I began to cry, and a well-meaning nurse told me "you're okay, you don't need to cry, you're fine." I'm sure the tears started as a response to the painful procedure, but I'm more certain that the tears continued as a result of fear due to knowing what surgery to remove a mass could mean for my future. Yet in that moment, it didn't matter why I was crying, but that someone who was not in my shoes felt they could tell me I was okay. I was offended and annoyed by those words, and it made me consider that if I was experiencing this as an adult who is fully able to process emotions and thoughts, how do the countless children and teens feel when they hear those words in their own hospital experiences?

Crying is one of the ways we know when a child is in distress, as it is a natural and automatic response (Kuttner, 2010). Tears are the avenue for a person's body to release the physiological tension that is produced by trauma or pain. From birth, babies spontaneously cry in response to distress, but as children grow, crying is increasingly inhibited or repressed. All cultures and societies have well-defined attitudes about whether crying is allowed, under what circumstances, and what crying means at those times. However, adults can cause harm when they disapprove of

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a child's tears instead of supporting their efforts to gain control of their distress (Kuttner, 2010). If a child is told that it is not acceptable to cry, his or her ability to express distress in a natural and healing manner is impaired. Furthermore, children and adolescents are very sensitive to the judgement made about their pain or fear experiences, and if they do not feel heard or supported, they may become increasingly distressed in the moment, which can lead to deficits in their emotional intelligence, overall emotional well-being, and struggles with cooperation and compliance with their medical treatment plan.

Emotional Intelligence (EQ) includes one's self-awareness, self-acceptance, impulse control, and empathy (Markham, 2012, pp. 92-93). Child life specialists are in a unique position to help nurture the EQ of children and adolescent patients. However, this opportunity can easily be missed if the child's emotions are dismissed by telling them that they are "okay." The most effective way to cultivate emotional intelligence is to learn to understand, accept, and work with one's emotions. Health care professionals are in an optimal and unique position to help nurture the EQ of children and adolescent patients by actively listening when they work to explain what they are feeling, and helping them to communicate their emotions when they are unable. Any moment a child is telling us or showing us that they are not okay, which occurs often in medical settings, is an opportunity to help build their emotional intelligence. However, this opportunity is often disregarded through the act of dismissing a child's attempt at communicating their distress.

There are a variety of reasons why health care professionals may tell an upset child, "you're okay"— to comfort and reassure, to avoid a meltdown, to ease any personal feelings of guilt for performing painful procedures, or even their own personal belief that the child needs to toughen up. Witnessing a child in pain or the panic of a fight vs. flight response is distressing, no matter how many times you experience it. But by falling back on the statements of "you're okay, you're fine," we are impeding the child's ability to know and express themselves emotionally (Smith, 2016). In discounting a child's experience and feelings, not only are we sending the message that their story is not worth telling, but we also lend an increase to feelings of confusion, anger, agitation, and distrust — a distrust of the professionals taking care of them and an actual distrust of their own feelings. Too much empathy and reassurance can trigger a child's brain to sound a message of alarm about the pain, that it really must be very bad if an adult tells you they went through the same thing and reacted in a similar manner. Research has shown that when parents and professionals use language that promotes reassurance (it's okay, you're fine, you're okay), are too empathetic (diving into stories about personal experience to make them feel better), or apologize to the child, this actually increases the child's pain reports (Blount et al., 2009; Chambers et al., 2002). On the other end of the spectrum of reactions when witnessing a child in distress, health care professionals can feel not only the desire to help, but also fatigue, helplessness, irritation, or even hopelessness. While it's natural to experience those feelings, we need to be mindful of our thoughts and actions. If you process or ward off the feelings just listed by avoiding or verbally minimizing a child's distress, this may be self-protective but is ultimately a blunted and negligent clinical response by an adult they are told they should trust.

AVOID SAYING

"It's okay, you're fine, you're okay"

TRY SAYING

"I see that you are still bothered by _____, could you tell me what feelings are happening in your body?"

So what can we do to help turn a painful or fearful situation into a more manageable one? When encountering an upset child, the first step is to affirm the child's experience and acknowledge the child's pain and/or fear, no matter your culture, belief system, or attitude toward the situation. Children in distress need their concerns to be consistently heard, believed, and addressed. It is absolutely crucial to their emotional well-being that no matter how nonsensical or frustrating the child's feelings and display of emotions may seem to us, that we acknowledge the importance of the experience to the child by responding sincerely and promptly, remaining engaged in the process of their release of emotions until they are able to work through that challenging moment.

When we encourage and support children and adolescents in working through their distress, we are better able to engage and develop connections between the right and left hemispheres of the brain. We feel emotions in the right hemisphere, but to put language to those emotions, the left hemisphere must be engaged. Through a regular practice of identifying emotions, we are better able to find balance in the short term, and in the long term a more integrated brain,

both of which are essential to one's overall health and EQ. Research shows that the simple act of assigning a name to what we feel literally calms down the activity of the emotional circuitry in the right hemisphere (Siegel and Bryson, 2012, p. 29). As child life specialists, if we allow our patients to physically release their emotions through crying and then help them identify what they were feeling, we are better able to promote positive coping and the development of the child's emotional intelligence.

After taking that first step of acknowledging the child's pain and/or fear, some additional effective responses to use next for a child in pain or upset include the following:

- Responding promptly in an empathetic, professional, practical manner
- Explain in child-oriented language what is happening in his/her body
- Offer a positive touch or hand to hold
- Acknowledge the pain, discomfort, fear, etc.
- Tell the child calmly and slowly what positive steps are being taken to help them in that moment
- Provide hope or insight that the pain or fearful feeling will get better
- Instruct the child on using non-pharmacological coping strategies
- Keep yourself calm and watch your tone of voice

If you feel that the child is becoming caught up in anxiety or pain, start by accepting and addressing their experience.

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A simple statement of, "I see that you're still bothered by ____; could you tell me what feelings are happening in your body?" can go a long way in showing the child you trust what they are feeling and want to know more about it to better support them. But this is where it is vital to be mindful of using reassurance and sympathy.

When a child or teen is expressing that they are hurt, angry, frustrated, or scared by crying, they need someone to stop and listen. Every individual person is the authority on their emotional and physical experience, and they deserve to be compassionately witnessed and supported, free of judgement, during their challenging moment. Child life specialists are in a crucial position that invokes a responsibility to take the time to skillfully respond to children and adolescents who are upset, in turn helping them integrate their brain function, develop their emotional intelligence, and practice communication skills that will last through their lifetime. We are all in a position to support a child in distress, even if we do not necessarily understand what the big deal is. If it is a big deal to them, it must be a big deal to us.

How Far Have We Come?

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In the Summer 2007 *Child Life Bulletin* article "But is it a Field?," Paul Thayer reflected on the first 25 years of the child life profession. A colleague had inquired about child life asking, "Is it a field of inquiry in addition to being a profession?" The question made Thayer take pause, before concluding that the profession had a long road ahead before it could also be a field of inquiry, a phrase used to indicate an area of research. Prior to 2007, child life was considered an applied science and relied on the profession's anecdotal patient outcomes to inform the craft. The term "field" is often colloquially used to refer to any profession. Like Thayer, we take pause because, in an emerging evidenced-based profession, "field" more appropriately defines a field of inquiry that has the goal of producing new knowledge through research. This distinction is important to the profession's growth as it informs our priorities as a community and the way we educate emerging child life specialists. Those of us eager to consider the profession a field of inquiry are focused on documenting our profession's outcomes in a scientific manner to ensure our evidence-based practice is contributing to new knowledge.

Thayer suggested that we could embrace both of our identities as an applied science and an emerging field of inquiry. He challenged readers to focus on both by making "equally impressive progress in the next 25 years toward becoming a leader in pediatric psychosocial research" (p. 3). Thayer (2007) outlined five goals for growing child life as a field of inquiry over the next 25 years:

1. emphasis on research at all levels of education,
2. graduate education that fosters leadership and academic skills,
3. preparation of child life academic teachers,
4. continued emphasis on evidence-based practice, and
5. built-in time for research and professional development.

This paper will consider the progress made toward reaching each of these goals by 2032 and outline future steps for nurturing the growth of child life as a true field of inquiry.

Examination of Our Progress

To start, we highlight evidence demonstrating child life's collective pursuit of research since Thayer's article. A paramount concept to comprehend in this discussion is the term child life, which is generalized when it actually encompasses four distinctly significant components: (a) the emerging academic discipline, (b) the field of inquiry referring to research, (c) the profession, and (d) the professional organization. Currently, most examples are housed in the professional association, because neither child life's academic discipline or the field of inquiry is mature enough to sustain the profession's research.

Emphasis on Research at all Levels of Education

Thayer's (2007) first goal was to emphasize research in all levels of education. In addition to the efforts described in Table 1, child life specialists are conducting more research with their interdisciplinary teams, students, and academic partners. The certification requirement of one research course provides child life students foundational research knowledge. As they become professionals, they carry this foundation, as well as academic relationships, into their interdisciplinary settings. As will be discussed when we look at Thayer's third goal, academic endorsement requires full time Certified Child Life Specialist (CCLS) faculty members to hold advanced degrees. This expertise ensures that child life students have a research resource and potential mentor at both the undergraduate and graduate level. Though more growth is needed, these efforts clearly support Thayer's goal.

Graduate Education that Fosters Leadership and Academic Skills

Thayer's (2007) second goal focused on graduate education for child life students. At the time his article was published, there were far fewer child life academic programs, and students were entering the profession from a number of interdisciplinary backgrounds. Today's certification requirements allow students to earn either an undergraduate or graduate degree, and the increase in child life-specific programs ensures that students have access to Thayer's hope for education that fosters leadership and academic skills like research.

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BULLETIN 25TH ANNIVERSARY EDITION • SUMMER 2007

But Is It a Field?

Paul Thayer, MA, MDiv, Wheelock College, Boston, MA

Recently I was talking with a child development professor from another college when he asked about the field of child life. I launched into my standard speech to educate him about the profession when he politely stopped me. "I know about the profession; but I was asking if child life is a field? How does it develop a new body of knowledge? Is it a field of inquiry in addition to being a profession?"

His distinction is helpful as we set an agenda for the next quarter century. Having spent the first 25 years establishing a new profession, setting standards for professional best practice, and establishing academic and internship standards for certification, we have made great progress in becoming a recognized profession in pediatric care. Can we make equally impressive progress in the next 25 years toward becoming a leader in pediatric psychosocial research? In other words, how can we continue to develop as a field as well as a profession?

What would it take to become a leader in research about psychosocial care in children's health? Five goals might be helpful to set an agenda for the next quarter century:

1. **Emphasis on research at all levels of education.** Research leads to inquiry about best practice and helps to convince others of the importance of our work. In addition, research can help set a future agenda for exploration of emerging issues.
2. **Graduate education that fosters leadership and academic skills.** Graduate education in child life allows students a chance to learn advanced research skills and apply research skills specifically to advance child life as a field of academic inquiry.
3. **Preparation of child life academic teachers.** There is a shortage of doctoral level professionals trained specifically in the field of child life. Colleges and universities must begin more programs to train academic leaders who are prepared to teach the next generation of child life specialists.
4. **Continued emphasis on evidence-based practice.** Evidence-based practice makes use of research to promote professional development. Presenting research findings at the annual national conference and local conferences stimulates critical analysis and best practice. Additionally, evidence-based practice is often our best advocacy tool to convince others of the need to improve care and fund additional positions.
5. **Build in time for research and professional development.** Job descriptions and department goals that specifically build in individual and department research promote and legitimize ongoing academic inquiry. Professional development activities stimulate critical thought and creative project planning.

We often use the term "field" interchangeably with the term "profession". As we set goals for continued development of our profession, we would be wise to remember that the establishment of our profession is especially indebted to the research findings of our early leaders. Establishing a clear vision of being both a profession and a field of inquiry assures that we will continue to lead the way to provide the best care for children and families coping with illness.

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How Far Have We Come?

The results of his vision can be seen in a number of outcomes. There is some data to suggest that research consumption amongst child life students is increasing. In 2019, 180 students (16% of the 1100 attendees) attended the Annual Child Life Conference, the most since the certification exam was offered at conference (email correspondence on 12/2/19 from R. Spencer, ACLP Director of Professional Development). Also, students at both the undergraduate and graduate level are engaging in scholarly writing projects that draw from their leadership and research knowledge. For example, in 2017, *ACLP's Bulletin* student column was created, and we have seen students sharing their writing with the community in this outlet. Of the ten Beyond the Classroom articles published since the column's inception, there

Table 1.
Research Evidence/Effort Categorized by Component of Child Life

SOURCE	DELIVERABLE	CATEGORY
ACLP's Mission	Research as a Value	Professional Organization
ACLP's/CLC's Strategic Plans	Research included in each of the strategic plans strategy (2008-2011) goal (2012-2014) goal (2015-2018) area of focus (2019-2021)	Professional Organization
Child Life Competencies	**2010** I. Competency A Knowledge – Cite relevant classic and current research. Skill – Implement child life services using evidence-based practice. III. Competency A Knowledge – Articulate basic research methods and statistics that apply to program review. **2016** IV. Research Fundamentals Competency – The ability to integrate clinical evidence and fundamental child life knowledge into professional decision-making. Knowledge – Describe research methodologies that are relevant to the child life field (qualitative, quantitative, mixed methods, evidence-based practice, and quality improvement). Articulate the role and purpose of research design.	Academic Discipline & Profession
2019 Certification Requirements	Require one research course for students to meet Academic Eligibility criteria	Profession
Academic Endorsement Standards	Undergraduate Standard E: Describe how the undergraduate academic program utilizes research with students. Graduate IV: Research Fundamentals Standard A: The ability to integrate clinical evidence and fundamental child life knowledge into professional decision making	Academic Discipline
Internship Accreditation & Curriculum Module Requirements	Module 13: Administration - Objective 7 Understand basic research and statistics as they apply to development and evaluation of child life services. Module 14: Professional Development – Research Fundamentals The ability to integrate clinical evidence and fundamental child life knowledge into professional decision making	Profession
ACLP/CLC Evidence-based Practice Statements	Evidence Based Practice Position Statement & Model Evidence-Based Practice Statement – Therapeutic Play in Pediatric Healthcare (2014) Evidence-Based Practice Statement – Child Life Assessment: Variables Associated with a Child's Ability to Cope with Hospitalization (2008) Evidence-Based Practice Statement – Therapeutic Play in Pediatric Health Care: The Essence of Child Life Practice (2008) Evidence-Based Practice Statement - Preparing Children and Adolescents for Medical Procedures (2007)	Academic Discipline & Field of Inquiry
ACLP	2020 Value Proposition Statement synthesizing the value of child life specialists on pediatric health care delivery	Academic Discipline & Field of Inquiry

has been a balance between bachelor's and master's student authors, suggesting mentorship for scholarly writing at both levels of child life education.

Academic endorsement helps institutions remain focused on the goal of fostering leadership and academic skills. With curriculum that specifically draws from the child life competencies, child life students enter the profession well-prepared to be leaders within their scope of practice. Too, the Certified Child Life Specialist faculty member must demonstrate how they remain informed of professional requirements in child life academics, internships, and certification to support students' professional development. Because of this, child life students have leadership models who are knowledgeable of the profession's evolving standards. In addition to offering child life courses required for certification and content relevant to child life practice, child life faculty in endorsed undergraduate academic programs must also guarantee students are academically advised and professionally mentored. This way, each student engaged in learning about child life has direct support for gaining academic skills.

Preparation of Child Life Academic Teachers

Thayer's third goal related to preparing child life academic teachers. The number of CCLSs teaching in child life academic programs has increased with the number of Certified Child Life Specialist faculty earning doctoral degrees. A review of the credentials of CCLS faculty teaching in the 65 university/college programs (80 degree programs: 51 undergraduate, 29 graduate) in the Child Life Academic Programs list on ACLP's website showed that 11 faculty members earned PhDs, two faculty members possessed EdDs, and 37 held master's degrees.

Recognizing the importance of Certified Child Life Specialist faculty leading child life academic programs, the ACLP's Academic Endorsement standards require one full-time CCLS faculty member hold an advanced degree and have program oversight. The faculty member's advanced degree and full-time dedication to the academic role offers professional credibility and bolsters quality child life education, which allows for long-term sustainability of all components of child life including the field of inquiry, the emerging academic discipline, the profession, and the professional organization. Too, the Child Life Certification Commission mandates faculty teaching the child life required topics of study hold the Certified Child Life Specialist credential and have fulfilled 4000 hours of paid work experience or minimum of two years teaching child life subject matter. This requirement ensures faculty have child life clinical practice experience to benefit students' learning. Thayer's goal of improving the preparation of child life academics is already well-developed, and we anticipate this goal will continue to develop as the profession sustains its popularity.

Continued Emphasis on Evidence-Based Practice

Child life, formerly an applied science, once relied on professionals' training and anecdotal patient outcomes to inform the craft. After evidence-based practice was introduced to pediatric health care (Sackett et al., 1996), it became clear child life specialists, as health care professionals, must also be able to translate new knowledge into clinically useful forms that can be implemented across systems and measured in terms of meaningful impact on practice and health outcomes. Evidence-based practice requires collaboration between contributors to the field of inquiry and those practicing in the profession. Child life practitioners must have skills integrating research into practice, while researchers must understand the practitioner's workload so they can propose realistically replicable research.

ACLP has made strides in supporting evidence-based practice since Thayer's publication. In 2011, Jones and Bonjour published the evidence-based practice model for child life. Later, in 2016, smaller research and scholarship committees were combined into the Scientific Advancement of Professional Practice Committee, a large work group focusing on varied research initiatives. In 2017, the Child Life Professional Data Center (CLPDC) was launched to provide access to clinical data from programs across the globe. These initiatives are responses to the growth in research engagement amongst our community. Evidence of this engagement is also seen in ACLP's growing Resource Library which provides access to a catalogue of empirical journal articles, books, websites, and organizations related to child life that have been curated by the association. Finally, an increase in research engagement amongst our community led to the decision to separate *Child Life Focus* from *ACLP Bulletin* and rename it as *The Journal of Child Life: Psychosocial Theory and Practice*.

While progress has been made, this goal needs more attention in order to adhere to the idea that a field contributes to a new knowledge base. Evidence-based practice is a bridge between our applied identity and the scientific world of health care. Sharing our evidence beyond the walls of child life will help to solidify our role as an important contributor to pediatric research with novel and innovative ideas.

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Build in Time for Research and Professional Development

Finally, Thayer recommended a goal of building in time for research and professional development in clinical settings. In the 2019 ACLP member survey, a lack of time was cited as the greatest barrier for not submitting writing, whether scholarly or research, to the *ACLP Bulletin* or *Child Life Focus*. Anecdotally, more clinical child life departments are protecting time for specialists to consume and conduct research; however, we need to see specific data on how this is being funded and what those roles specifically entail. Since Thayer's publication, we are seeing an increase in child life-related publications by child life specialists in pediatric journals, implying there is more time to devote to research efforts (Boles et al., 2020). Again, this needs to be documented and program leaders need to share how these projects are supported by their health care institutions.

ACLP donor partnerships that emphasize evidence-based practice also help support efforts to prioritize research. From 2012-2014 ACLP was cumulatively awarded $1 million from Disney Citizenship to support multiple play initiatives, including a national survey on play and two studies examining the economic value of child life interventions in hospital settings. These grants enabled child life authors to take protected time from their clinical duties and focus on conducting and disseminating (Grissom et al., 2015) their research. But because child life is a small profession, we cannot depend on grant funding for each research endeavor. As such, child life academic and clinical research partnerships are essential for boosting our emerging academic discipline and improving feasibility since academics can relieve research burden. This synergy improves the speed and ease of conducting clinical research and provides students access to clinical samples for learning.

Hopes for the Future of Child Life

Evidence suggests we are making progress toward meeting Thayer's goals for 2032. Efforts by the professional organization such as academic endorsement and the launch of *The Journal of Child Life: Psychosocial Theory and Practice* highlight the profession's commitment to both our identities as an applied science and emerging field of inquiry. By looking at each component of child life more closely, we consider the growth needed to meet his vision.

The Field of Child Life

Child life's field of inquiry bears much responsibility for the development of all other components of child life; thus, much time and effort must be dedicated to the growth of research. Without a solid field of inquiry, the academic discipline will not grow and the profession will not improve services to children and families. For the sustainability of our field of inquiry, we hope full-time academic Certified Child Life Specialist faculty with research responsibilities (Sisk & Burns-Nader, 2020) continue to demystify research for students. We encourage practicing child life specialists to tap into their natural curiosities observing, wondering, questioning, and assessing with a research structure to support our field of inquiry. A future hope would be for clinical program child life leaders to have support to provide their teams research training and protected time to conduct research.

We encourage practicing child life specialists to tap into their natural curiosities observing, wondering, questioning, and assessing with research structure to support our field of inquiry. A future hope would be for clinical program child life leaders to have support to provide their teams research training and protected time to conduct research.

The Academic Discipline of Child Life

Child life is emerging as an academic discipline as the field of inquiry continues to grow, providing evidence that the child life profession's scope of practice has value. This necessitates an increase in research literacy amongst the community responsible for maintaining this data. Child life academic programs continue to work toward enhancing their clinical research training so more students contribute to the field of inquiry. Emphasizing practical, clinical research methods offers students a foundation of skills to use in their future practice. When they enter the profession, they bring with them knowledge of how to contribute to a field of inquiry as well as relationships with academic mentors. Because the academic discipline is only emerging, it is essential that these relationships between clinical child life specialists and academic mentors are well nourished so the momentum for collaboration pushes us closer towards Thayer's vision.

The Profession of Child Life

A primary hope for the future of the child life profession is that we continue to passionately and professionally serve children and families experiencing stressful life events. Increasing diverse perspectives will enhance the research produced that informs practice. The profession's focus on diversity, equity, and inclusion will bolster our research as diversity of practitioners and educators within research are all needed to achieve the highest level of professional quality. We also noted one area of growth is Thayer's fourth goal of promoting evidence-based practice. As a profession, we can support the evidence-based practice skills of our colleagues, trainees, and selves by accessing professional development that translates research into practice, teaches us how to consume research, and encourages us to disseminate our work outside of the child life silo.

The Professional Organization of Child Life

ACLP supports the child life profession by providing a structure for credentialing, access to evidence-based practice recommendations, a code of ethics, and resources for peer connection. *The Journal of Child Life: Psychosocial Theory and Practice* is an example of an ACLP resource designed to support child life's field of inquiry. By emphasizing interdisciplinary collaboration and peer-review, the publication establishes itself as a vehicle for sharing the latest inquiry on pediatric psychosocial care. However, this publication is primarily accessible to ACLP members and not searchable on scientific databases such as PyschInfo or Google Scholar. In order to share our work with others in pediatrics, a future hope for our profession is to continue seeing more child life specialists publishing outside of our professional organization in interdiscinplinary journals and collaborating with other pediatric providers to produce research that will advance our field of inquiry.

Conclusion

In 2007, Paul Thayer was asked two important questions: "How does child life develop a new body of knowledge?" and "Is child life a field of inquiry in addition to being a profession?" These questions compelled us to consider how far child life has come in the past 13 years. Coincidentally, it is a mid-point progress report to Thayer's question: "Can we make equally impressive progress in the next 25 years toward becoming a leader in pediatric psychosocial research?" (2007, p. 3). As summarized above, it appears child life has made progress as a field of inquiry impacting the emerging academic discipline, profession, and professional organization.

Child life's current challenge is to continue making positive contributions in each area of our collective identity as we pursue research that benefits not only our field of inquiry, but especially the children and families we serve. Helping people is the primary motivating factor that drives child life professionals to provide best practices in psychosocial care, advocate for changes to create optimal health care experiences, and face challenges that promote professional development. Translation of these clinical elements into motivations that fuel child life research is pivotal for all aspects of child life to thrive. Let's not wait another 25 years, but focus to accelerate our progress in building a child life-specific body of knowledge within the next ten years. With this goal in mind, child life professionals must ask themselves, "How can I contribute to building child life's field of inquiry through research?"

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LOOSE PARTS

Creating and Constructing

Medical Play for Children Who Have Trachs

Amber Aparicio

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

According to the developmental interaction approach, children learn by actively engaging with their environment (Luongo & Vilas, 2018). Working with loose parts encourages such engagement and empowers children to use their imaginations, problem-solve, and make meaning (Luongo et al., 2018). When children play with these materials, they may also improve their self-regulation and self-esteem (Luongo et al., 2018), participate in open-ended play opportunities, and make self-directed discoveries (Belinda, 2009). This loose-parts project allows children with tracheostomy tubes to explore a toy representation of their medical equipment, which can promote normalization and coping.

A trach provides an air passage for children who otherwise have difficulty breathing and is placed into a small opening at the trachea (Mayo Clinic Staff, 2019). After getting the procedure, children and families will learn the necessary skills and components of trach care from members of the multi-disciplinary health care team. The nurse may devise a plan for daily trach care, which consists of cleaning the site and suctioning, changing trach ties, and providing humidity via a Heat and Moisture Exchanger or mist collar. Adding humidity prevents secretions from becoming dry and irritating the lungs (Kelly & Chisholm, 2011). To avoid build-up of mucus, the trach tube is typically changed once a week. The skin around the site must stay dry and clean, and a suctioning machine can be used to clear excess mucus. If the child requires oxygen, the tube can be attached to a ventilator (Kelly & Chisholm, 2011). A speech-language pathologist may suggest a device to redirect the child's airflow to generate speech or teach the child other methods of communication (Mayo Clinic Staff, 2019).

This activity will address the experience of having a trach, putting on the Heat and Moisture Exchanger, and suctioning secretions. The activity can prepare children who are getting a trach for the first time and normalize the experience for children at any point in their trach experience. Creating mock secretions and helping to suction a doll's trach can alleviate anxiety or embarrassment that some children may experience. The family can assist in the creation process with scaffolding and support from a child life specialist, which can help the child and family together learn more about trachs. This project is ideal for school-aged children between the ages of six and 11 who can develop confidence and competence by creating the project and selecting materials. However, children in early childhood can also benefit from talking to the doll (e.g., communicating feelings, misconceptions) and handling the doll (e.g., performing suctioning).

The child life specialist has the potential to increase comfort and coping for patients and their siblings through play opportunities, such as this loose parts activity. By creating this loose parts project with children and families, child life specialists can normalize trach care, provide preparation, scaffold learning, and empower the family.

List of Materials

The Trach

- white foam spool of thread or modeling clay
- white plastic spool of thread
- fabric for the trach's strap (e.g., strap of an old baseball cap)
- thin plastic tube (e.g., medical tube, clear plastic straw)
- Velcro
- scissors
- hot glue gun
- doll or stuffed animal

Suctioning Machine

- turkey baster
- thin plastic tube

Secretions

- bowl
- ½ cup of water
- 3 gelatin packets
- ¼ cup of light corn syrup
- gloves
- napkins

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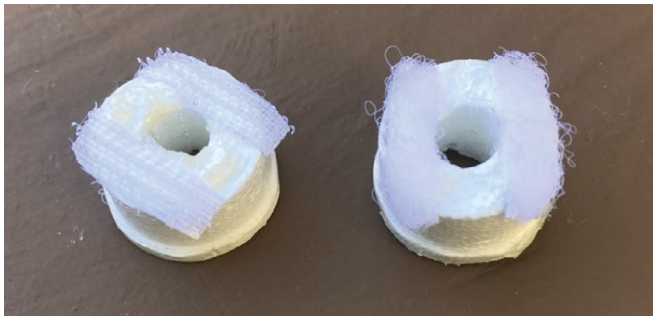
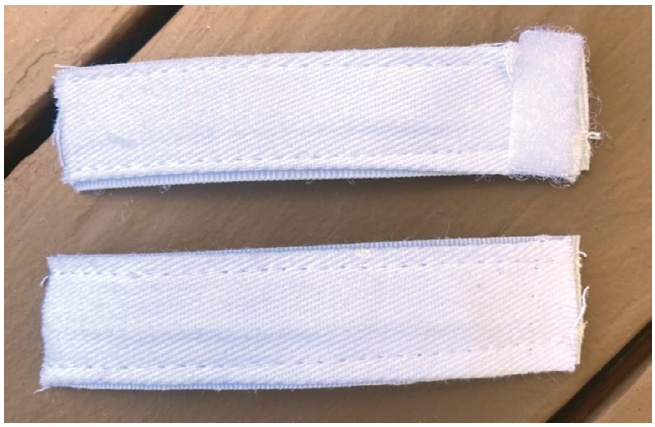


Step 1



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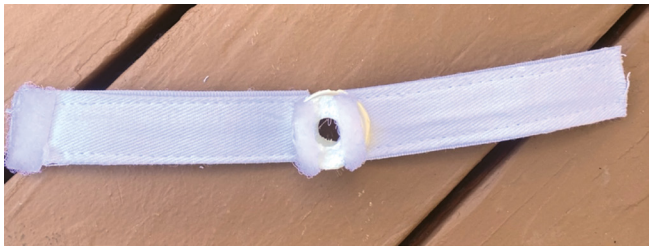

Step 3

Step 4

Instructions for Creating the Trach Doll

1. Cut white foam spool of thread in half. Modeling clay can be used in lieu of a foam spool (e.g., form clay into a 2-inch-long cylinder, poke a hole through the center, and cut in half). Put small pieces of Velcro on the sides of the cut ends so that it can be put back together again.
2. Cut two pieces of white fabric 3 ½ inches long and 1 inch wide to make the neck plate/trach ties. Place Velcro on the end of the fabric to fasten the straps around the doll's neck.
3. Select one half of the foam spool. Hot glue the two pieces of fabric on the side of the foam spool without Velcro.
4. Select the other half of the foam spool. Hot glue a small piece of a tube to the top half of the foam spool to serve as the inner cannula. Place additional Velcro on the outer side, which will later attach to the Heat and Moisture Exchanger.
5. Velcro the fabric around the doll's neck. Velcro one half of the foam spool to the other half. The tubing will pass through the bottom half of the spool and can be tucked under the doll's shirt. Alternatively, a small incision can be made in the doll for the tubing.
6. Use a white plastic spool of thread to serve as the Heat and Moisture Exchanger. Place a piece of Velcro on the white plastic spool. Attach the Heat and Moisture Exchanger to the trach using the Velcro.

Secretions and Suctioning

7. To make the secretions, heat ½ cup of water, add 3 packets of gelatin, gently stir and let cool, and add ¼ cup of light corn syrup (Chloe, 2015).

Step 6

Step 5 & 6

8. Attach the tubing to the end of the turkey baster to create a longer tube extension coming from the baster, which constructs a small suctioning machine.

Step 7

9. Use gloves and place secretions in and around the trach. Clean the doll using the suctioning machine by squeezing the end of the turkey baster, and use wipes to clean up the excess.

Step 8

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2020 Professional Research Award Winner: Toni Millar, MS, CCLS

Toni Millar, MS, CCLS

Reducing Anesthesia Use for Pediatric Magnetic Resonance Imaging: The Effects of a Patient- and Family-Centered Intervention on Image Quality, Health-Care Costs, and Operational Efficiency

Mastro, K.A., Flynn, L., Millar, T.F., DiMartino, T.M., Ryan, S. M., & Stein, M.H.
Journal of Radiology Nursing. Volume 38, Issue 1, March 2019, 21-27.

Abstract: Children with complex medical problems who require anesthesia are known to be at risk for acute adverse physiologic events related to anesthesia. The risks of anesthesia include short- and long-term psychological and neurobehavioral issues. Magnetic resonance imaging (MRI) has emerged as the standard of care for diagnosis and follow-up of many conditions, and more children are being subjected to anesthesia to ensure acceptable motion-free image quality of the MRI scans. The aim of this study was to evaluate the effectiveness of an anesthesia-free patient- and family-centered intervention through an analysis of MRI quality, health-care costs, and operational efficiency as compared with other approaches. This study retrospectively reviewed patient data extracted from electronic medical records of children aged 3-17 years, who underwent outpatient MRI at an urban academic medical center from 2015 to 2016. A total matched sample size of 500 children, 125 per group, was used to investigate the outcome variables including the quality of magnetic resonance image, health-care cost, and procedural time. The groups included are as follows: (1) intervention group, patient- and family-centered preparation of the child, and no anesthesia given (PFC/NA); (2) comparison group, no structured preparation, and no anesthesia given (SC/NA); (3) comparison group, certified child life specialist preparation, and anesthesia given (CCLS/A); (4) comparison group, no structured preparation, anesthesia given (SC/A). The PFC/NA intervention group was found to have significantly lower costs ($p < .0001$) and shorter procedure times ($p < .0001$), and 96.8% of the MRI images were of acceptable or better quality than those of the SC/A and CCLS/A groups. The PFC approach provides a way for children to undergo outpatient diagnostic MRI without the need for anesthesia, thus reducing risk, costs, and procedure time.

Tell us about yourself

Toni Millar: After starting my career as a pre-school teacher, I found the field of child life serendipitously in my mid-30's and knew it was what I was truly meant to do professionally. In 1995, I graduated with my master's degree from Wheelock College, then worked as a CCLS in pre- and post-surgery units. Shortly into my career, I was asked to step into the role of Child Life Director and remained in that position for the next 20+ years in two major children's hospitals, in Ohio and New York City. I then became the Vice President for Patient Experience for the New York-Presbyterian Hospital System, becoming more involved in the data aspect of health care.

My most recent position is with a non-profit, Project Sunshine. Based on the importance of play, it provides free play opportunities for children (and their families) facing medical challenges, and has brought me back to my beloved world of child life and pediatric patients and their families. Also, throughout most of my professional child life career, I became involved in various positions with the Child Life Council (prior to becoming ACLP), including President. I have continued to contribute to ACLP through various committee roles, and co-authored a chapter in "The Handbook of Child Life-A Guide for Pediatric Psychosocial Care, 2nd ed."

Why did you decide to undergo this research project and what was your experience with research before you took on this project?

Toni Millar: Prior to my role as Director of Child Life and Patient and Family-Centered Care at New York-Presbyterian Morgan Stanley Children's Hospital, I had never been directly involved in a research study. As director, I reported to the Chief Nursing Officer, Kari Mastro (who now serves as a Public Member on the ACLP Board).

Kari brought a concern to my attention that got me interested in undergoing this research project. She noticed that most pediatric patients were being sedated for their MRIs. As an avid child life supporter, she wanted to create a study that looked at utilizing child life preparation to minimize the need for MRI sedation while preserving the quality of the image, decreasing health care costs, and increasing operational efficiency. I was excited that this research could further support the work of child life specialists and decided to take it on.

What was your role in the research study?

Toni Millar: As the Child Life Director, I laid the foundation and acted as a consultant of what child life could provide and would need. I collaborated with the pediatric radiology department leadership and staff to create the position description, then I hired and managed the CCLS. I also negotiated a space for pre- MRI preparations with the mock MRI.

What were the biggest things you learned during the process?

Toni Millar: On a professional level, I was thrilled that the study supported what child life specialists have intuitively known for years- that preparation, coping skills, and psychosocial support can frequently offer a non-pharmacological alternative for some procedures, while helping children master the experience. I learned how important it was to have Kari, at her level, as an advocate, and helping to secure the financial support needed to fund a position in Pediatric Radiology that had not existed before. I also learned that there are various stages with various complications that occur during the process of a research study.

What were the biggest challenges during the process?

Toni Millar: The biggest challenges, from my point of view (Kari may have a few to add!), occurred in the months leading up to and following the implementation of the child life role in Pediatric Radiology. The Pediatric Radiology unit had rarely used child life services other than to provide toys for their staff to give out to patients or for last minute requests to help very anxious children whose "uncooperative" behavior was delaying the procedure. Therefore, introducing child life's role and psychosocial approaches, such as preparation, support, and parental presence were challenges because they were unfamiliar to the Pediatric Radiology staff. In addition to agreeing to a dedicated space for pre-procedure preparations, a mock MRI, and distraction items, the Pediatric Radiology team needed to make operational changes such as scheduling additional time prior to the procedure for preparation.

What tips would you give to someone just starting out in the research process?

Toni Millar: The tips I would offer to anyone starting out in the research process would be to follow your instinct that your research idea is valid, identify key leadership advocates that will support the study both conceptually and financially, and to be patient- it doesn't happen as fast as you'd like!

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

Non-Pharmacological Pain Management for Children with Sickle Cell Disease and Other Sources of Pain

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Non-pharmacological pain management refers to any method of pain management used that does not involve medications (Geziry et al., 2018). As child life specialists, we use these techniques on a daily basis in providing coping strategies and opportunities for distraction from pain and discomfort. We aim to promote coping with acute and chronic pain by teaching children coping strategies such as guided imagery, deep breathing, and distraction techniques. While this article highlights the significant need for non-pharmacological pain management in children with sickle cell disease, these resources may also benefit the many children coping with acute and chronic pain associated with other illnesses, disabilities, and hospital experiences.

Children with sickle cell disease (SCD) can often struggle with acute and chronic pain associated with vaso-occlusive events (VOE). VOE not only causes pain crisis for some patients with SCD, but may also cause damage to bones, spleen, brain, liver, lungs, kidneys, and joints (Zouki et al., 2018). This organ damage can result in additional need for pain control. VOE occurs when "sickled cells" stick together in a blood vessel blocking blood flow to a certain part of the body. VOE is the most common reason for hospital admission for children and teens with SCD (Zouki et al., 2018). Increased pain and suffering can escalate a patient's vulnerability to psychiatric illnesses such as depressive disorders, anxiety disorders, and post-traumatic stress disorder (Geziry et al., 2018). It is vitally important that all pain is acknowledged and that non-pharmacological pain management techniques work in partnership with pain medications to provide better pain management for SCD patients and other children coping with pain.

Many families may not be aware of or have access to options for non-pharmacological pain management due to lack of insurance coverage, lack of availability in the community, or lack of education and referrals for services. Child life specialists, social workers, hospital psychologists, and health care providers are often the medical team members best positioned to provide education, information, and resources to encourage and equip patients with tools and ideas for non-pharmacological pain management. The resources below will provide a starting point for professionals seeking to support their patients as they are coping with pain. While many of these ideas are from clinical experience working with children with sickle cell disease, most of the ideas are applicable for children coping with pain due to other sources. Some ideas include massage therapy, acupuncture, guided imagery, meditation, progressive muscle relaxation, music therapy, effective pain rating scales to identify pain accurately, and deep breathing exercises.

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Zouki, T., Haroutunian, A., & Malcom, T. (2018). Pain management for the sickle cell patient. In N. Shallik (Ed.), *Pain management in special circumstances* (pp. 15-32). IntechOpen.

ARTICLES & INFORMATIONAL GUIDES FOR PARENTS

- *Kids Health*. This website provides a basic overview of sickle cell pain crisis, what it is, how it is caused, what it feels like, how to respond during crisis, and how to try to prevent a crisis from occurring. This is a great teaching sheet available in English and Spanish for helping educate teenagers about their pain and for starting the conversation about pain management strategies. https://kidshealth.org/en/teens/sickle-crisis.html
- *Centers for Disease Control (CDC)*. This organization offers multiple PDF fact sheets about sickle cell disease that can help promote understanding for parents, teens, school teachers, or other members involved in supporting a child with sickle cell disease. Through additional education and clear, concise teaching resources, patients and families can have a better understanding of pain, pain management, and how to partner with healthcare providers to manage pain. https://www.cdc.gov/ncbddd/sicklecell/materials/factsheets.html
- *Practical Pain Management*. This website provides an excellent article written by Rosemary Black that can be a helpful tool for parents as they care for a child with chronic pain or long-term frequent acute pain. It gives great tips for how to react when a child is in pain and how to help a child manage their pain. https://www.practicalpainmanagement.com/patient/resource-centers/chronic-pain-management-guide/when-your-child-living-chronic-pain

- *About Kids Health*. This website is a source of helpful information for parents who are parenting an older child with chronic pain. This specific article provides ideas for keeping regular routines, establishing good sleep patterns, supporting children through transitions in school, taking care of yourself as a parent, and advice for when to seek professional help for your child. https://www.aboutkidshealth.ca/article?contentid=3651&language=english
- *Health Engine*. It is so important for non-pharmacological methods of pain management to be used in combination with pain medications. Health Engine acknowledges how important this is in their article and provides a list of 10 examples of methods of non-pharmacological pain management. https://healthengine.com.au/info/control-of-pain-in-children-paediatric-pain-management
- Joint Commission, Division of Healthcare Improvement. (2018, August). *Quick safety: Non-pharmacological and non-opioid solutions for pain management*. https://www.jointcommission.org/-/media/tjc/documents/resources/pain-management/qs_nonopioid_pain_mgmt_8_15_18_final1.pdf
  - This article from the Joint Commission lists evidence-based, non-opioid options for treating pain. It provides a thorough list of non-pharmacological pain management ideas that are supported and validated by research.

MAKING A PERSONAL PAIN SCALE

- *Pain Doctor*. This website provides a helpful article about 15 different pain scales and how to find the best pain scale. The "personalized pain scale" and "Randall pain scale" are the two scales that I have used with children in the hospital setting. It is so important for patients to have a way to describe and rate their pain for effective pain management to occur. https://paindoctor.com/pain-scales/
- *Functional Pain Scale*. This is a link to a more thorough description of a "functional pain scale" and examples of how this type of pain scale could be created and used with a patient. https://www.caltcm.org/assets/Pain-file/functional%20pain%20scale%20u%20of%20iowa_2001.pdf
- *Randall Chronic Pain Scale*. This website provides additional information about the "Randall chronic pain scale." This pain scale can help patients rate their pain with descriptions and personalized examples of when various levels of pain have been experienced previously. http://www.infomin.org/painscale.html#howto

BOOKS

- Culbert, T., & Kajander, R. (2007). *Be the boss of your pain*. Free Spirit Publishing.

  This book is an excellent tool for providing education about non-pharmacological pain management and teaching tangible skills to children. Some skills discussed include acupressure, aromatherapy, biofeedback, the jettison technique, changing the image of your pain, and belly breathing.
- Arteaga, M., & Celej, Z. (2013). *Inside my imagination*. Cuento de Luz.

  This peaceful, calming story has beautiful illustrations that promote relaxation and encourage children to use their imagination. This book can also create the opportunity for a child to learn how to use imagination as a technique for distraction from pain. This book is available in both English and Spanish versions for purchase.
- Clarke, C. (2014). *Imaginations 2: Relaxation stories and guided imagery for kids*. Bambino Yoga.

  This book provides guided imagery stories for each season of the year and for specific environments in nature such as rainbows or waterfalls. Some stories are lengthy but are perfect for pain management moments when a longer reading is preferred.
- Clarke, C. (2016). *Imaginations 3: Guided meditations and yoga for kids*. Bambino Yoga.

  A wonderful children's book that provides prompts for leading a child or teen through guided meditation. Additionally, this book provides information about the basics of yoga and yoga routines for kids of all ages to enjoy for relaxation and stretching.
- Hsu, L., Rodrigues, C., & Brandalise, S. (2019). *Hope and destiny jr. workbook*. Hilton Publishing.

  This is a workbook and learning guide designed specifically for adolescents with sickle cell disease. It provides education about types of pain and provides a place to track pain and symptoms. It also offers learning activities and journal pages to write about challenging experiences.

OTHER RESOURCES

- *Sleep Talk Down Guided Meditation: Fall Asleep Faster with Sleep Music and Spoken Word Hypnosis*. This YouTube video shows soothing images of outer space and guides the listener through soothing spoken word and guided meditation to help promote sleep and relaxation. https://www.youtube.com/watch?v=69o0P7s8GHE
- *Moshi*. This app has wonderful guided imagery and relaxation stories that are designed to help children fall asleep. Many of the stories are free and do not require additional payment within the app. There are also "sounds" available without words that could be used as background music for story time, guided imagery, or as a sound machine for relaxation. https://www.moshisleep.com/?gclid=Cj0KCQjw-af6BRC5ARIsAALPIIVnyLr2opB8imxOuluw8YyzeyIRI4w8_D_RVro8wr8U3aSyuyQzsWgaAk_9EALw_wcB

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Non-pharmacological pain management for children with sickle cell disease and other sources of pain

- *Breathe2Relax*. This app provides guided deep breathing exercises which can help with relaxation and non-pharmacological pain management. The app helps remind the listener to create a calming environment before beginning each deep breathing exercise. It also provides reminders for best body posture and reminders to breathe intermittently throughout the exercises. https://apps.apple.com/us/app/breathe2relax/id425720246
- *Calm*. This App is free with the opportunity to purchase additional resources within the app. It provides 7-day educational sessions such as "how to meditate" or "7-days of calm" which could help introduce these concepts to patients and families. There are guided relaxation sessions catered to sleeping and in the "more" section of the app you can find "breathing exercises" which guide the user through deep breathing with a visual bubble. https://www.calm.com/
- *Pain Scale*. This app not only creates a place to document pain level and pain's location on the body but it also helps document triggers and patterns as each person tracks their pain over time. It provides daily ideas for pain relief, videos for daily guided meditation, and additional articles and videos for education, encouragement, and building a base of non-pharmacological pain management strategies. https://www.painscale.com/
- *Fully Loaded Electronics*. This company offers virtual reality (VR) systems that are already pre-loaded with games. Their VR systems are user-friendly for child life specialists and they offer payment by invoice (which most hospitals need). They offer a wide array of games that can promote relaxation, diversion, and pain management with multiple bundle options. https://fullyloadedelectronics.com/collections/virtual-reality-vr-therapy
- *Childrens Healthcare of Atlanta Virtual Reality Case Study*. This article provides an overview of a case study done at Children's Healthcare of Atlanta to assess the benefit of virtual reality to patients while coping with procedures, pain, and/or anxiety. Overall, the article highlights games that were beneficial to promote patient coping, previous studies done showing the effectiveness of VR, and patient and staff quotes after the use of VR in this study. https://www.wsbtv.com/news/national/hot-topics/children-s-healthcare-of-atlanta-using-virtual-reality-to-help-young-cancer-patients/943030453/

Jessica Westbrooks has been a child life specialist for six years and has worked with patients and families in an outpatient hematology/oncology setting for five years. In her time working in this environment, she has created functional pain scales with patients to help with better pain rating and she has used techniques such as virtual reality, diversion, guided imagery, essential oils, and deep breathing to promote non-pharmacological pain management. Jessica is passionate about connecting patients with resources to support their coping in the hospital environment and at home. Jessica can be reached at jessica.westbrooks@choa.org.

MOMENTS FROM THE PAST

Alexis Plumb, MSEd, CCLS
ACLP ARCHIVES COMMITTEE CHAIR-ELECT
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Reflecting on Our History to Make a More Inclusive Future

Members of the child life and ACLP community have full access to the archived history of the child life profession stored in the ACLP Child Life Archives at Utica College. Among the many shelves and drawers are pictures, letters, teaching tools, and other artifacts that honor the work of various child life specialists and the growth of our field over time. However, upon reviewing the archives, a significant gap is realized surrounding topics and historical contributors in diversity, equity, and inclusion (DEI) in the field of child life.

Child life as a profession strives to support children and families without exemptions. The children and families most often served represent diverse backgrounds, and child life specialists seek to honor those differences through their work. However, it is without a doubt that child life professionals do not represent a diverse population. As a profession and organization, it is essential we take steps necessary to grow to become more accessible to future professionals and better serve our families. While many continued conversations, efforts, and space need to be provided to address this issue, two "moments" in our organization's past represent initial efforts made to limit barriers present in forming a more inclusive ACLP community.

ACLP International Scholarship

In 2010, the Child Life Council (CLC) initiated an important step in the growth of the child life field by creating an ACLP International Scholarship. This scholarship functions to provide the child life conference opportunity to health care professionals around the globe who are interested in providing psychosocial care to children ("International Scholarships," n. d.). Upon its' initiation in 2010, four winners were able to attend the 28th annual conference in Phoenix, Arizona. In a reflection piece in the Winter 2011 *Bulletin*, the recipients commented on their experiences and the motivations that the CLC conference provided to them professionally.

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2010 CLC International Scholarship Winners. From left to right: CLC President Eugene Johnson; CLC President-Elect Toni Millar; scholarship winners Rachel Jacobson, Crissa Nacionales (front), Dragana Nikolic, and Carlo Moretti; CLC Past President Ellen Good; CLC Executive Director Dennis Reynolds.

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Reflecting on Our History to Make a More Inclusive Future

One recipient, Dragana Nikolic from Serbia, reflected how the ACLP International Scholarship provided her with the opportunity to develop connections ("2010 Conference-An International Perspective," p. 4). Nikolic shared about their opportunity to spend time with the child life team at Johns Hopkins Children's Center in Baltimore in the days leading up to conference. Nikolic, as well as the other ACLP International Scholarship recipients, expressed that it was the connections formed with other child life professionals that truly made the most of their experience and would impact the projection of their work the most.

Since 2010, five ACLP International Scholarship Award recipients have been recognized each year and have been given the opportunity to travel from their home country to the ACLP conference where their airfare, lodging, conference registration, and dining are sponsored. This experience not only impacts those working as pediatric health care professionals in other countries, but also has been instrumental in the growth of the field of child life. The 2019 ACLP Year in Review shared that ACLP membership was comprised of individuals from twenty-six countries. The ACLP International Scholarship Award is an important aspect of supporting child life specialists not living in the United States.

ACLP Diversity Scholarship

In 2017, ACLP recognized the need to support students from diverse backgrounds wishing to become Certified Child Life Specialists. The educational path to become certified often comes with many barriers, including the financial burden of a semester-long internship. ACLP's Diversity Scholarship serves to "support students from diverse backgrounds who may otherwise struggle to complete an internship as well as students who are uniquely qualified to work with diverse populations" ("Diversity Scholarships," n. d.). Since the ACLP Diversity Scholarship began, over 50 students have been awarded the financial support during their internships.

As continued learning and growth takes place to ensure ACLP and the child life community is inclusive and equitable in their practice, the Archives Committee recognizes room for growth as well. We are aware there are many gaps in artifacts preserved in our Child Life Archives and encourage all to submit artifacts so that an authentic, diverse history is preserved. To submit an artifact, please contact archives@childlife.org or by visiting the *ACLP Archives website*. The ACLP Archives Committee looks forward to taking steps to make the Child Life Archives more accessible and inclusive for all.

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ACLP Calendar

APRIL

1 *CLPDC data entry* for 2021 annual data and 2021 Q1 data begins

MAY

24-28 *Virtual Child Life Annual Conference*

28 Last day to register for the *Virtual Child Life Annual Conference*

JUNE

1-30 Abstract submission for 2022 Child Life Annual Conference in National Harbor, MD

JULY

1 Submission deadline for *ACLP Bulletin* articles for consideration for the Fall 2021 issue

7 Call for nominations for the 2022 *Distinguished Service Award* open

7 Call for nominations for the 2022 *Mary Barkey Clinical Excellence Award* open

AUGUST

10 Deadline to apply for the August administration of the *Child Life Professional Certification Exam*

15-30 Child *Life Professional Certification Exam* administration testing window

22 Deadline to submit transcripts and other documentation in time to apply for the *2022 Winter/Spring Internship*

30 2022 *International Scholarship* applications open

31 Application and supporting documentation due for 2022 Distinguished Service Award

31 Application and supporting documentation due for 2022 Mary Barkey Clinical Excellence Award

SEPTEMBER

5 Application deadline for the *2022 Winter/Spring Internship*

TBD Application deadline for *Mentor Program*

OCTOBER

1 Submission deadline for ACLP Bulletin *articles* for consideration in the Winter 2022 issue

1 Application open for *2022 Research Recognition Awards* (Professional and Student)

5 Applications due for *International Scholarships* for the 2022 Child Life Annual Conference

18 Deadline to submit your coursework documents for review in time to register for the November *Child Life Professional Certification Exam*

27 Deadline to apply for the November administration of the *Child Life Professional Certification Exam*

31 Deadline to apply to *recertify through PDUs*

JOIN US FOR AN UPCOMING WEBINAR

April 15:
Diversity and Inclusion: The Student Population (An EBP overview of practice)

April 30:
Emotional Safety: Screening and Assessment Pillar

May 14:
Emotional Safety: Intervention Pillar

June 15:
Emotional Safety: Environment Pillar

June 30:
Connecting the Dots: Race and Pediatrics and the Role of Child Life

July 15:
Emotional Safety: Staff Communication, Education, and Training Pillar

July 30:
Supporting LGBTQ+ Youth and Families: The Role of Child Life

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