

ACLCP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

FALL 2021 | VOL. 39 NO. 4

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12 Crossing the Chasm to Adult Care Settings

17 The Imposter Phenomenon



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CEO Shares

by Alison E. Heron, MBA,
CAE

New Beginnings! Stepping into the new role as Chief Executive Officer for ACLP more than 60 days ago has been exciting and quite busy. I had an intensive onboarding process as Bailey Kasten, former ACLP COO and Interim CEO, was transitioning out to a new opportunity. Many thanks to Bailey and all others who reached out to welcome me and share their passion for child life and ACLP.

My listening tour continues, and I want to connect and forge valuable relationships with members, staff, volunteer leaders, students, and partners. I am interested in getting to know you better and understanding how we can best meet your needs. I want to learn what we are doing well and how we can improve so that we can build together and identify areas for you to hold us accountable. My commitment to you, however, is to work hard to get this work right because the moment that we are in requires that level of respect, urgency, and intentionality. As I know the work is not easy, I request in advance for grace, mercy, and patience for not only myself but our rockstar staff and leaders as we may stumble (and even fall). However, we will rise again...stronger.

We continue to deal with an unprecedented pandemic and variants as the world tries to assimilate to new normalcy. We also face a rising call for equity and equitable treatment and outcomes for all, as the nation and ACLP reckons with the unfortunate history of racism. While these

matters present many challenges in addressing them, I am also encouraged by the opportunities they provide.

I am most excited about ACLP's continued partnership with Racially Conscious Collaboration (RCC) and the opportunity to work alongside you and our talented staff to plan a path forward that we can all be proud of; a path that leverages our strengths and successes, learns from our past, and paves the way for a bright future...for all. I've attended two workshops within my first 30 days to learn more about RCC and how ACLP can work towards becoming a racially inclusive organization. I also attended the Foundations of Racially Collaboration seminar in early October to learn the foundations, connect with participants, and gain a greater perspective on effective communication about race.

ACLP membership remains steady. The recent 2021 Membership Survey report provided me with some insights into high priority areas such as Emotional Safety and Diversity, Equity, and Inclusion (DEI). It highlighted our need for improved transparency and communications across the organization to ensure we are keeping you informed of the board, committee, and staff work.

In preparation for our upcoming 2022-2024 strategic planning session in late October, I am working with an experienced consultancy group to conduct an unbiased review of how well programs, products, and experiences fulfill ACLP's mission and

vision. The outcome goal of the study is to ascertain where we as an organization need to invest resources, pivot, or sunset. It may be possible to do all things, but not do them well, and we want to deliver outstanding programs, products, and experiences. ACLP has a multitude of programs, however, our staff capacity and bandwidth is a major concern and priority for me.

Enthusiasm is rising with our call for nominations for the Board of Directors. As Mahatma Gandhi stated, "you must be the change you wish to see in the world". My ask of you is to consider throwing your hat in the ring or nominating someone to serve. Our goal is to present a diverse slate of candidates and your support is needed. Visit our website to view open positions, responsibilities, and how to become a candidate.

I am so appreciative for the opportunity to serve you in this capacity and look forward to the work ahead of us. Thanks again for all you do and aspire to do in the child life community. Remember to reach out if you need help, give grace and mercy, and take care of yourself and your family.

Respectfully,

Alison E. Heron, MBA, CAE



President's Perspective

by Quinn Franklin, PhD,
CCLS

Welcome Alison Heron – the new Chief Executive Officer (CEO) for the Association of Child Life Professionals! The Board of Directors and the appointed Transition Task Force knew that the association's next CEO should be a strategic, compassionate leader with a keen interest in enhancing the child life profession. Specifically, the next CEO should be someone who could understand the need to support and implement changes for and with the association's marginalized communities and also to drive change in Certified Child Life Specialists' work with all infants, children, youth and families, regardless of their demographics.

The changes the membership will create with Alison's help will advance our shared goal of improved care for infants, children, youth and families. The members have also clearly expressed a desire for the association to enhance the profession as a whole especially with expanded engagement and opportunities for marginalized members and marginalized Certified Child Life Specialists.

Alison has the ideal skillset and is joining this journey with a listening mindset and critical lens. Plus, she will be able to actively participate in ACLP's Strategic Planning Session later this month. As you continue reading this Bulletin, you will get to know her and capture a glimpse into her approach to association leader-

ship and the intentionality she brings to her work with ACLP.

ACLP's Strategic Planning Session is slated for October 27 – 28, 2021. The Board of Directors, ACLP staff leadership and numerous other invited members (e.g. early professionals, DEI Summit participants, program leaders, academicians) will be working together to establish the 2022-2024 Strategic Plan. It is imperative that the participants have a rich body of evidence to help to inform the dialogue and the association's strategic initiatives for the next three years. That rich body of evidence will be comprised of new diversity, equity, and inclusion (DEI) initiatives as well as a comprehensive review of all ACLP programs.

As a part of ACLP's commitment to DEI, the members of the strategic planning session will be using several new DEI initiatives to guide in the creation of the 2022-2024 Strategic Plan. One of those initiatives is a revised DEI Position Statement with key DEI priorities. This revised DEI Position Statement was developed during the summer 2021 DEI Summit and will be going before a member of color panel for review and approval.

The member of color panel is comprised of Black, Indigenous, People of Color (BIPOC) DEI summit participants. In addition to the revised DEI Position Statement, the members of the strategic planning session

will also be using findings and recommendations outlined by Tony Hudson of Racially Conscious Collaboration in the independent DEI needs assessment he conducted.

Did you know that ACLP has more than 35 programs available to members? The Association's programs (e.g. webinars, conference, internship accreditation, academic endorsement, certification, scholarships) have been systematically reviewed to learn more about each program's effectiveness, the experiences of members, and the financial impact resulting in the Program Impact report.

The DEI Needs Assessment findings and recommendations, revised DEI position statement, key DEI priorities, and the Program Impact Report make for a stellar body of evidence. This, combined with the knowledge, experience, and expertise of the Strategic Planning Summit participants will create the 2022-2024 Strategic Plan that allows ACLP to excel as the leader in the field of child life. We are eager to get this work started and are excited to report back to each of you soon!

If you are interested in being involved in ACLP's efforts, please reach out to president@childlife.org. Also, please check out www.childlife.org for upcoming events and important dates.



From the Executive Editor

by Kathleen McCue, MA,
LSW, CCLS

Scope of Practice Statement: Is Child Life Ready?

Three years ago, I was asked to write an article for *ACLP Bulletin* on scope of practice in child life and its relationship to professional identity. Less than a year later, I expanded that article into a webinar for ACLP. It was a fascinating endeavor for me, and the clear take away from my research on this topic was that most other healthcare professions have a published scope of practice statement, and child life does not. We have official documents, standards of practice, and a code of ethics, but no official scope of practice. We even refer to scope of practice in some of our other primary documents, but have yet to develop such a statement. In both the article and the webinar, I provided numerous examples of the dilemmas faced by child life specialists as they try to determine if a certain intervention, activity, or even word usage is within the scope of practice of child life. A scope of practice statement, that could be agreed upon by the majority of professionals in this field, would resolve most of those dilemmas. However, such a statement should not exist until we are completely clear about the parameters that we all can endorse as our scope of practice.

As I reviewed the articles for this issue of *ACLP Bulletin*, the topic of scope of practice returned to the forefront of my mind. In several of the articles, it is a subtle theme. Lauren Dulude provides us with an intriguing look at some of the earliest records

of child life. In her article, "A Deep Dive into Boston-Based Child Life Programs: Uncovering History," she introduces evidence of an even earlier date than previously considered for the first child life professional. Even though she documents trusting relationships and play as the most significant components of practice of these initial programs, she admits it is difficult to uncover historical records relevant to child life when early practitioners went by many names, including play ladies, teachers and even occupational therapists. These varying titles also implied a range of practice that differed widely among programs.

In her personal and revealing article, "Imposter Syndrome," Sarah Framarin discusses scope of practice as one of the issues that increases the likelihood of experiencing imposter reactions. She says, "As familiar as we may be with our own defined scope of practice, there is so much nuance to the role of a child life specialist." She goes on to explain that even the title "specialist", which has been studied in nursing, "...was thought to place a heavy burden on the individual who saw it as their duty to be an expert across all their job tasks."

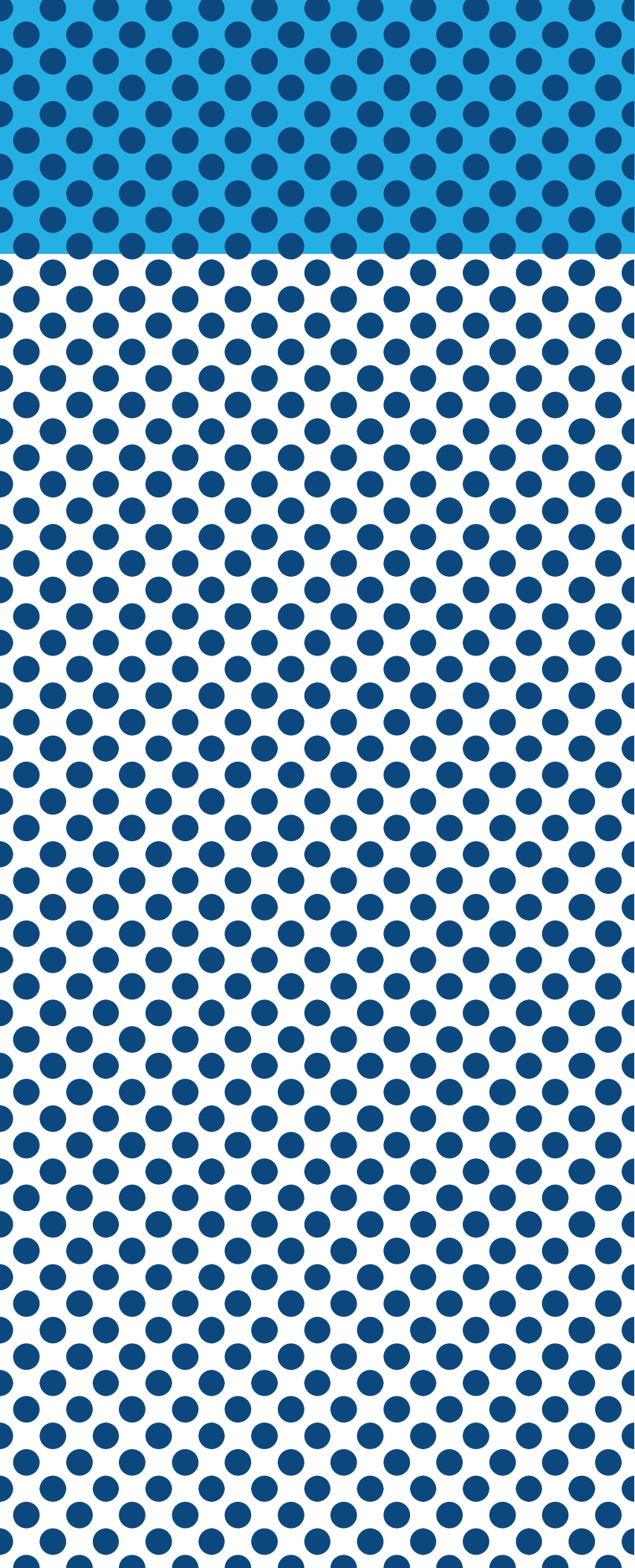
In Sammi Starkey's Specialized Resources article on hemophilia, she provides an excellent range of resources that are appropriate for children, teens, and adults. Although we usually think of adults in terms of the adult family members of a child, some of these resources seem to be directed to adults with hemophilia.

Are adults with an illness an entirely separate and unique entity from children with the same illness? Or is it possible that there is a continuum of reactions and needs in relationship to illness from earliest childhood through adulthood and even into senior years, and helpful, coping interventions can ebb and flow across the entire human life span? Could child life have some appropriate role in assisting adults cope with an illness that began in childhood or perhaps even provide a valuable service to any adult experiencing a challenging medical event?

The authors of the wonderfully provocative article, "Crossing the Chasm," clearly grapple with the issue of scope of practice for child life professionals. Over time, we have moved from inpatient units, to outpatient settings, to dentist's offices, to community services such as hospice and bereavement support, to sibling services, to embracing a "children and families" philosophy, to the children of adult patients. This last category is an excellent example of how our perception of scope of practice has changed over time.

We embrace it now, but 10 years ago many said that working with children of adult patients was outside our scope of practice. Is our next step working directly with adult patients who are facing their own fears, confusion, and distress around medical intervention? In the article, Dr. G Michael Deeb appears to answer this question, stating, "I believe the ideology and scope of practice of Child

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Life needs to be transitioned into the adult healthcare world, where the unique child life skills and tools can be used to fill a huge void that currently exists for treating the emotional and psychological needs for the adult patient population.” The authors of this article list the transferable skills of child life professionals, and if you read that list, you will see that none of them are exclusive to the pediatric population. Even the existence of the Child Life Disaster Team is evidence of an expanded scope of practice.

Here are the questions to ponder as you read these articles. Can the philosophy and practice of child life bring something special and unique to a wide variety of settings, client ages, and challenging situations? Is child life practice, in its essence, applicable to children traumatized by natural disasters or family crises, even when unrelated to healthcare? As a professional organization, we do emphasize a goal to “reduce the impact of stressful or traumatic life events” in our Mission Statement. Can child life services be applied to help a terrified child cope with an encounter with the court system? Isn’t this an example of a traumatic life event?

We reference “families” in all of our Official Documents. Don’t families include adults of all ages? Is child life practice, in its essence, applicable

to adult patients in healthcare? If the answers to these questions are “yes,” then we need to have some serious discussions about how we describe ourselves in our professional documents, prior to developing a scope of practice statement.

Perhaps the reason we do not yet have a scope of practice statement is that we are still not clear on, nor are we in agreement about, the actual parameters and limitations of our profession. Is there something that is uniquely child life that isn’t already part of some other profession? Therapeutic relationships are a component of many professions and definitely a significant part of any mental health profession. Child development is also a primary consideration of many other pediatric professions including nursing, several of the professional therapies, and mental health.

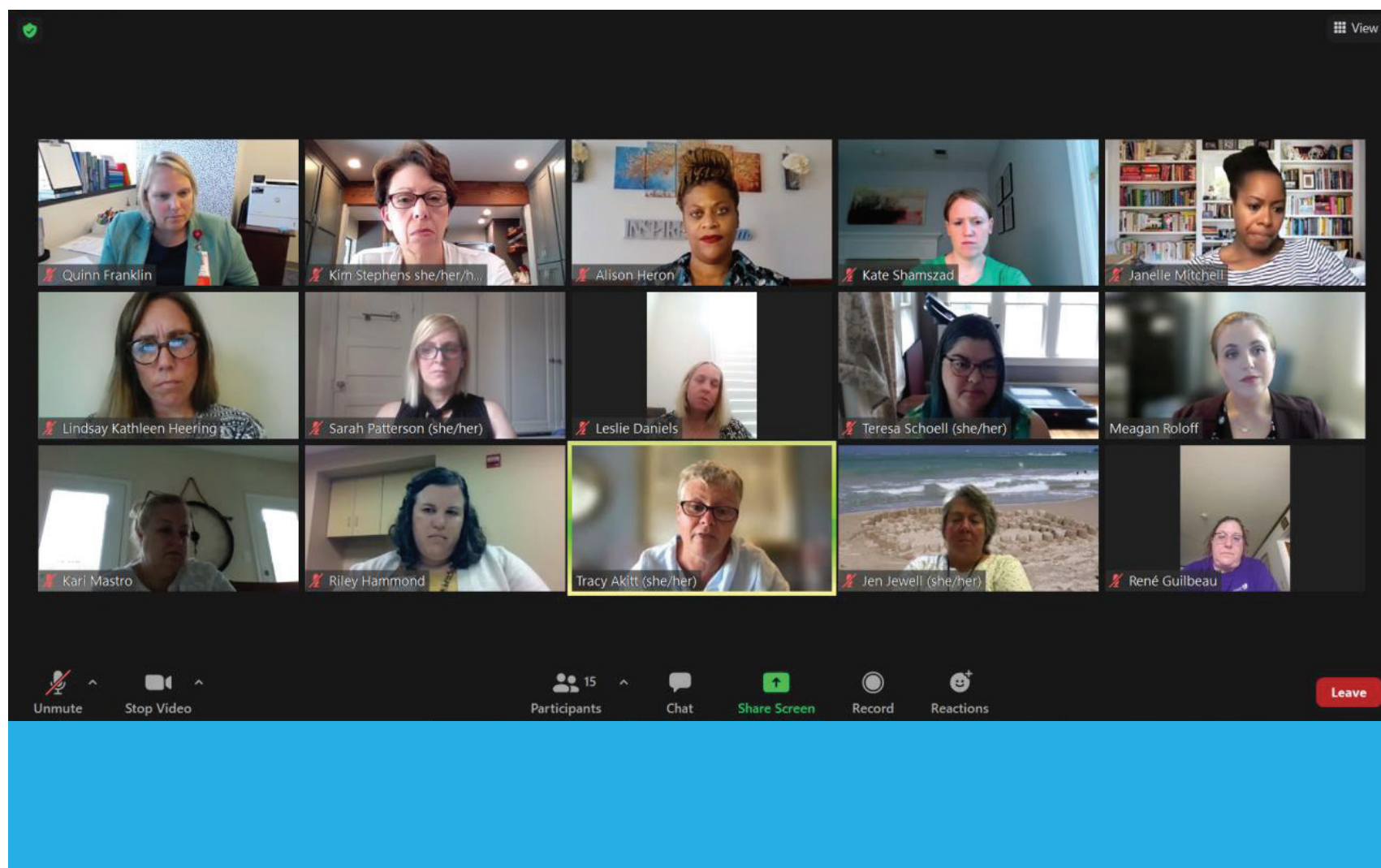
Even play, a hallmark of child life, is included in the scope of practice of play therapists, recreation therapists, and pediatric occupational therapists. In my 2018 *ACLP Bulletin* article, I suggested that perhaps what was unique about child life wasn’t the population served nor was it the services and activities provided, but rather it was the focus on prevention, coping, and health enhancement. Most of healthcare has an orientation that is reactive and problem-solving and, although child life can certainly

assist in solving emotional, behavioral, and developmental problems, it has always been our focus to try to prevent them. If this is true, then we need to realize that our current professional documents do not emphasize nor embrace this focus. If, at our core, the essence of child life is to provide preventive, supportive interventions that enhance coping, then there is nothing that restricts us from including a much wider range of recipients, locations, and types of service into an ultimately all-inclusive scope of practice. Yet, as long as we keep changing and adding different populations and services to our repertoire, the development of a scope of practice statement will be premature.

However, I do believe that we can come together as a group of professionals and agree upon the unique core essence of child life in order to develop a true scope of practice statement. The time to do this work is now, and the people to do it include both those professionals who remember where we came from, as well as those newer to the profession who have the broadest vision for the future. We can honor our past and our heritage and still relate the heart and spirit of child life to a scope of practice that meets the comprehensive needs of the world today.

WELCOME TO THE BOARD ROOM

by Kim Stephens, MPA, CCLS, Immediate-Past President



I am thrilled to be writing the initial “Welcome to the Board Room” column for ACLP! The purpose of this new column is to increase transparency around the governance of ACLP and to demystify what it is like to be a board member. ACLP members are asking to better understand how the board functions, the decision-making process, the priorities of the board, and how they can have their voices heard.

This new column will serve as one avenue for the board to communicate and share what we are working on, current priorities, and the details on what it is like to serve on ACLP’s Board of Directors. I hope this will help all members better understand the role of the board and to consider how they might serve to ensure we have a diverse and representative board.

The Board of Directors (BOD) holds four annual board meetings. Typically, we have in-person, multi-day board meetings in November and May with two shorter virtual meetings in August and February. The multi-day meetings typically include:

- » a review of the board reports sent in from the 24 ACLP working groups and committees and voting on motions brought forward,
- » financial updates from the Treasurer,

- » budget approvals in November
- » headquarters and administrative updates
- » review of our key performance indicators and strategic plan alignment and progress

The virtual meetings are held to address any committee actions or information needs that arise as well as to continue to monitor our progress on all ACLP programs and strategic initiatives.

Our August 20th meeting began with a Welcome and Call to Order by BOD President Quinn Franklin which included a review of our ACLP Inclusivity Goals for meetings. We were excited to welcome our new CEO, Alison Heron, and our new board member, Janelle Mitchell, to their first board meeting.

- » **Headquarters Update:** Alison provided a headquarters update that included information on the ACLP headquarters relocation which occurred August 30th - September 1.
- » **Reviewed and Approved Charters:** The board reviewed and approved charter updates for the Child Life Certifying Commission and the Community-Based Practice (formerly known as Community-Based/ Non-Traditional Role) committee. The board also voted to approve the

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creation of a new ACLP Publications Committee that will facilitate the process of creating and maintaining all ACLP publications including books, white papers, and official documents.

- » **Treasurer's Update:** ACLP Treasurer Teresa Schoell provided an update on ACLP finances and the work of the finance committee which included progress on the 2020 audit and IRS Form 990 preparation as well as work on learning more about Socially Responsible Investing for ACLP.
- » **DEI:** Camille Fields, Coordinator of Member Inclusion, provided an update on the work following the ACLP Diversity, Equity, and Inclusion (DEI) Summit held in June. Two working groups are currently compiling a list of priorities for action and updates to the DEI position statement to be completed prior to the ACLP strategic planning session (October 2021).
- » **Membership:** Meagan Roloff, Director of Member Engagement and Partnerships, provided the board with a summary of the 2021 member survey and key findings.
- » **Internship Accreditation:** Emily Eagon, Director of Online Education, and Internship Accreditation Oversight Committee chairs, Alisha Saavedra, and Vicky Isaacson,

provided an update on Internship Accreditation as our board continues its strategic review of key programs.

The board has a very busy Fall ahead as we continue to prepare for strategic planning. Strategic planning occurs every three years, and this year will again be facilitated by consulting firm Vista Cova. The strategic planning process also includes pre-work including a Program Impact Matrix that is examining the current programs and services provided by ACLP to guide us as we look forward to setting our goals for the next three years.

Strategic planning will be quickly followed by our November Board Meeting at which we will review and approve the budget for the next fiscal year amongst many other items. We look forward to our next update in the Winter Bulletin to share our progress as we continue to serve our community.

In your service,
Kim Stephens,
Immediate Past President

ACLP Inclusivity Goals

During all Association of Child Life Professionals meetings, we will utilize the diversity of thought within the group and do not allow power dynamics to stifle idea sharing. When this environment is created, there is no one person or person's ideas that manifest privilege over another.

- » All ideas will be given space and afforded active listening from the entire group.
- » We will allow all members of the group to speak uninterrupted.
- » We will each alternate using our voice and making space for other voices.
- » We will give credit appropriately.
- » We will use pronouns proactively.
- » We will criticize respectfully, constructively, and appropriately.
- » Important decisions will occur DURING the meeting where everyone will have a voice and a vote.

ALPHABET 2.0: Z IS FOR ZOOM

by Denise Matsuyama Lai, MA, CCLS,
CIMI Certified Child Life Specialist II,
UCLA Mattel Children's Hospital

and Millicent Ongaco, MS, CCLS
Certified Child Life Specialist II,
UCLA Mattel Children's Hospital



The Association of Child Life Professionals has been using Zoom professionally for years. This platform has allowed child life specialists in our field to network and help our professional community. In this past year, many child life specialists have become proficient in using Zoom, not only for professional networking reasons but also to support children and families. Zoom is just one of many virtual platforms that have been allowing connections for both personal and professional reasons. For purposes of this article, we will be referring to any virtual platform as Zoom. There is so much to explore in the use of Zoom and the limitations that accompany using an electronic internet-based program. While we are not experts on the issues that accompany the limitations of Zoom, such as screen-time concerns, “Zoom fatigue”, or internet access and connectivity, we do have expertise in working with children. In this article, we will review some child development-focused considerations for Zoom and explore the use of virtual platforms by our hospital-based child life team and other child life programs in the community.

Left: Barbie-themed bingo during a play session

Developmentally Appropriate Zoom Practices for Use by Child Life Professionals

In 2016, long before the pandemic, the American Academy of Pediatrics had revised their standings on the “no screen time” rule for children under the age of 2 years. While they continue to discourage screen time for children younger than 18 months, they do make an exception for live video chat (Council on Communications and Media, 2016). Whether or not the child on Zoom is a toddler, teen, or somewhere in between, there are a few things to consider when interacting with them on Zoom:

Acknowledge and welcome the individuals (children/patients/family members) joining the Zoom. As child life professionals, we strive to initiate and maintain trusting and meaningful therapeutic relationships. By welcoming and connecting with each participant, we are laying the building blocks to create a safe and trusting environment via Zoom.

Be present and mindful of your interactions with the individuals (children/patients/family members) on Zoom. One of the main tenets of child life is being able to assess and identify the psychosocial needs of in-

fants, children, youth, and families. In all interactions, including Zoom, we want to be present and mindful. On-screen distractions may be more noticeable, so being respectful, kind, and open allows the child life specialist to create a safe environment for supportive care plans.

Use self-talk (describe your actions) and parallel talk (describe the participants’ actions) during activities on Zoom. As child life professionals, we value facilitating communication in all forms to allow children and families to express their needs. Silence is sometimes needed for thinking space, but silence can also be stressful to a child who doesn’t know what to say. Self-talk and parallel talk can provide a soothing and inviting door to someone who doesn’t know what to say or do.

Don’t focus on having video on for each participant. Allow control over having the camera on or off and let the child decide what they feel most comfortable with. In a personal discussion with a school counselor, they mentioned that they had advocated for a student to keep her camera off which led to increased self-esteem, and eventually the student turned on her camera with a big smile for

the counselor who supported her decision. This is a perfect example of how child life professionals can advocate for the rights of the infant, child, youth, and family, which will lead to overall emotional safety and better coping.

Encourage the child/teen to voice their wishes on how medical care is provided when they are utilizing Zoom for school, meetings, or other activities while in the hospital or outpatient clinic settings. Normalizing the hospital experience is an area in which child life professionals excel and encouraging the child/teen to speak with the medical team to come up with a comfortable plan will go a long way. A child may ask the nurse to position their line and IV pole away from the camera, allowing the RN access to it where the class can’t see, or a teen can time certain types of cares or therapy sessions around important class times. Work together, consider HIPAA, and compromise.

Innovative Zoom Practices in Hospitals

Since April 2020, the Chase Child Life and Creative Arts Therapy Department at UCLA Mattel Children’s Hospital has been using Zoom for

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“Don’t focus on having video on for each participant. Allow control over having the camera on or off and let the child decide what they feel most comfortable with.”

group playroom sessions. The Zoom Playroom sessions have allowed for our patients to connect through play. Our Zoom Playroom sessions are seven days a week with a few extra sessions for specific age groups (toddlers/preschoolers, teens, and parents). Each room is equipped with iPads, and the Child Life Department has iPads to loan out if a patient does not have access to a device. Each session is led by a child life specialist with the addition of volunteers who provide additional “voices” during the sessions.

The volunteers can join the Zoom Playroom at home the same way the patients do in their individual hospital rooms. Our volunteers have found innovative ways of interacting with our patients from a distance – playing games, offering sewing lessons, creating a craft, doing a science project, and reading stories. One of our volunteers has been finding digital books, turning off the sound, and reading and interacting with the children while the animation of the book plays. Even patients in isolation can join the Zoom Playroom sessions and interact with the child life team, volunteers, and other patients.

Zoom Playroom sessions have not been limited to the physical space of the playroom. These Zoom sessions allow for interaction and the ability to explore different environments – which can reach beyond what can be offered through other types of programming like CCTV. We have taken advantage of visiting places the pediatric patients typically do not have the opportunity to visit. Some of

our volunteers have shared their home gardens with the patients. Our community partners that normally come and provide programming in the hospital and outpatient areas have even joined forces with us leading magic shows, safari tours, movie viewings, and other fun activities. Our People Animal Connection program has brought the experience of playing ball with dogs in their backyards to the patients in the hospital. We even visited the hospital kitchen to find out where a patient’s meal comes from. The music therapy team has been using Zoom to host not only music therapy programming but also a Virtual Coffee House which allows the team to bring in musical artists from throughout the US. There are many activities available through Zoom such as virtual field trips, digital books, online games, and much more – most of these activities can be found through simple internet searches. As we slowly return to normal, many of the Zoom Playroom interactions have allowed us to think about incorporating these aspects in our programming alongside in-person group activities as it becomes safe to return to “normal” operations.

We have also utilized the Zoom platform to further our services and connections to families outside of the hospital setting. As visitor restrictions were tightened and only one caregiver and no siblings were allowed to visit, specialists set up sessions to continue therapeutic interventions and teachings to further support the patient and family during crisis. This has been a vital way



UCLA Zoom Dodger PR

for specialists to continue providing services and for families to feel supported and heard.

Volunteers are also a crucial part of our Child Life Program. Coming in weekly and interacting with the patients in the playroom or at bedside is an important part of their lives. Seeing the impact of not being able to volunteer due to staff restrictions and closure of playrooms, our program used Zoom to connect with volunteers to check-in and strengthen the child life specialist and volunteer relationship during the pandemic. Some volunteers have taken it a step further and have coordinated Zoom sessions between themselves without child life involvement to help with their own coping.

Innovative Zoom Practices in the Community

Wonders and Worries, a community-based child life program that provides support to children of adult patients, also began providing support to the families they serve through virtual programming

during the pandemic. Crystal Wilkins from Wonders and Worries shared, “We did have to adjust our curriculum to effectively meet the needs of the families we served. Thankfully, being a team of child life specialists, we are especially gifted at creativity and flexibility.” These skills enabled the team at Wonders and Worries to transition to a virtual platform in a matter of weeks to continue to serve the children and families during the pandemic.

Allison Moore is the Child Life Program Supervisor for Children’s Comprehensive Care, located in central Texas. Allison provided child life services via Zoom for the program, to meet with patients and their siblings as well as children of adult patients during the pandemic. She said virtual platforms such as Zoom “has allowed me to reach more children than I was able to pre-pandemic due to circumstances that would otherwise prevent patients and families from coming to our clinic in-person. For example, distance, transportation challenges, weakened immune systems, and technology dependence.” Although she can’t

wait to meet with her patients in-person again, Zoom has allowed for therapeutic relationships with the children with whom she works.

Zoom: A Tool with Expanding Potential

This past year has challenged us as child life professionals in ways we could never imagine. Our adaptability, flexibility, and creativity, the building blocks of our child life skills, have been put to the test and pushed us to continue providing education, support, and play during a crucial time. Zoom and other virtual platforms gave us the opportunity to continue our work in the hospitals and communities we serve and have even presented some new and exciting possibilities for service. These tools have given us continued life during a time when in-person connection was not allowed. Nothing can replace in-person interactions or play, but until the time comes when we can safely gather, virtual platforms such as Zoom are allowing us to maintain and even expand our work.

CROSSING THE CHASM

to Adult Care Settings: A Journey of Discovery and Research

Certified Child Life Specialists (CCLS) are commonplace in pediatrics; however, this type of support is not established in adult healthcare, nor is it known if it would improve adult outcomes or satisfaction. Medical experiences often evoke fear, anxiety, and uncertainty and these stressors do not disappear just because we reach adulthood. The psychosocial and emotional needs of adults related to fear and anxiety with painful procedures often have gone unmet, and proven strategies effective with children could be explored further. Some adult hospitals have effectively used nonpharmacologic techniques to reduce hospitalization stress. We designed a feasibility study which informed a subsequent clinical trial to study the CCLS role in the adult world as an Adult Life Specialist (ALS) to provide psychosocial and emotional support, including nonpharmacologic interventions in adult cardiac surgical care. Knowledge gained from this research has developed insight about what is important to adult patients regarding their overall healthcare experience.

Inspiration for the Study

Our large academic medical center includes a children's hospital which is physically connected to the adult hospitals. Though the needs are unique in pediatric versus adult care settings, we have discovered there are also growing opportunities to share ideas for collaboration to support patient-family experiences across the health

system. It's often unclear whom to contact and whom to provide information and resources from one area to another.

Initiatives in the children's hospital, like individualized procedural care plans, were increasingly requested by pediatric patients transitioning to adult care settings. These tools demonstrated to be helpful to patients, families, and health care professionals, ensuring reduced pain and anxiety and improving overall patient experience. So why did they need to stop being utilized in adult care settings? Was there a way to continue the efforts that had taken years to develop, to build upon empowerment and coping skills and enhance their new adult care environment? These were some of the questions the team pondered. Conversations related to patient experience, comfort initiatives, and increased pain management, preparation and psychosocial support needs in adult care settings led to exploring research options. It turned out we were not the only ones wondering about the disparities on the adult side. Nursing, social work, phlebotomy, spiritual care, and advanced practice providers were also curious why the services of child life were exclusive to pediatrics - could they be adapted and expanded to adult care settings?

But how? Dr. G. Michael Deeb shared a similar concern with escalating complex adult health care needs, which fueled opportunities to begin formulating research questions: "What would be beneficial to patient experience, individualized care, pain and anxiety reduction, and increased

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“I think a lot of adults enter the healthcare world, with fear and hesitation, and sometimes without proper support. Having a dedicated person to go an extra step to provide comfort and teach coping, could change the fear associated with healthcare and could have potentially large impacts on patient satisfaction and hopefully long term healing.”

mining why child life, careful consideration was given to the specific child life knowledge, skills, and abilities that are transferable to serving adult populations. These included preparation, procedural support, nonpharmacologic pain management, diagnosis education, development of coping skills, anxiety management, patient and family-centered care, individualized care plans, and assessment and attention to

the emotional safety of patients and families. Child life specialists connect with patients, meet patients where they are, help them understand, provide comfort and support and cultivate resilience.

The foundations of child life, our educational background, theoretical framework, and scope of practice provide a strong foundation for child life specialists to step into work with adult patients. With the disparate gap in supportive care services for adult healthcare, the addition of any psychosocial service would be valuable to adult patients and families. Child life has an opportunity to fill this void. We are qualified and poised to do this work, and we have the foundational knowledge, skills, and abilities to capitalize on this opportunity to further make our mark on healthcare and to continue to evolve as a

profession. Additionally, this work may serve as a new opportunity for child life specialists, who have plateaued in their pediatric clinical work, to be presented with a new challenge, and to create a whole new path to grow and evolve professionally. In turn, this may create more entry level child life job opportunities within pediatric settings.

To determine if the comfort coach could become a valuable, contributing member integrated into the adult surgical clinical care team, careful consideration was given to the transposition of evidence-based child life interventions used with pediatric patients for use with adult patients having aortic surgery. In addition, the research team sought to determine if these adult patients would respond positively to these techniques, which included preparation for their surgery and postoperative experience and development and provision of individualized coping plans inclusive of various distraction (i.e., conversation, art activities, virtual reality) and relaxation (i.e., guided imagery, deep breathing, music, mindfulness) strategies. Secondary aims of this study were to determine if the nonpharmacologic interventions could reduce anxiety and improve the overall patient experience. In the later clinical trial, we also examined the impact of child life procedural support during two cardiac procedures, since this core child life intervention further differentiates child life from other allied health professions.

Multidisciplinary Stakeholder Consideration

Stepping into the adult world came with significant and thoughtful consideration. Are there gaps in our current child life curriculum to transcend into adult healthcare? Yes. This work has, however, been initiated within the safe space of research as the preliminary step to explore possibilities and determine next steps for further consideration. Our study team engaged an array of multidisciplinary stakeholders, including cardiac surgery, nursing, advanced practice providers, social work, psychiatry, spiritual care, music therapy, art therapy, patients, families, and

awareness of the needs shared by adult patients, families and multidisciplinary staff?” The impact of what we were proposing needed to be explored through a scientific study. After testing the waters initially through a feasibility study with internal grant funding, we then expanded to an externally funded randomized clinical trial at the Frankel Cardiovascular Center (FCVC) at Michigan Medicine.

Role of Child Life in Adult Settings

Scope of practice has been an ongoing conversation with child life specialists serving in our “comfort coach” role (the initial title given to our proposed Adult Life Specialist), our research team, multidisciplinary stakeholders, and senior leaders. In deter-



Above: Dr. Deeb: “People have empathy for children when they are dealing with pain from surgery... where’s that same empathy for adults? They hurt, too.”

Right: Frankel Cardiovascular Center inpatient unit - Dr. Deeb rounding with patient and family pre-COVID

QUOTES FROM COMFORT COACHES:

(CCLS Dedicated
Research Team)

"I thought this was a wonderful opportunity and experience that allowed for growth within myself."

"I look forward to the doors it will open for others down the road to pursue."

"Every patient has unique needs and being able to assess those needs and provide support as needed is a big reason why what comfort coaches do is so effective."



our Office of Patient Experience and obtained buy-in from senior leaders from our adult cardiovascular and pediatric hospitals.

Engagement with the Association of Child Life Professionals (ACLP) was critical for us when working toward institutional and departmental buy-in. We had ongoing conversations, from the beginning, with ACLP leadership to seek their input and keep them apprised of our work. While they shared similar thoughts, questions, and concerns around what it would mean to expand our scope and gaps in our education and clinical training, they have been supportive of the innovation and opportunities our research and next steps could present.

Training

Comfort coaches were oriented to the adult cardiac setting by the co-primary investigators, a research coordinator, and interdisciplinary cardiovascular center team members and spent time observing the clinical workflow across the care continuum. To move child life specialists into a new setting, intentional effort was directed to supporting

the comfort and confidence of the staff providing such services in the adult care setting. Orientation to the cardiovascular center's environment included wayfinding and making connections for supportive communications with key players and teams in each clinical area to learn the usual care process, timing for identified research benchmarks, and specific cardiovascular center protocols.

When designing the study, a great deal of time was spent communicating with multidisciplinary staff, cardiovascular center administration, and child life specialists serving as comfort coaches. Additional training focused on adult learning styles, lifespan development, individual and team meetings, relevant research articles, and an overview of the physical, psychological, and emotional implications of cardiac surgery provided by Dr. Alex Brescia, co-primary investigator, and cardiac surgery resident. "In some ways it was like going from Venus to Mars," says Dr. Deeb. "There is a comfort, and rightfully so, from years of experience in pediatrics...this is a whole new paradigm shift."

Our study necessitated funding to hire a full-time primary comfort coach. In selecting our primary

comfort coach, we were seeking a CCLS with a master's degree (i.e., counseling, therapeutic recreation, social work), education in lifespan development, and an experienced CCLS. Selecting our primary comfort coach was key. While Jessica Jenkins, our first and primary comfort coach, is currently pursuing a master's degree, she has experience working in various clinical settings including surgery, an ambulatory clinic, emergency department, and an inpatient unit within three children's hospitals and health systems. She is a strong clinician with solid communication and advocacy skills and is especially talented in building collaborative relationships with her multidisciplinary colleagues, patients, and families alike. Her well-rounded experience, passion, professionalism, emotional intelligence, and willingness and excitement to try something new collectively positioned her to successfully step into this role.

Due to the need for a comfort coach back-up team, we initially asked for volunteers from our child life staff. It then became apparent to our study team that we needed around-the-clock coverage, and we

expanded our comfort coach team to 15 additional CCLS based on scheduling to account for evening, weekend, and overnight study needs. Fortunately, we have established 24/7 child life coverage that has previously encompassed consults to our adult hospitals which have steadily increased over time. Buy-in from our staff participating in the study, was crucial. Lindsay Heering, Director of Child and Family Life, met with each CCLS to share our passion, vision, and excitement for this innovative work, building a sense of pride among our team; we have gone from being one of the first recognized child life programs originating in 1922 to now engaging in this pioneering work. We outlined the importance and application of research and individually walked through their questions, concerns, and ideas. Our study would not have been possible without our team effort. We have so much gratitude for our comfort coach team for their adaptability and courage to step into a whole new world.

Reflections from the Lead Comfort Coach Jessica Jenkins, CCLS

“I wish there were child life specialists for adults” is a phrase we often hear from parents of the kids we are working with and multidisciplinary colleagues as they learn what we do. Fear, anxiety, and vulnerability surrounding healthcare experiences are prevalent across the age continuum along with the desire to be informed about what is happening. The psychosocial support, education, preparation, pain management, and coping strategies used by child life specialists are adaptable and transferable to the adult population and were welcomed by our organization. We expected roadblocks, uncertainty, and advocacy needed for this type of work and were surprised and overwhelmed with the positive response. Nurses, patient care techs, respiratory therapists, and advanced practice providers identified the need for this support and recognized that their workloads did not allow them to spend the time with patients as they wished, subsequently resulting in moral distress around this void in care. Medical staff were given a survey at the completion of the clinical trial.

When asked what benefits this role might have, a step-down unit nurse said, “They would help the patients cope with what they were going through, help the nurses in providing individualized care and help the hospital reduce pain med usage and complaints about pain control.” A cardiovascular ICU nurse

answered, “I worked with a comfort coach multiple times, and they were extremely helpful in comforting patients and reducing need for possible pain/anxiety medicine. The comfort coach was able to reduce anxiety, and I could focus on the procedure and getting the patient extubated more efficiently.” Lastly, a physician’s assistant responded, “The advanced practice team and nurses are pulled in a million directions. Often, they don’t have as much time as necessary to assist patients through the anxiety, stress, and experience of their surgery and hospitalization. Having an additional person to provide active listening, empathy, validation, and most importantly time would go a long way.” It was the focus on establishing the “comfort coach role,” building partnerships and collaborating with the multidisciplinary team that made this transition into the adult world so successful.

Reactions from Other Professionals

We had some questions regarding the scope of practice and boundaries of the adult life specialist raised by the psychology and social work representatives involved in the development of the trial. In child life, we maintain strong boundaries and refer to social work and psychology when needs go beyond our scope of practice. These same bound-

aries apply in the adult setting. We had conversations to clarify and reassure that these boundaries were identified and would be maintained. The social workers in the ICU and the step-down unit were both highly supportive of the comfort coach role. They both identified gaps in the support available to their adult patients and confirmed needs related to fears, anxieties, stress and pain that affect hospitalization. “Inpatient social work does not have the workload capacity to spend an extensive amount of time with patients to do this, however, this is a concern for many,” FCVC ICU social worker. It was astonishing to see the support for the comfort coach role grow as the trial continued and the role gained traction. In daily care team huddles, advanced practice providers and social workers often identified needs for patients not enrolled in the trial and spoke to the desire to have these services available regularly. “During the study, we often had it brought up that another patient (not enrolled) would benefit from the same services,” FCVC ICU Respiratory Therapy Leadership. “Anxiety is very present in these patients and support such as this really helps pain and anxiety,” FCVC ICU Leadership.

The Comfort Coach Name

Our study team, with cardiac surgery representation, identified the need to avoid the use of the “child life specialist” title when working with adult

patients to avoid confusion and gain broader acceptance. For our clinical trials, the title “Comfort Coach” was selected. It was a term that was vetted through our patient-family advisory council, multidisciplinary staff, and providers to determine if it was understood, respectful and informative, enough that patients, families, and staff would have a clear understanding of expectations for the deliverables from this individual. We acknowledge the title necessitates deliberation on a greater scale if work with adult patients were to be validated and embraced as an extension to the child life profession. Additionally, we recognize the connotations comfort has in relation to palliative or comfort care. We have also had several coach titles surface within our institution giving us pause on the applicability to this title.

Hope for the Future.

Dr. G. Michael Deeb reflects on his vision for the future, “For our hospital and institution: I would like the University of Michigan School of Health Sciences to develop a Child Life Specialist Post-Graduate Advanced Practice Certificate Program to educate, train and render certificates for Adult Life Specialists (ALS). I envision Michigan Medicine (MM) Hospitals partnering with the University School of Health Sciences to become the epicenter for the practical clinical in-hospital training rotations through an

institutional commitment to help develop and support a strong MM clinical ALS program.”

“In addition, I would like to see strong partnership, collaboration and integration of Social Work, Care Management Specialists, Spiritual Care, and the Office of Patient Experience with the ALS program. ALS will not compete with these other specialty groups but augment and enhance the level of comprehensive care by adding a unique set of skills and tools. This type of institutional collaboration and commitment to patient/family experience and emotional wellbeing will improve patient clinical outcomes and safety. Another goal for our institution is to develop reinforced learning tools for coping strategies so patients can continue to use these types of intervention after discharge from our institution and for future health care encounters.”

“For the profession of Child Life: I believe that the ideology and scope of practice of Child Life needs to be transitioned into the adult health care world where the unique child life skills and tools can be used to fill

a huge void that currently exists for treating the emotional and psychological needs for the adult patient population. There is no reason to continue to cloister this essential skill set exclusively to the pediatric patient population. Children grow into adults that continue to have the same emotional and psychological needs that were present in childhood and become compounded through further life experience. Developmentally appropriate care needs to continue beyond adolescence. We, as health care facilitators, need to fulfill those needs through innovative programs using the current skills available and expanding and developing new skills and tools through educational and academic research programs. Through our initiative here at Michigan Medicine, I would like to see ALS expand globally as standard care for the adult patient population.”

Publication Reference:

Brescia, A. A., Piazza, J.R., Jenkins, J.N., Heering, L.K., Ivacko, A.J., Piazza, J.C., Dwyer-White, M.C., Peters, S.L., Cepero, J., Brown, B.H., Longhi, F.N., Monaghan, K.P., Bauer, F.W., Kathawate, V.G., Webster, M.C., Kasperek, A.M., Garvey, N.L., Schwenzer, C., Wu, X., Lagisetty, K.H., Osborne, N.H., Waljee, J.F., Riba, M., Likosky, D.S., Byrnes, M.E., Deeb, G.M. (2021). The impact of non-pharmacological interventions on patient experience, opioid use, and healthcare utilization in adult cardiac surgery patients: protocol for a mixed methods study. *JMIR Res Protoc*, 10(2). <http://dx.doi.org/10.2196/21350>



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THE IMPOSTER PHENOMENON

by Sarah Framarin M.Ed., CCLS, CTRS Child Life Specialist III, Pediatric Procedure Unit Baystate Children's Hospital, Springfield, MA

In 2008, I vividly remember walking the hallways of the Franciscan Hospital for Children. I was a newly minted child life volunteer, and I just couldn't believe my great stroke of luck. "Me? Really? I can't believe they think I'm qualified to be a volunteer here." I have had echoes of this feeling before. Prior to my time at Franciscan, I felt that same feeling when I was accepted to the university where I did my undergraduate work. I thought, "It must be because I applied to such a small program, they probably needed to fill those slots."

Throughout my early adulthood, I tended to explain away any success I had. With each milestone came a growing sense of fear, "When am I going to be found out?" I wondered when 'they' would realize their mistake, the 'they' being whoever had hired me or given me a chance, or new opportunity. This fear culminated when I was hired for the child life position that I currently hold. The then-manager of the program was well-known in our field, and I had

been cautioned by my internship supervisor as to her extremely high standards. So, of course, when she hired me my first thought was "Wow, I tricked her! I can't believe I fooled her into thinking that I would make a good child life specialist!" That was nearly nine years ago. Now, I know that the feeling that I was experiencing has a name: the imposter phenomenon.

The Imposter Phenomenon, or IP, as I'll refer to it here, was first formally identified by Suzanne Imes and Pauline Rose Clance in 1978. They presented IP as something experienced primarily by "high achieving women." More recent studies, however, have discounted the importance of gender when it comes to the experience of IP feelings (Rohrman et al., 2016). To put it simply, the imposter phenomenon describes an individual's feelings of fraudulence despite objective evidence to the contrary. In lay society, this feeling is commonly referred to as the "Imposter Syndrome," and in academic literature

as the "Imposter Phenomenon." Even when termed the more clinical sounding "Imposter Syndrome," IP is not a clinical diagnosis found in the DSM or ICD-10. Many who experience IP believe that they are alone in feeling fraudulent about their skills and abilities when in fact, almost 70% of high-achieving individuals experience imposter feelings at some point in their careers (Hirschfeld, 1985). There are also 'prime times' in a person's life that imposter feelings may spike (Clance, 1985). A rise in imposter feelings is often coupled with significant transitions, such as the acquisition of a new job or a promotion. In preparation for writing this article, I assembled an 'imposter timeline' for myself. On this timeline, I listed each significant career milestone that I'd achieved over the past several years. Each spike in my own imposter feelings has correlated directly with a new promotion or responsibility in my educational or career journey.

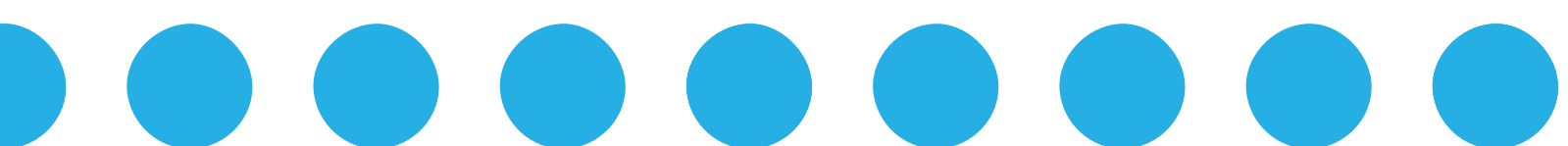
According to Clance (1985), individuals that experience the imposter phenomenon typically exhibit at least some of the following characteristics:

- » The need to be special or the very best
- » "Superwoman" or "Superman" characteristics
- » Fear of failure
- » Denial of competence and discounting of praise
- » Fear of and guilt about success
- » Extreme over-preparation
- » Procrastination and utilization of self-handicapping behaviors

Due to feelings of incompetence and self-doubt, some are hesitant to seek promotions or other advancement opportunities due to the fear of being 'found out', which has major impacts on career

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mobility. Such behavior helps one avoid potential exposure as an imposter (Buchanan, 2006). Obviously, this has a very detrimental impact on our field if IP is preventing Certified Child Life Specialists from taking risks and seeking out opportunities for achievement.

Why Child Life? What the Research Tells Us

The reason I felt so passionately about diving deeper into this concept is because of my chosen profession. I was hard-pressed to think of another field so at risk for their practitioners experiencing the imposter phenomenon as I believe the field of child life is. A great deal can be learned from research on IP and how it is seen in other fields.

Being an Authoritative Figure

In a 2014 study, researchers looked at IP and its impact on college and research librarians. Librarians are often charged with playing a variety of different roles throughout the day. Of course, the same could be said for child life specialists. “Striving to be seen as an authoritative figure can lead to internal conflict when the librarian does not feel he or she is knowledgeable or experienced with the subject at hand. Furthermore, college and university librarians often serve as liaisons to faculty with more education and experience, which can exacerbate those feelings” (Clark et al., 2014, p. 255) Child life specialists are called upon to be authoritative in stressful health-care situations with children and families. We are asked to identify what, in each situation, is the ‘best case scenario’ to facilitate coping through an experience. Oftentimes, we find ourselves in a new role or setting or assisting with an unfamiliar procedure. Even when we are familiar with the technical

dynamics of what needs to happen for a patient and family, we are asked to speak authoritatively to physicians who likely are more technically educated and may be more experienced, which can spur self-doubt.

On-the-Job Learning

An additional finding of the study by Clark et al. (2014) noted that feelings of inadequacy resulted from minimal training coupled with high expectations of new professionals. It was found that many college and research librarians felt inadequate related to their workload. One respondent stated that they had a feeling of not being able to give one hundred percent on any task or project (Clark et al., 2014) What a familiar feeling that is for child life specialists, with our time often being split between administrative tasks and patient care. I do not think I would ever characterize our education and training as ‘minimal;’ however, there is a great deal of on-the-job learning that must occur, which can leave new specialists feeling unprepared by their education.

Recent studies of students in the dental, medical, pharmacy, and nursing fields showed that their imposter feelings were associated with perfectionism, burnout, and depression. (Henning, Ey & Shaw, 1998). For medical students, high ratings on the imposter scale were significantly associated with burnout, reporting high levels of emotional exhaustion, depersonalization, and diminished feelings of personal accomplishment (Villwock et al., 2016) Professionals who were in their first three years of work as college and research librarians had much higher IP scores than their more experienced colleagues. (Clark et al., 2014). A study of physician assistants revealed similar results, specifically that imposter experiences seemed to peak early in one’s career and tended to re-emerge at expected times, like with new promotions or challenges (Mattie et al., 2008).



Appearing Intelligent

There is a very high incidence of IP experience in both medicine and academia where the appearance of intelligence is crucial to success (Kets de Vries, 2005). By the very nature of these positions, medical and academic professionals are supposed to be ‘experts’ in their field. They have students, patients, or both for whom they are providing guidance. This fact has huge implications for the child life specialists that are academicians. A 2018 study of 28 physicians and their experiences revealed doctors are not spared from imposter feelings, and, for many, success, positive feedback, and awards did not mitigate their imposter feelings (LaDonna, Ginsburg, & Watling, 2018). Even those in advanced career stages were noted to be questioning the value of their achievements. Additionally, it was found that the culture of medicine is not conducive to discussing doubts, for fear of being perceived as ‘weak’. IP has also been found to be strongly associated with the fourth year of medical school and medical residents (Leach et al., 2018), supporting the idea that transitions are peak times for imposter feelings.

The Power of the Word “Specialist”

We can learn a great deal from a study of clinical nurse specialists and the impact of the imposter phenomenon. One of the many things that this study pointed out was the impact of having the word ‘specialist’ in one’s title (Sweeney Haney et al., 2018). With clinical nurse specialists specifically, this word was thought to place a heavy burden on the individual who saw it as their duty to be an expert across all their job tasks.

A Broad Scope

As was evident in a study of new librarians entering their field, a lack of clarity in the scope of one’s position can contribute to IP feelings (Lacey & Parlette-Stewart, 2017). We are all too accustomed to competing demands for our time and resources and not having ‘enough’ time for either our patients or our projects. As familiar as we may be with our own defined scope of practice, there is so much nuance to the role of a child life specialist. At times, this makes our scope difficult to define and quantify. We are accustomed to ‘picking up the pieces’, pitch-

Take the Clance Imposter Phenomenon Scale and Scoring Instructions (CIPS) by Pauline Rose Clance:

<https://paulineroseclance.com/pdf/IPTestandscoreing.pdf>

ing in wherever we're most needed and sometimes we find ourselves doing something that we'd never dreamed we'd be asked to do as a part of our daily work.

Addressing the Imposter Phenomenon in Child Life Specialists

Both the academic research and lay literature are filled with strategies on how to address IP. I've done my best to condense that advice and highlight what I've found to be most helpful in my own experience.

Record Positive Feedback

To dissociate oneself from imposter feelings, it is important to take a step back when receiving praise or good news. If it is coming from a reputable source, we would do well to accept it at face value (Young, 2011). Evidence of positive feedback can be found everywhere once you start looking. Recommended strategies include jotting down verbal praise and saving items like thank you cards from patients and families. These can be kept in a folder or portfolio along with feedback from any formal evaluations. This collection can be looked at as a reinforcement for the individual struggling with imposter feelings and can also be used as hard evidence of success when it comes time for an annual review.

Cognitive Strategies

It may be helpful to remind oneself that it is appropriate to feel like a novice in any new position

or role and eventually progress will be made to an expert level (Sweeney et al., 2018). It is also recommended to work from a growth mindset, rather than a performance mindset. With a growth mindset, errors are perceived as a natural part of the learning process rather than a personal failure (Molinsky, 2016).

Incorporate IP into Training

It is strongly recommended that IP be incorporated into orientation and training materials for students and new staff. For current staff, it can be part of ongoing supervision or integrated into annual competencies.

Experience

Time and experience are both mitigating factors for imposter feelings. If we can pinpoint exactly what behaviors or situations are increasing imposter feelings (talking to physicians, for example), we can create opportunities to make that behavior more familiar.

Name Your Feelings and Talk About Them

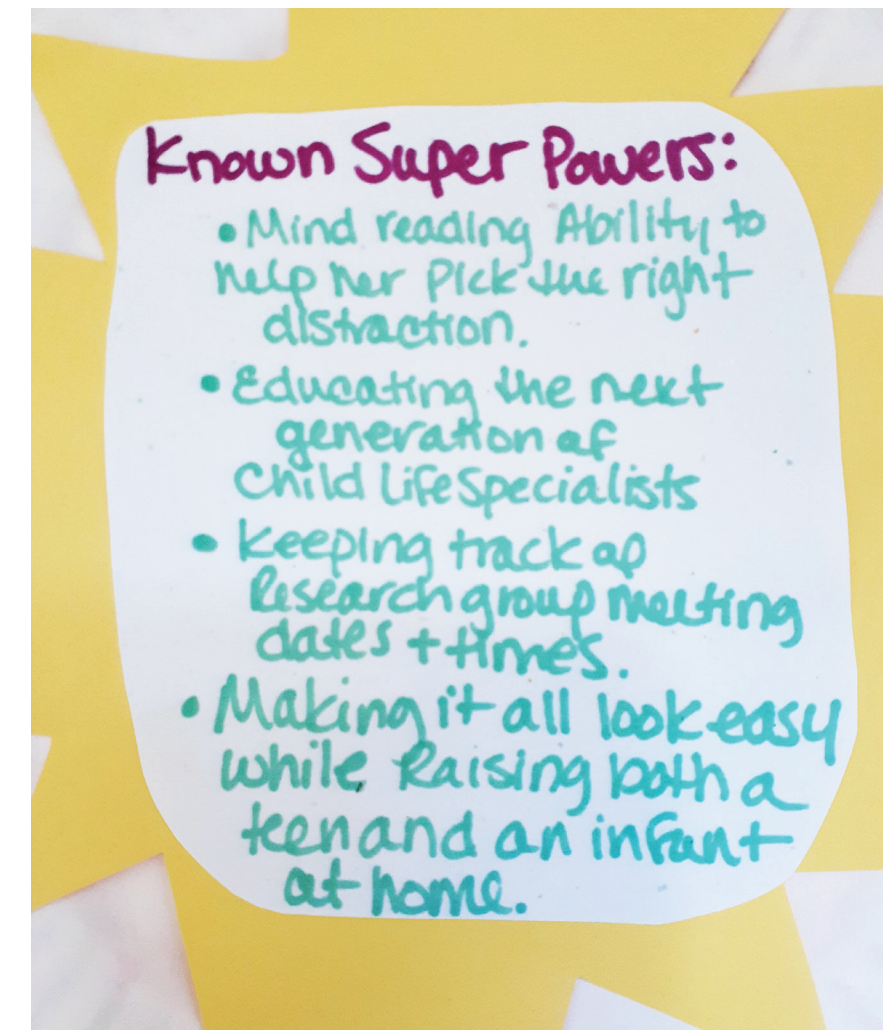
If the feelings I've described are familiar to you, take the Imposter Test developed by Clance (1985) to see your IP rating. If it indicates you are experiencing IP, the next step is to talk about those feelings. Identifying and talking to a mentor to receive realistic feedback can be helpful (Sweeney et al., 2018). If you are not quite ready to say these things out loud to someone, journaling is another option (Roche & Kopelman, 2013).

The Special Responsibility of Managers

Managers have the challenge of supporting those that experience the imposter phenomenon among their employees while likely dealing with some degree of imposter feelings themselves (Rohrman et al., 2016). Managers should remain alert for signs of the imposter phenomenon in their employees, most notably: fear of failure, fear of success, perfectionism, procrastination, and workaholicism (Kets de Vries, 2005).

Seek Therapy if Desired

The imposter phenomenon does not need to be a clinical diagnosis to merit exploration through therapy. Likely interventions of a therapist might include delving into an individual's family dynamics and the early experiences which may have contributed to imposter feelings, as well as teaching cognitive techniques to address imposter feelings as they come up (Langford & Clance, 1993). Individual counseling or group therapy may be appropriate (Clark, et al., 2014). Even though imposter characteristics don't necessarily require psychological treatment or prevent success, they do have an impact on one's ability to enjoy their success and is therefore worth examining (Rohrman et al., 2016)



A colleague created this list of positive characteristics about me that I keep looking back on when I need reinforcement.

Coming to Terms with the Imposter Phenomenon

When I first learned about IP, I stayed quiet. My experience of feeling like a fake had been a part of me for so long, it was a major piece of my identity that I had to disassemble. The moment that did push me into firm action against my own imposter feelings is crystal clear in my memory. It was around 2013 and I was reviewing something with my manager in her office. She offered me a compliment about my work, and I quickly began to demure, probably saying something like “Oh, well it wasn’t just me…” or “Anyone could have done that”. She stopped me, mid-sentence, and looked straight at me as she advised, “Just say thank you.” Even now, writing that, I must take pause and reflect. That seemingly simple statement changed everything, and it lines right up with what I have learned about IP. Though it took me a bit longer to internalize praise when I receive it, I never again have denied a compliment. Now, I just say “thank you.”

Recently, a nurse that I work with asked me to speak to her clinical nursing students about child life via Zoom. There was that old voice again, asking, “What could I possibly have to say to these students?” Very quickly, I was able to remind myself that I have plenty to say to those future nurses.

Our field absolutely merits a more formal study of how the imposter phenomenon impacts child life specialists. I would hypothesize that we would see a spike of imposter feelings in the first few years of employment and subsequent spikes with new roles and transitions, as is seen in other professions. Knowing what we do, however, I wonder, would there be high IP scores throughout our careers just by the nature of our role? I was greatly encouraged when I saw that there was a presentation offered related to child life and the IP at the 2020 Child Life Annual Conference. The more the language of imposter-ism becomes commonplace in our field, the more equipped we’ll be to deal with these feelings as they arise.

References:

Buchanan, L. (2006). The imposter syndrome: why do so many successful entrepreneurs feel like fakes? *Inc.*, 28(9), 37-38.

Clance, P.R., & Imes, S. (1978). The imposter phenomenon in high achieving women: dynamics and therapeutic intervention. *Psychotherapy Theory, Research and Practice*, 15(3).

Clance, P.R. (1985). *The Imposter Phenomenon: Overcoming the Fear that Haunts Your Success*. Atlanta, GA: Peachtree Publishers, Ltd.

Clark, M., Vardeman, K., & Barba, S. (2014). Perceived inadequacy: a study of the imposter phenomenon among college and research librarians. *College & Research Libraries*, 75(3), 255-271.

Henning, K., Ey, S., & Shaw, D. (1998). Perfectionism, the imposter phenomenon and psychological adjustment in medical, dental, nursing and pharmacy students. *Medical Education*, 32(5), 456-464.

Hirschfeld, M. (1985). Is there an imposter in your office? *Management Review*, 74(9), 44-47

Kets de Vries, M. (2005). The dangers of feeling like a fake. *Harvard Business Review*, 83(9), 108-116

Lacey, S., & Parlette-Stewart, M. (2017). Jumping into the deep: imposter syndrome, defining success and the new librarian. *Partnership: The Canadian Journal of Library and Information Practice and Research*, 12(1).

LaDonna, K. A., Ginsburg, S., & Watling, C. (2018). “Rising to the level of your incompetence”: what physicians’ self-assessment of their performance reveals about the imposter syndrome in medicine. *Academic Medicine*, 93(5), 763-768.

Langford, J., & Clance, P. R. (1993). The imposter phenomenon: recent research findings regarding dynamics, personality and family patterns and their implications for treatment. *Psychotherapy Theory, Research and Practice*, 30(3), 495-501.

Leach, P. K., Nygaard, R. M., Chipman, J. G., Brunsvold, M. E., & Marek, A. P. (2018). Imposter phenomenon and burnout in general surgeons and general surgery residents. *Journal of Surgical Education*, 76(1), 99-106.

Mattie, C., Gietzen, J., Davis, S., & Prata, J. (2008). The imposter phenomenon: self-assessment and competency to perform as a physician assistant in the United States. *The Journal of Physician Assistant Education*, 19(1), 5-12.

Molinsky, A. (2016). Everyone suffers from imposter syndrome - here’s how to handle it. *Harvard Business Review Digital Articles*, 2-4.

Roche, J., & Kopelman, A. (2013). *The Empress Has No Clothes: Conquering Self-Doubt to Embrace Success*. San Francisco, CA: Berrett-Koehler.

Rohrmann, S., Bechtoldt, M. N., & Leonhardt, M. (2016). Validation of the imposter phenomenon among managers. *Frontiers in Psychology*, 7, 1-10.

Sweeney Haney, T., Birkholz, L., & Rutledge, C. (2018). A workshop for addressing the impact of the imposter syndrome on clinical nurse specialists. *Clinical Nurse Specialist*, 32(4), 189-194.

Villwock, J., Sobin, L. B., Koester, L. A., & Harris, T. M. (2016). Imposter syndrome and burnout among American medical students: A Pilot Study. *International Journal of Medical Education*, 7, 364-369.

Young, V. (2011). *The Secret Thoughts of Successful Women: Why Capable People Suffer from the Imposter Syndrome and How to Thrive in Spite of It*. New York, NY: Crown Business.

BEYOND THE CLASSROOM:

THE POWER OF POSITIVE CO-INTERN RELATIONSHIPS

by Kelly Schmitz, CCLS and Jacklyn Butler, CCLS

“**A**nthing is possible when you have the right people to support you” - Misty Copeland. No matter where you are in your child life career, these words hold true. As previous interns together at Mayo Clinic Children’s Center, we believe it is important to encourage child life students to utilize one of the best resources they have: each other. Previous research with physician interns has shown that the internship process is often a unique experience for each intern and offers students different opportunities to grow in the field (Fischer et al., 2019). During internship, students are taught, tested, and trialed with many challenges. Zabar and colleagues (2019) found that “young professionals must regularly assimilate new norms as they rotate from one clinical service to another, all while under pressure to learn and perform the responsibilities” (p.773). Other factors that contribute to the potential stress interns face include relocating, balancing clinical hours and schoolwork, the development of necessary skills, and the emotional impact that comes alongside gaining real-life experiences.

Though interns may face challenges, these situations serve as opportunities to collaborate and support one another. Students often go through experiences with their fellow

child life interns that are like coworker relationships. Tran and colleagues (2018) found workplace relationships have been shown to be a primary source of emotional support and career development. Their research went on to find that “the positive effects of high-quality workplace relationships on working manners include higher commitment, lower level of reported job stress, and increased perception of social impact” (p.1). Knowing the importance of positive workplace relationships, our time as fellow interns encouraged us to support each other as students and use these skills as we transitioned to working professionals. Through our exploration of this topic and our personal experiences, we feel it’s important to share ideas on how to build a mutually supportive relationship with your fellow child life interns.

Don’t compare

As interns, it is often easy to compare yourself to each other throughout the process, though we found it important to focus on each person’s unique set of skills and appreciate diversity rather than comparing yourself to one another. Everyone has different strengths and areas of growth that contribute to the overall team dynamic. We feel this is



Above: Pictured right Jacklyn Butler and left Kelly Schmitz

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valuable to realize early in one's child life career and to encourage acceptance and confidence in yourself while appreciating each individual skill set within the multidisciplinary team.

Learn from one another

Although interns are going through many of the same challenges, they often have different experiences, rotations, and interactions. We found it helpful to use these varying experiences to our advantage in an effort to offer and discuss different ways of practicing child life. For example, Kelly more regularly worked with chronic patients in intensive care units, whereas Jacklyn spent more clinical time with acute patients in the outpatient setting. Through appro-

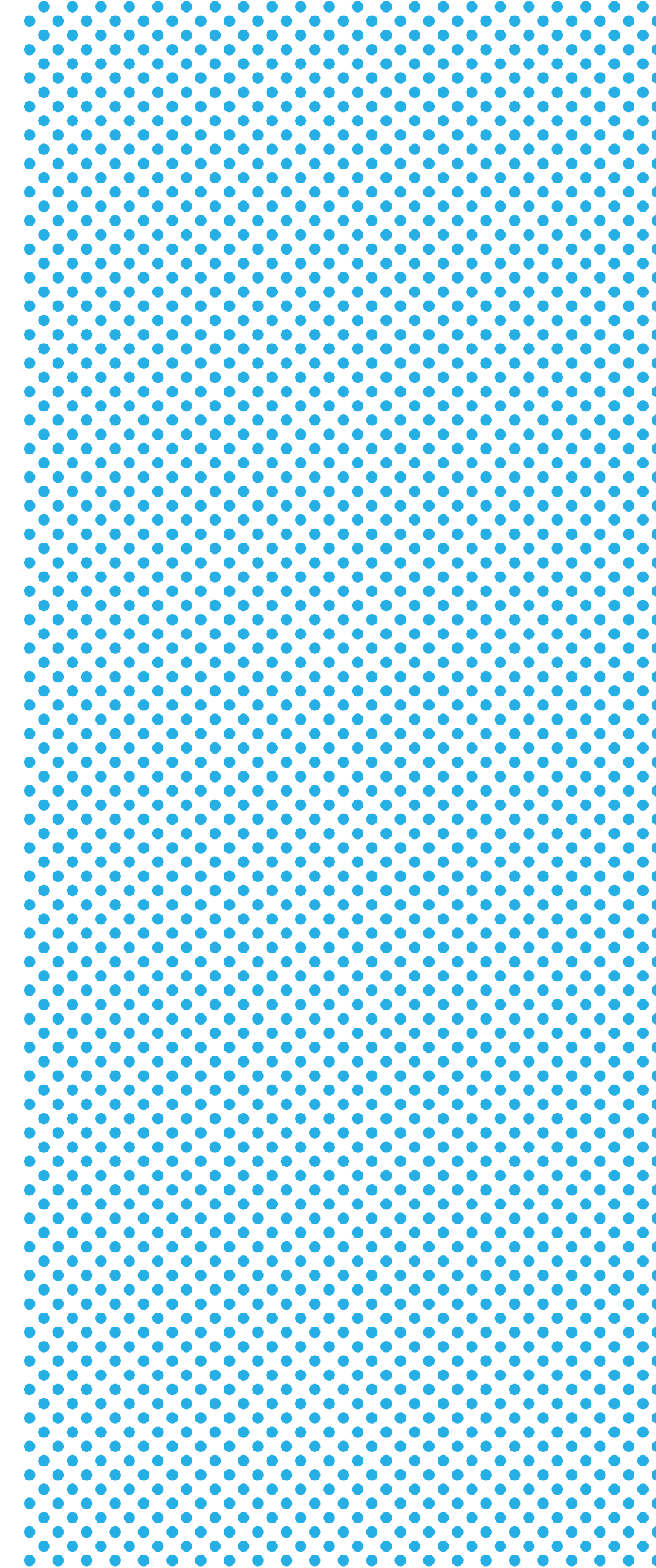
priately discussing our different experiences, we were able to learn about certain scenarios we did not encounter, fostering opportunities for us to learn through each other.

Be each other's cheerleaders

Throughout internship, it can be challenging to navigate the role of being a student. We found it beneficial to continuously express our accomplishments and child life "wins". This allowed us to grow closer in ways that fostered opportunities for us to cheer each other on without judgement, while also encouraging confidence in our child life skills. This was not only important for our role as interns, but by practicing these behaviors we were able to form posi-

tive habits that can be used to support, motivate, and inspire coworkers in the future.

While this list can go on, we feel these approaches were most beneficial for us when creating a supportive intern relationship and had a significant impact on our overall experience. Although not all child life programs have multiple interns, we believe this kind of support can come from various departments, such as music therapy interns, practicum students, and other interns at local hospitals. Having a strong and supportive child life relationship with each other can help create a positive transition to being a working professional, no matter where your child life journey takes you.



CHANGING PERSPECTIVES:

Establishing the Need for a Virtual Child Life Practicum

by Belinda Hammond, EdD, CCLS, CIMI, Eastern Washington University, Cheney, WA,
American Public University, Charles Town, WV,
Child Life Connection, Founder / Child Life Practicum Supervisor



In the midst of COVID-19, many hospitals decided to halt student programming, leaving child life students without clinical opportunities and preventing them from moving forward in their quest for certification eligibility. Recognizing the short-term need for clinical placement not reliant on hospital access, the long-term needs for equalizing access for students unable to relocate, as well as the long-term inability to cover costs associated with traditional practicums or other barriers related to insufficient resources, a virtual child life practicum is explored as a possible solution to the above issues. An action research-focused study on the development and implementation of a virtual practicum is in analysis. The following provides a justification for developing a virtual practicum experience.

Child Life Practicum Standards

As defined by the ACLP, the practicum is “designed as an introductory experience for individuals interested in pursuing a career in child life. Through experiential learning and observation of CCLS’, child

life practicum students begin to increase their knowledge of evidence-based, developmentally appropriate interventions including therapeutic play, preparation and education that support and reduce fear, anxiety and pain for infants, children, youth, and families as they cope with the stress and uncertainty of illness, injury and treatment.” (n.d.-a). While the ACLP does not state how practicums are delivered, historically practicums have been provided in person, with a majority of practicums offered in hospital.

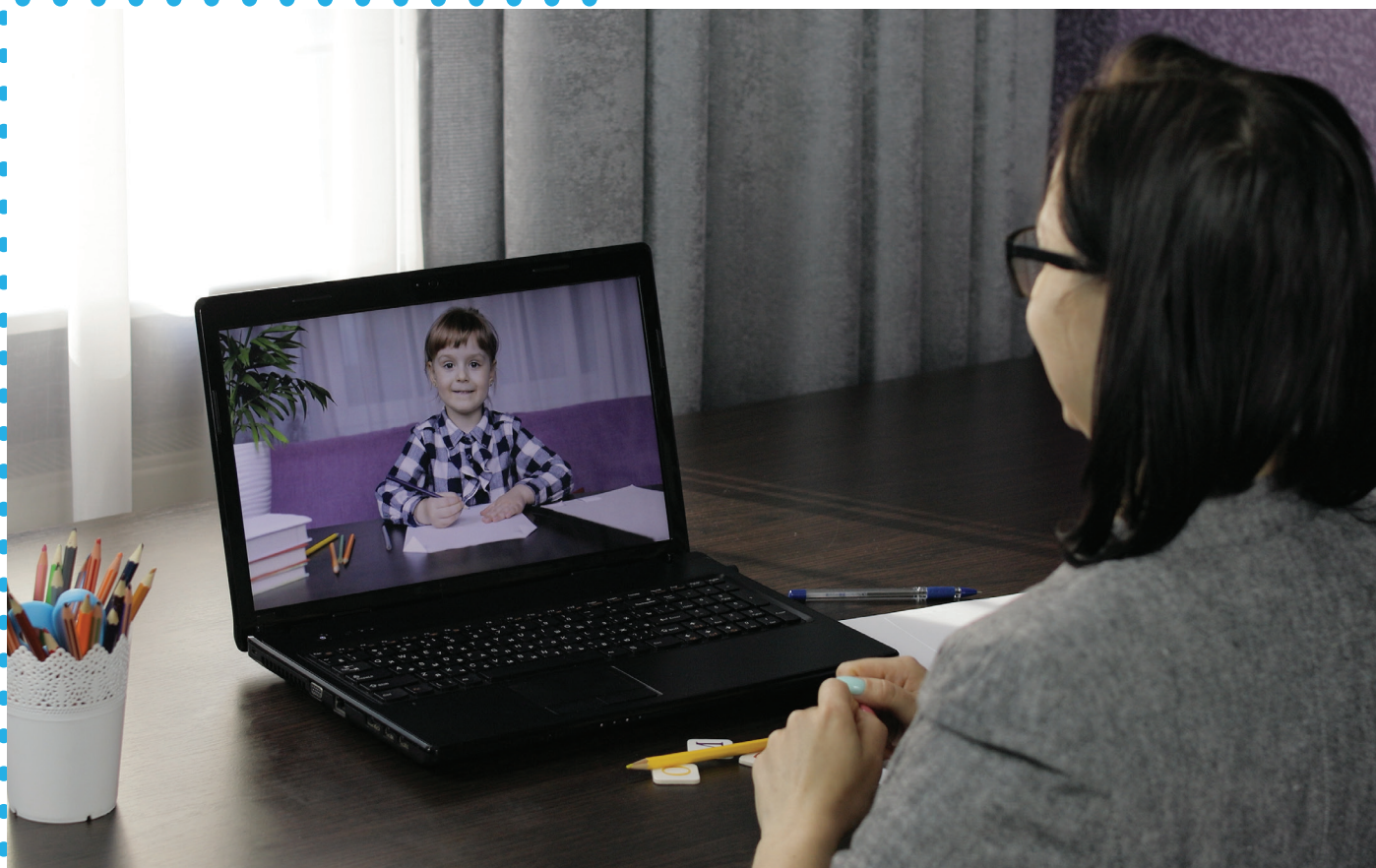
Even though there is no ACLP requirement for completion of a practicum (ACLP, n.d.-b), most internship providers recommend completing a practicum prior to consideration for internship.

Rationale for a Virtual Practicum - Advantages for the Child Life Profession

While the ACLP identifies practicum standards, there is still a range of experiences students gain during traditional practicums which is reliant on procedures being done and family needs presenting themselves during rotations, impacting

each student differently in what they can observe. A virtual practicum has the unique ability to standardize practicums, so every participant experiences a range of settings, diagnoses, and patient/family needs. Rather than seeing a typical single unit, students in virtual practicums experience multiple units plus non-traditional settings. This range of experiences provide greater insight into the role child life plays while also allowing students to explore personal strengths and areas of interest. Virtual practicums provide an opportunity for CCLS’ in academic settings to lead practicums. The development of a virtual practicum not only removed barriers to access but allowed child life specialists in academic settings to lift the responsibility hospitals had been carrying by offering practicums virtually, thereby having the potential to reduce the number of students needing hospital-based practicums, and therefore potentially increasing the number of internships those same hospitals could support moving forward.

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Concerns of Access and Equity in the Field of Child Life

The addition of online course options in higher-ed expanded flexibility while also opening opportunities for contemporary students (i.e., career changers, single parents, military families, those without resources or those with physical geographic limitations) to pursue academics around other commitments. For contemporary students, virtual opportunities offer flexibility, removing more barriers to access. Many students pursuing certification have found the more flexible they are geographically, the easier it is to secure experiences necessary for certification eligibility. While there are recommendations to apply to at least 10-15 hospitals for child life practicums and internships, many apply to significantly more. For students with limited resources or the inability to relocate, securing far away experiences creates immovable obstacles to certification. This may contribute to the lack of racial and ethnic diversity in child life.

While discrimination based on race/ethnicity, na-

tional origin, gender or disability was prohibited most recently through the Civil Rights act of 1964, Title IX, Section 504 of the Rehabilitation Act of 1973, and Americans with Disabilities Act, we recognize that most post-secondary institutions traditionally lack diversity (Zamani & Brown, 2003). While laws attempt to broaden higher education institution diversity, barriers to access still exist. Zamani and Brown (2003) focused their research on general access and equity in higher education and educational mobility for graduating high school and higher education students. They learned that limited financial resources prevent students from relocating for education, leaving students with limited available resources for continued learning. When finances prevent students from relocating for academics, requirements for certification or licensure become greater barriers. While diverse populations are technically eligible to apply to higher education institution, many historically underserved students experience invisible barriers.

I envision incredible growth in the use of virtual programming in child life, and the student participants of this virtual practicum are now moving into the field with experience providing therapeutic play virtually and are prepared to implement child life supports virtually for any population in need. Virtual practicums can easily integrate the use of technology to reach the most challenging of populations, providing therapeutic interventions through play that otherwise would not be provided to these children, thereby reaching a more diverse population with a more diverse and contemporary child life student.

Summary

The child life profession is currently lacking diversity in the type of clinical learning opportunities that, while not required for most child life internships, have become essential experiences for internship consideration. Virtual practicums overcome many of the geographic challenges some students face when exploring the need to relocate for practicum experiences, while also providing unique skill sets that will impact their current and future child life practices. Virtual practicums also provide essential flexibility for many candidates who require continued employment or for whom other barriers to access exist in moving forward towards certification eligibility.

This virtual practicum also allows students to explore areas of interest for child life practice in a way most traditional practicums cannot, while also providing consistent experiences for contemporary students rather than relying on current patient populations and needs. In a future issue of *ACLP Bulletin*, I will explore in detail the elements of the virtual practicum I developed and how the virtual practicum prepared them for internship and their child life career.

References:

Association of Child Life Professionals (n.d.-a). *Child Life Practicum Recommended Standards*. <https://www.childlife.org/certification/forms-and-other-resources/practicum-students>

Association of Child Life Professionals (n.d.-b). *Becoming Certified / Eligibility*. www.childlife.org/certification/candidates.

Zamani, E.M. & Brown, M.C. (2003). Affirmative action in postsecondary educational settings: the historic nexus of meritocracy and access in US higher education. *Higher Education Policy*. 16, 27-38. <https://doi.org/10.1057/palgrave.hep.8300004>.

SPECIALIZED RESOURCES

Patients and Families Affected by Hemophilia

by Sammi Starkey, MS, CCLS,
Levine Children's Hospital, Charlotte, NC

While working as a child life specialist in a pediatric hematology-oncology clinic, one is exposed to a variety of diagnoses including cancer and sickle cell disease. Included among those diagnoses is hemophilia—a rare genetic condition, most common in males, in which the blood does not clot properly due to low amounts of certain proteins called factors (Centers for Disease Control and Prevention, 2020). The three main forms of hemophilia are Hemophilia A (most common form of hemophilia caused by lack of factor VIII), Hemophilia B (deficiency of factor IX), and Hemophilia C (lack of factor XI) (Stanford Health Care, 2019).

Hemophilia is also classified by level of severity: mild, moderate, or severe based on level of factor in the blood. Since the blood does not clot properly, people with hemophilia can bleed longer and heavier after injuries or medical procedures. Hemophilia is a lifelong condition requiring medical interventions, and treatment

for each individual depends on the type and severity of their hemophilia. Typically, the best and most common treatment for hemophilia is to replace the clotting factor by administering factor intravenously (Centers for Disease Control and Prevention, 2020). Often, parents and children must learn to self-access veins and administer factor.

Although hemophilia is not as common as other hematology-oncology diagnoses, it is still prevalent with 1 in every 5,000 male births in the United States being born with a type of hemophilia (Centers for Disease Control and Prevention, 2020). Early and continuous education for patients and their families is vital in ensuring appropriate diagnostic understanding and treatment compliance. The following resources include various multimedia assets to provide developmentally appropriate education and peer support for patients and families affected by hemophilia.

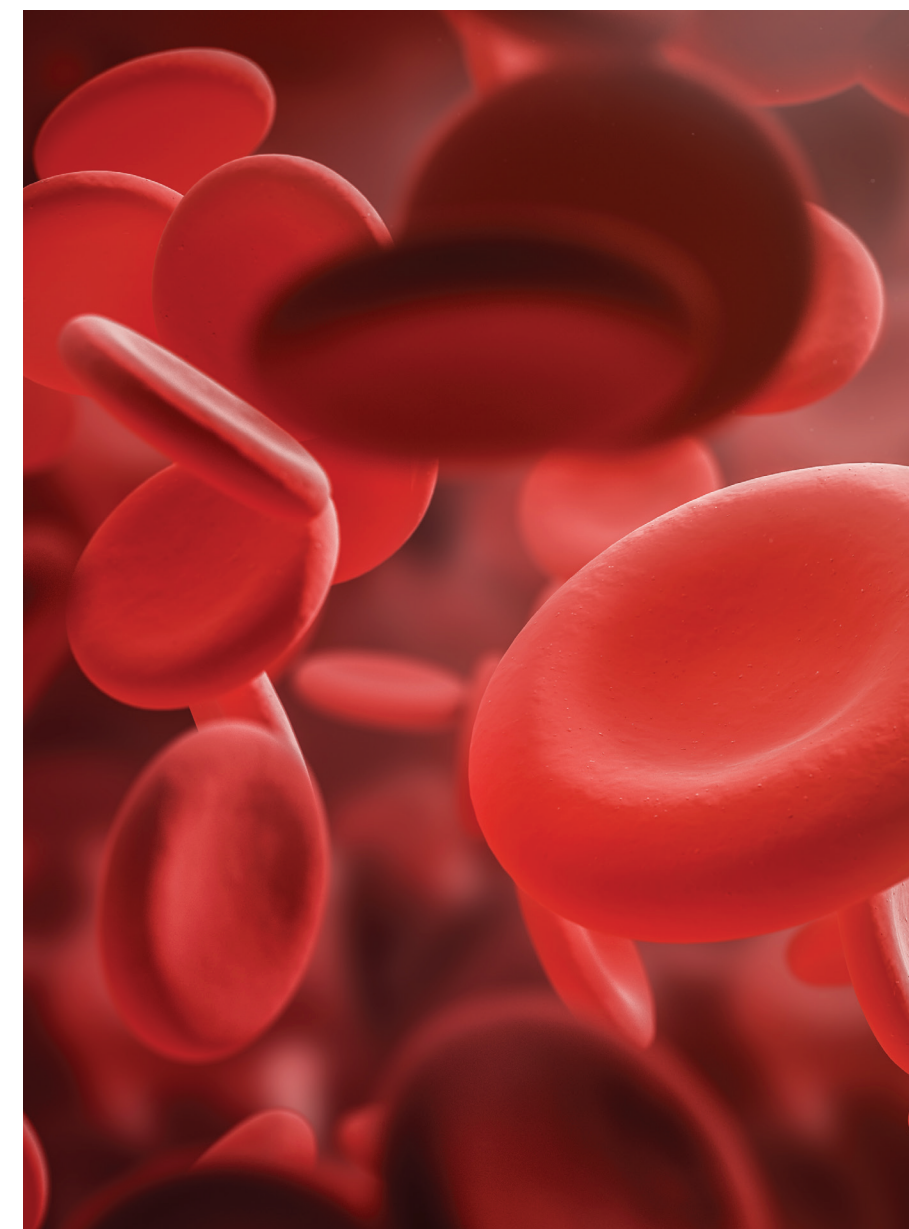
Publication Reference:

Center for Disease Control and Prevention. (2020, May 12). What is hemophilia? CDC. <https://www.cdc.gov/ncbddd/hemophilia/facts.html#:~:text=Hemophilia%20occurs%20in%20about%201,are%20living%20with%20the%20disorder>.

Stanford Health Care. (2019, December 3). Hemophilia. <https://stanfordhealthcare.org/medical-conditions/cancer/hemophilia.html>.

Bio

Sammi Starkey, MS, CCLS, has been a practicing clinical child life specialist since 2017. Sammi has worked in all units found in a children's hospital but has spent most of her career working in pediatric hematology-oncology. Formerly, Sammi was the primary CCLS at her facility's Hemophilia Treatment Center. Sammi can be reached at samantha.k.davis@atriumhealth.org for any inquiries regarding this article.



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Written Resources

National Hemophilia Foundation. (2011). Guidelines for growing: An action plan for parents of children with bleeding disorders. Center for Disease Control and Prevention. Guidelines for parents of children with bleeding disorders categorized by age groups. Each brochure focuses on both the social and developmental milestones specific to the age range of a child with a bleeding disorder.

Caremark. (2013). Zachary has fun at the doctor's office. CVS Specialty Pharmacy. One of many in the Zachary series, following a young boy with hemophilia, this interactive brochure focuses on preparation and diagnostic education for hemophilia doctor's visits. The series also includes Zachary receiving medication (factor) and going to school with hemophilia.

Barnes, C. P. (2006). The great inhibitor. Diplomat.

An illustrated picture book following a 6-year-old boy named Nate, who has hemophilia and an inhibitor. Inhibitors are antibodies developed by the immune system (Hemophilia Federation of America, 2021). The book was written to help children similar to Nate feel powerful.

Brush, S., & Henson, B. (2012). My first factor: Hemophilia. LA Kelley Communications Ltd. Boxed set of 10 books on hemophilia for children 18 months – 4 years of age. Each book introduces a basic sight word central to life with hemophilia.

Websites

National Hemophilia Foundation for All Bleeding Disorders.

<https://www.hemophilia.org/>

Organization that focuses on education, research and advocacy for individuals with bleeding disorders. Provides education and resources for child life professionals providing services to patients and families with bleeding disorders.

Hemophilia Federation of America.

<https://www.hemophiliafed.org/>

National nonprofit organization that assists, educates, and advocates for the bleeding disorders community. Provides education and resources for child life professionals providing services to patients and families with bleeding disorders.

WFH - World Federation of Hemophilia.

<https://www.wfh.org/>

International nonprofit organization dedicated to introducing, improving, and maintaining care for people with bleeding disorders world-wide. Provides education and resources for child life professionals providing services to patients and families with bleeding disorders.

Hemophilia (for parents). (2020, February).

Nemours KidsHealth. <https://kidshealth.org/en/parents/hemophilia.html>

Educational resource for parents regarding hemophilia.

Videos

Hemophilia: Sports and fitness | Cincinnati Children's. (2019, December 19). [Video].

YouTube. <https://www.youtube.com/watch?v=sZvmmWCqfTQ>

Video for children and families regarding exercise safety for children with hemophilia. Available in both English and Spanish.

Hemophilia: Keeping the Motivation | Cincinnati Children's. (2019, December 19). [Video].

YouTube. <https://www.youtube.com/watch?v=sZvmmWCqfTQ>

Video for children and families regarding keeping motivation to live their life fully regardless of limitations for children with bleeding disorders (specifically hemophilia). Available in both English and Spanish.

Hemophilia: Healthy Choices | Cincinnati Children's. (2019, December 19). [Video].

YouTube. https://www.youtube.com/watch?v=py0GBI0e_Ic&feature=youtu.be

Video for children and families regarding healthy choices, both nutritionally and with exercise, for children with bleeding disorders (specifically hemophilia). Available in both English and Spanish.

What is hemophilia? (2017, April 17).

[Video]. YouTube. <https://www.youtube.com/watch?v=BoXBuJSURTI>

Video created by a biotherapeutics leader within the pharmaceutical industry to explain hemophilia to school-age children, adolescents, and adults.

Understanding hemophilia - Jumo Health. (2019, January 23). [Video].

YouTube. <https://www.youtube.com/watch?v=Vddj1krd3ul>

Video following a boy with hemophilia on his journey to learn how his clotting factors work, how hemophilia affects his body, and how to manage it.

RESEARCH CORNER

Interview with a Colleague: Tips for Research Success

by Jenny Chabot, PhD, CCLS, Associate Professor, Ohio University, Athens, OH



As a professor of child and family studies/child life in the Department of Social and Public Health at Ohio University, I am surrounded by colleagues who are outstanding teachers and scholars. One who stands out is Cory Cronin, Ph.D., Associate Professor in Health Services Administration. I am in awe of his lengthy research publications and successful grant writing, so I asked him to share how he has been successful as a scholar within his discipline of health administration. Given his experience, Cory is very familiar with the child life profession and has been a supportive colleague to our program and our students. Below is a transcript of our conversation, edited for brevity and clarity.

Cory, what have been your experiences that led up to you being a professor at Ohio University?

As a kid, my family had some health issues. My grandfather in particular was a vet and he had M.S. And so, he was in and out of the Veteran's Administration, my whole childhood. He was someone I looked up to a lot. But, by the time I was junior high age or

so, he was completely bedridden and needed care. My grandmother had a very hard time having a career because of his health needs and wanting to keep him out of an institutionalized setting. I guess those ideas were there early. I knew I didn't want to be clinical, but I was very exposed to people with health needs and then around them, the professions, and the informal care. And so, I came to know about the major I teach in today, health administration, and just talking about how complex US health care is, as I'm especially fascinated by policy and the ideas that do or do not take and the reasons why they do or do not take and how we can use policy as levers to change the way things are.

So, this is where your research focus comes from, your initial family experience?

I take a focus of a health equity lens, the way we can use policy to improve things that will apply to all different populations. One project I did get brought on to was that our system was going to open a school-based health center. And this was the first time that I had seen really how research can be brought into a health care facility. By inserting

preventive health primary health care, especially to kids, how valuable that could be to those individuals, but also to this organization I work for.

Talk more about your research focus since you began your career as a professor.

So, my research agenda is interesting. My primary line of research is on hospitals as organizations and the decisions that they make. I'm really interested in how organizations can affect community health.

Another research area is the topic of hospital community engagement, or what the vast majority of hospitals call "community benefit," which is uncompensated care through the emergency department. And the hospital hopefully doesn't send them to a debt collector and instead just says, "OK, this one, we're going to classify this one as uncompensated care." That's 85% of what hospitals call community benefit. And to me, that's a really ineffective way to make somebody healthier because they don't get follow up care. They don't get access to medications. Maybe that is what led them there. And so those patients, you often see the

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same patients over and over needing that benefit of uncompensated care.

I also have a passion for children's health that comes out of school-based health centers. And my real interest in research there is around the role of parents in children's health. The idea that especially with things like health, what happens early in life can really affect later life opportunities. It's not just about their health later in life, but maybe their ability to get work or be a successful student. And how important it is that we approach parents with that they are the decision makers, but then also give them resources to be good decision makers for their children.

You're involved in a lot of fascinating research. What are some of your go-to methodologies that you use?

So before talking about methods, I want to talk about data. One of my favorite things about health care is how freely available data is out there if you're willing to be creative with it. I most often use secondary data sets, administrative records. They're being created for other bureaucratic purposes. But as a researcher, they are out there. And if you can be creative and think about methodologically and strategically how to use them, then they're still so valuable.

You're obviously a very successful researcher and you collaborate, you pick what you're passionate about, and that shows. What do you think makes you such a great researcher?

I'm sure you are familiar with imposter syndrome, so I don't know that I have a great answer other than I have been very fortunate that I've never had to sit

down at my desk and say, "I have to do research today." I get to work on what I'm interested in.

I do think, and I think it's somewhere I could improve: am I doing this as an academic product that will stay only in academic circles, or can I engage with the actual people I research?

What I would encourage is don't be scared by researchers. Engage with them because they probably have a skill set, they can bring, like the technical side of research. And then the people who are more in the field day-to-day could bring a perspective to the research. I think it's a perfect pairing that often goes missed.

Cory, you have been a prolific grant writer and have landed incredible grants. Funding is always an issue in child life departments. What advice would you have for professionals who

are wanting to incorporate a research agenda that would be funded? What are your best practices for searching for and landing those grants?

To me, it comes back to storytelling, and I think you have to consider the reviewers of those grants and how many of them they see and how almost identical they are. And so, I know it's easy to say, "make your proposal stand out," but I really do think some of it comes down to communication. And early on in your writing, like in your introduction, you need to tell them why it matters or what impact it will make. And I think some people just write all the technical stuff, and they assume anyone who reads this knows my bigger idea. To me, you need to communicate the bigger idea, you need to make that clear and something they won't forget. And then I find a pri-

vate foundation whose mission is more in line with exactly what I'm trying to do. What I would encourage for somebody who's maybe tried funding and been unsuccessful, my first question to them would be, "have you moved away from federal and state and have you put in the legwork to seek out different foundations who do this work?" Because sometimes I have found they tend to have smaller, more dedicated teams. You can talk to someone there before you submit and put a name to material that's coming in. If you can communicate your idea and get feedback again, sometimes I found more foundation-based places who have money. They seem to be structured as an organization in a way that you can be a little more personal with them, rather than just number two hundred and five on the stack of papers.

That's just really good advice. And then what do you tell your young professionals, your new graduates, the advice that you give both inside and outside the classroom?

A lot of collaboration. I think you can collaborate with somebody who thinks very similar to you, but I think collaboration is actually more rewarding sometimes when there are two perspectives meeting somewhere on that idea. I think it improves projects when you can do that. A classic example would be the students I have worked with; they're often very interested in the biological side of things or the very clinical side of things. And they may not consider someone with more social science like me as someone to collaborate with. But I actually think those pairings are fascinating and often lead to good research. But my advice would be to not limit yourself, don't stay within your major, or if it's somebody who's newly in a career, you don't stay within your department, see what's going on across the organization. Something could be happening in another part of the unit or another part of the organization that your voice, again, could be very valuable to you and your experiences and perspective could be very valuable to you.

And then the other thing, and this is probably the most clichéd thing I will say, is you must stop yourself from being affected by rejection. You must manage rejection. In research, more than anywhere else in any of my career experiences, very good ideas are going to be shot down, sometimes more kindly than other times. To have any success in research, you have a pile of rejection letters first. I think that's a hard perspective to have, especially if you're trying for the first time. It's easy to go into a mindset of like, "oh, I should just stay out of this, stay over

here." You've got to have a perspective on research that it's a good system in the way that review happens, but it's not a perfect system. So you've got to read a rejection letter or a reviewer's comments and say like, "OK, that's your perspective. These pieces of your perspective are actually valuable and things that I can use. And so, I'll take those. Thank you." But it doesn't make what you did not worthwhile. It's still worthwhile.

Right. That's great advice. Or even when I think of the system our students have to go through for internship and practicum selections and how you said you have to learn how to manage rejection. Other words of advice that have helped you be successful in your research? Or any last thoughts?

I would say know your role because one of the reasons I knew this path was right for me is the things that I do in research were things I was already doing on the weekend, like engaging in the literature and thinking of collaboration. I think that's key to not getting burnt out. My favorite thing about research, and one way I think to approach it, is I love the way it connects me to other people to talk about health care. You and I talking today. I really do view research as a conversation. I love it when it's an actual human interaction conversation. Like when you reach out to somebody who wrote a paper and you're like, "hey, I just read your paper, let's talk about this," or people reach out to me. Or I can share my research with a student, and they can tell me about an experience they have that relates to it.

And I think when people hear that, they connect more strongly to research. I work with a lot of students and young professionals who are intimidated by research. They don't see it as reachable for them when it absolutely is because they're already on multidisciplinary teams, they're already having conversations with different colleagues across the US and globally. They love having conversations and learning new things from their team members that have very different roles than they do. They just may not realize that it's all part of the research process.

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MOMENTS FROM THE PAST

A Deep Dive into Boston-Based Child Life Programs: Evidence of Earlier Origins

by Lauren H. Dulude, MS, CCLS,
Boston Children's Hospital, Boston, MA

As child life specialists, we can agree that the field of child life is often misunderstood. Taking a deep dive into the foundation of this profession alongside the culture of individual hospitals can be key to understanding how misconceptions of our role formed in the past, how the field operates in the present, and how to further expand the field in the future. Partially due to the numerous names the profession has held over the years, the history of child life is murky. It can be difficult to decipher historical transcripts that reference early child life pioneers as volunteers, play ladies, and hospital teachers. For this article, the title child life specialist will be referred to regarding the roles previously mentioned, unless otherwise noted. The research contained in this article will focus primarily on the historical context of child life programs in Boston, Massachusetts, in three leading children's hospitals: Boston Children's Hospital (BCH), MassGeneral Hospital for Children (MGHfC), and Tufts Children's Hospital. What began as a historical review quickly became a data-collection project far more valuable than one ever imagined.

This research began from encouragement from a graduate child life profes-

sor, Claire White, to take a deep dive into the history that was documented in Turner and Grissim's research in the chapter "Care and Conditions of Children in Hospitals" in *The Pips of Child Life* (Turner, 2014) as well as Wojtasik and White's research in the chapter "The Story of Child Life" in *The Handbook of Child Life* (Thompson, 2018). A tremendous amount of data was collected through one-on-one interviews, reviews of transcribed historical timelines, personal accounts by child life specialists, and physical documents. The physical documents collected included newspaper clippings, signage, photo captions, booklets, pamphlets, and more provided by Evelyn Hausslein, former employee of Boston Children's Hospital, Martha Stone, former Coordinator for Research and Reference at MassGeneral Hospital, and Andrea Colliton, Director of Child Life Services at Tufts Medical Center. Physical documents were used as valuable primary sources since dates were typically transcribed and individuals were named and quoted, and, therefore, could be researched further.

The Association of Child Life Professionals (ACLP) Historical Timeline is the accepted basis for child life history and

is well-known in the child life community. The timeline highlights that many child life programs were developed in the 1970's and 1980's, with the earliest known play program dating back to 1922 at Mott Children's Hospital in Ann Arbor, Michigan (ACLP, 2021). However, the research gathered through this project suggests that there is child life history prior to 1922, beginning at MGHfC.

MGHfC's Chief of Children's Medical Services, Fritz B. Talbot, MD, hired the first play lady, in conjunction with the founding of Children's Medical Service at MGHfC (The General Hospital Corporation, 2007-2021; The Playground and Recreation Association of America, 1922). Isabelle Whittier was hired for the play lady role bringing to the position her experience working in kindergartens, Montessori schools, and settlement houses (The Playground and Recreation Association of America, 1922). One key primary source that indicates that Isabelle Whittier was the first known play lady is Whittier's article in the August 1922 edition of *Modern Hospital*. The first sentence reads: "For over a year now I have worked in the children's ward of the Massachusetts General Hospital, trying to find what two hours daily of organized play will do for sick children" (Whittier,

1922, p. 135). Although the term child life was not yet coined, Whittier's nonchalant introduction offers an alternative to the child life historical timeline, indicating that she began her role as a child life specialist in 1921, if not earlier.

The benefits of child life in its early stages were supported by Fritz B. Talbot, MD, who shared, "Miss Whittier has filled the lacking gap in our ward and the results have been beyond my expectations...I feel that there is a place for such work as Miss Whittier carries out in all hospital wards for children" (The Playground and Recreation Association of America, 1922, p. 489). Her role solidified play to have therapeutic and medical value resulting in faster recoveries, demonstrated that comfort, distraction, and wellness were critical for both healthy and sick children, and was deemed "one of the most heart-warming jobs and one of the most heart-breaking jobs" (Bedini, 1995; Sibley, 1929, p. 51; The Playground and Recreation Association of America, 1922).

Following MGHfC's lead, Tufts Children's Hospital hired their first child life specialist, Kristine Angoff, in 1948. She was hired as a playroom teacher by the Department of Pediatric Psychiatry Child Guidance Unit (Angoff, 1965; Angoff,



MISS ISABELLE WHITTIER

1982; Prinz & Van Schaik, 2014). Angoff's role primarily served to develop a trusting relationship with patients, provide diversional activities, and bring the toy cart around to rooms each morning (Prinz & Van Schaik, 2014). Her effects were recognized in 1951 when the Psychiatric Service team suggested the child life role aided in family satisfaction, staff education, decreased hospital costs, and helped patients that were adjusting to hospitalization (Freeman & Garfield, 1951).

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In 1959, approximately 10 years following Kristine Angoff's start at Tufts Children's Hospital, a five-person "Play Program" directed by Barbara Patterson was launched at BCH (E. Hausslein, personal communication, April 3, 2019). BCH's child life program was greatly supported by Dr. T. Berry Brazelton, an internationally known pediatrician and scientist (Brazelton Touchpoint Center, n.d.; E. Hausslein, personal communication, April 3, 2019). Brazelton worked closely with child life professionals to learn about infant/toddler brain development and study the effects of caregiver separation. He firmly recognized the role of child life and even asked them to attend rounds. Momentum continued throughout the 1970s as BCH officially changed titles from play ladies to child life specialists and began advocating for family presence, procedures to take place in treatment rooms, and the role of child life in procedural preparation (E. Hausslein, personal communication, April 3, 2019).

This research uncovers groundbreaking findings that, in the Boston area, child life was operating earlier than previously recorded. This may be the case for other parts of the country as well. A deep dive into the history of child life in other locations, hospitals, and child life programs may produce equally interesting findings. After all, knowing our professional roots will only aid in gaining valuable insight into the profession's power in its entirety.



ACLP UPCOMING WEBINARS

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

October 29, 1pm EST

Tragedy, Trauma, or Typical: The Ethical Impact of Coping with the Stressors of Clinical Healthcare Delivery

November 30, 1pm EST

Indigenous Perspectives in the Clinical Setting

4-part webinar series in November,
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CALENDAR

UPCOMING EVENTS AND IMPORTANT DATES

OCTOBER 8: Applications available for the 2022 Research Recognition Awards (Students & Professionals)

OCTOBER 15: ACLP Live Webinar, "All of Me: The Impact of Intersectionality on Work as a Child Life Specialist"

OCTOBER 21: Applications available for the 2022 winter/spring Diversity Scholarships

OCTOBER 25: Deadline to submit transcripts and other documentation for review in time to register for the November Child Life Professional Certification Exam

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

OCTOBER 29: ACLP Live Webinar, "Ethical Focus on Academic Programs and Clinical Internships: Increasing Diversity in the Profession"

OCTOBER 31: Deadline to apply to recertify through PDUs

NOVEMBER 1-15: November dates for Child Life Professional Certification Exam administration testing window

NOVEMBER 15: Applications available for 2022 One-Person Program Conference Scholarships

NOVEMBER 18: Applications due for 2022 winter/spring Diversity Scholarships

NOVEMBER 30: ACLP Live Webinar, "Tragedy, Trauma, or Typical: The Ethical Impact of Coping with the Stressors of Clinical Healthcare Delivery"

DECEMBER 20: Deadline to submit transcripts and other documentation in time to apply for the 2022 Summer Internship

DECEMBER 31: Last day to reinstate lapsed CCLS credential

JANUARY 1-31: Start planning your Child Life Month events and activities for March!

JANUARY 1: Submission deadline for ACLP Bulletin for consideration in the Spring 2022 issue

JANUARY 5: Applications due for 2022 Research Recognition Awards (Students & Professionals)

JANUARY 5: Application deadline for the 2022 Summer Internship

JANUARY 24: Applications due for 2022 One-Person Program Conference Scholarships

JANUARY 31: Deadline to pay 2022 certification maintenance fees