ACLP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS
FALL 2020 | VOL. 38 NO. 4

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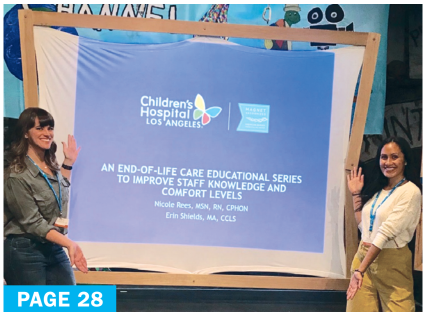

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For information on advertising in *ACLP Bulletin*, please refer to the Advertising page on the ACLP website.

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CONNECT WITH US

from the Executive Editor

Kathleen McCue, MA, LSW, CCLS

The Power of Stories

The value of storytelling is wonderfully described in a Native American proverb: “Tell me the facts and I’ll learn. Tell me the truth and I’ll believe. But tell me a story and it will live in my heart forever.” Storytelling is a concept that is completely familiar to child life professionals. We all tell stories to children, whether by reading stories from a book, using dramatic visual or play techniques to share stories, or inventing fantasy stories which will have meaning and significance to a child or family.

What is the relationship between storytelling and *ACLP Bulletin*? Our intentional focus to include more storytelling began in the Summer 2020 issue, with a moving account by ACLP CEO, Jennifer Lipsey, when she shared her experience being confronted by a racist stranger in the grocery story. As I read Jennifer’s article, the issue of racism struck me at the core of my being in a very profound manner. That story truly will live in my heart forever.

In this issue, there are three amazing examples of personal stories, and they each demonstrate the power of telling a story about an important life experience. Magellan Taylor-Brickey openly and honestly describes her own experience with moving forward from burnout. Kevin Xuereb, a burn center nurse, reveals his heart-warming interactions with child life during COVID-19. Finally, Teresa Schoell, in an article that brought tears to all of our eyes, helps us viscerally understand the difference between being “not a racist” and being an anti-racist. Several other articles use personal stories to bring life to the lessons they are sharing. I urge you to find the time to read this issue from cover to cover. You will be moved!

Everyone has stories: of triumph, of sadness, of loss, of challenge. Maya Angelou once said, “There is no greater agony than bearing an untold story inside you.” I want to encourage everyone who is moved by these personal stories to think about your own experiences and child life journey. Please reach out to any one of the editors with your thoughts and ideas, and we will help you to turn your story from a concept to a completed article. We want to hear the untold story inside you!

> ***“Stories create community, enable us to see through the eyes of other people, and open us to the claims of others.”***
>
> *— Peter Forbes*

As you settle in to be inspired by this issue, let me leave you with one last quote, by Peter Forbes, the Co-Founder of Center for Whole Communities. I believe it captures a core truth about storytelling and its impact on society and human equality. Mr. Forbes said, “Stories create community, enable us to see through the eyes of other people, and open us to the claims of others.” I hope the following stories enhance your sense of being part of a child life community.

President's Perspective

Kim Stephens, MPA, CCLS

History as defined by Dictionary.com is the branch of knowledge dealing with past events. Additionally, it is further characterized as acts, ideas, or events that will or can shape the course of the future. Around the country, we have been seeing the physical removal of Confederate statues as society begins to reflect on its racist past. Tough questions are beginning to be asked. What monuments or symbols from our past must be reconsidered or simply discarded? What stories from the past do we need to hear to change the future? How should our foundational history be defined and shared? As I reflect on the work ahead, I find myself asking those very same questions regarding our profession and organization.

As child life professionals, our Child Life Code of Ethics, Principle 3 states that we "are called to ensure that **all** in our clinical care and with whom we work are not the subject of racism or discrimination." Yet as I have had conversations with child life professionals, academicians, and students, it is very clear that we are not consistently living up to this principle. There has been a lot of discussion as to how our profession became a white and female-dominated profession, while in our Diversity, Equity, and Inclusion position statement it is noted that current projections predict that between 2000 and 2050, racial and ethnic minority groups will grow to account for nearly one-half of the population in the United States. Why do we not reflect our patient population? How has our history played a role in that?

I do not have the answer to these questions, but I do think it is time to look at our "monuments" to determine what needs to be renamed, reframed, or pulled down entirely. We must explore the relevance of our foundational texts and developmental theories to the necessary knowledge base needed **now** to understand how health disparities, privilege, and bias inform how different patient population(s) respond to child life services. We must evaluate the historical path to certification to see how it is impacting those able to enter the profession. We must listen to the stories and experiences being shared by our own BIPOC members to forge a new path to equity. We must instill the principles of diversity, equity, and inclusion into everything we do—every committee, every policy, every standard—until it is in the very fabric of our field. Changing years of systemic racism requires the internalization of the history, values, principles, and context for its existence. And that internalization will be painful. But as Ibram X. Kendi states, "Pain is essential to healing. When it comes to healing America of racism, we want to heal America without pain, but without pain, there is no progress… before we can treat, we must believe. Believe in the possibility that we can strive to be antiracist from this day forward. Believe in the possibility we can transform our societies to be antiracist from this day forward."

I believe in our association and its members. Once our history is acknowledged, together, I believe we can take the steps necessary to make true change for our profession, our association, and the children and families we serve.

Our organization is also facing another big change. The Board of ACLP received, with sincere regret, the resignation of its Chief Executive Officer, Jennifer Lipsey. Jennifer has been an exemplary leader for the past three years as our organization's CEO. She has led us with grace, fortitude, and vision to a place of stability, strength, and growth. A transition task force led by President Elect, Quinn Franklin, has been formed that will be responsible for identifying an executive search firm or consultant to begin the search for ACLP's next Executive Leader. We hope you will join us in celebrating Jennifer through the months to come and express our gratitude for her contributions to our organization.

In your service,
Kim

CEO Shares

Jennifer Lipsey, MA

"What's the difference between morals and ethics?"

This was the first question my graduate school Law & Ethics professor posed to our class. Perhaps you can quickly articulate the distinction between the two. I could not. But it is a valuable, important distinction to make especially when it comes to defining associations' roles in the current climate of anti-racism activism. Here is my attempt to articulate the difference between the two:

Ethics are the rules or a set of behaviors that define what is legal and what is illegal. This is important to an individual's professional practice in that the profession's code of ethics provides the scope within which one is expected to practice. A violation of the profession's code of ethics can result in disciplinary action or legal risk. This differs from morals as morals relate to an individual's values, opinions, and beliefs of good versus bad. A violation of one's morals can manifest in guilt, offense, insult, or internal conflict, but legal action cannot be taken. Individuals have a professional responsibility to decipher when one's morals impedes one's ability to abide by the profession's code of ethics.

Why does it matter and how does this relate to the Association of Child Life Professionals (ACLP) and a Certified Child Life Specialist's (CCLS) responsibility in the space of anti-racism and discrimination?

ACLP's primary responsibility is service to its members - those who pay us to represent their industry, promote the efficacy of their practice, and further advance psychosocial care of children and families through education, research, and professional development. As your professional organization, ACLP operates within and is representative of the child life profession's ethics. Specifically tied to the CCLS credential, the Child Life Code of Ethics - owned and authored by the Child Life Certification Commission (CLCC) – is your industry's way of keeping you accountable, legally sound, and credible. The CLCC's primary responsibility is the protection of the public, hence they have a fully developed ethics subcommittee to manage any and all violations to the Child Life Code of Ethics. The CLCC has the authority to ensure all credential-holders are not in violation of the industry's code of ethics.

Both ACLP and CLCC hold responsibility in presenting our members with perspectives, research, and information to advance their practice with patients and families. In the current climate, the responsibility to our members and the public manifests in presenting content regarding equity in health care. That content could include highlighting health disparities, the influence of racism on the health care experience, context for mistrust in medical providers, and various testimonies of experiences that highlight how implicit and explicit biases have caused harm. These are areas raised by patients and peers in the health care industry as vital to your professional development.

Patients, peers, and the health care industry are demanding that each Certified Child Life Specialist not only abide by Principle 3 of the Child Life Code of Ethics — *Certified Child Life Specialists have an obligation to maintain an environment that respects variations in culture, age, gender, race, ethnicity, physical ability, sexual orientation, gender identity/expression, religious affiliation, veteran status, and socioeconomic status* -- but **exceed** it. One's professional responsibility lies in being able to decipher if and when one's morals impede one's ability to abide by one's ethics. Respect and comprehend the history, oppression, and influence of each variation to elevate your practice and advance your industry.

As always, the association will heed the demand to service its members by supporting you in exceeding expectations for inclusive practice and improving your patients' lived experiences.

Key Initiatives, Takeaways, & Reflections

The Diversity, Equity, and Inclusion (DEI) task force has nearly completed their primary charge of drafting an updated position statement on the Association of Child Life Professional's (ACLP) value of Diversity, Equity, and Inclusion. For the past year, the DEI task force, co-chaired by Rechelle Porter, CCLS, and Divna Wheelwright, CCLS, met monthly to discuss the intended audience, framework, and goals of the position statement. The *ACLP DEI Timeline* was also established during this process. The group's efforts revealed a need for the association to commit to: diversification of its membership to better reflect the patients and families under their care; education of its members on existing health disparities and the impact of racial trauma on child development and medical distrust; and the necessary work of self-reflection to understand how one's biases impact the ability to provide equitable care.

To create systemic change, action is required by all players of our association: **A**cademics, **C**linicians, **L**eaders, and **P**erson. Each must flex their self-reflection muscles, take accountability for how their words, actions, and decisions either uphold or dismantle systemic racism and discrimination, support one another through challenging, sometimes difficult conversations, and commit to processing the discomfort together to gain clarity in viable solutions.

Aligned with our commitment to "do the work," ACLP staff participated in *America & Moore's 21-Day Racial Equity Habit-Building Challenge* after coming across the American Bar Association's pledge to participate. The ACLP Board was invited to join the staff in the challenge to gain a deeper understanding of where and how race, power, privilege, supremacy, and oppression intersect. For 21 days, participants completed the plan's daily suggested action that included a variety of readings, videos, or podcasts. The goal of these daily assignments was to increase awareness and engagement in the pursuit for racial equity. The assignments highlighted elements of Black history, identity and culture, and the Black community's experience of racism in America.

Each piece in the assignment highlighted how various moments in history informed decisions that kept some oppressed while allowing others to thrive. Regardless of whether the preceding decisions were made with the calculated intention to oppress Black people or other people of color, the result was just that – Whites thrived because policies, laws, and norms kept Black people and people of color at a disadvantage. Over time, the structures that created systems of leadership, power, and privilege become further solidified as did the disparities between White people and Black people. Rather than debating whether an individual was racist, let us accept the results for what they are. This goes for the homogeneity of our membership as well. We must acknowledge the fact that regardless of whether it is an intended consequence or not, the child life industry has become a privileged profession.

This almost exclusively White profession is providing services to a changing nation – a nation that is becoming majority people of color. Child life specialists provide emotional safety by assessing previous, current, and future risks for trauma; how can specialists acknowledge racial trauma in their practice without first understanding the systemic issues children and families face? Child life is an industry that holds fast to legacy, precedence, and standardization — but at what risk? While policy and precedence exist to protect those we serve, we must also be willing to seek "outside the box" alternatives to how we think, practice, engage, and connect. We are in a position to welcome all who come with novel ideas or experiences from which we can reflect upon our own reactions and biases (e.g. what about 'this' makes me uncomfortable and why) and challenge ourselves to more fully understand why we do what we do. Embrace heterogeneity in thought leadership, staffing, student, and intern recruitment and navigate change management with grace, reflection, and purpose. Take us out of auto pilot and into the driver's seat of a new vehicle. Change the narrative from disruptive or different to innovative and progressive.

We do not believe any of our members or leaders set out to exclude people of color. As with most communities, there is a common interest, value, or source of connection. That community forms its own cultural norms, language, and rules that only further reinforce who is welcomed and accepted. The process of becoming a community inherently provides opportunity for exclusion of those who are "different." We oftentimes gravitate towards the familiar as familiarity breeds trust and security. There is value in assessing famil-

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Diversity, Equity, & Inclusion: Key Initiatives, Takeaways, & Reflections

iarities when it comes to competencies but are we relying on a sense of familiarity when it comes to how others sound, talk, gesture, look, and present? What are we valuing when we recruit or select individuals because "they just get it" or will "fit in?"

ACLP is not interested in forming or becoming a committee on correct thought. We are, however, committed to advancing the industry of child life through research, professional development opportunities designed to supplement yet challenge our members' approach to patient- and family-centered care, and connecting members for support, exchange of resources, and expansion of their peer network. What we continue to witness, in our role as your industry's association, is our members' hunger for accountability to their patients, families, and peers. With AAP's policy statement on "The Impact of Racism on Child and Adolescent Health," and media coverage highlighting the murders of George Floyd, Breonna Taylor, and Ahmaud Arbery (to name but a few), our members are demanding more of themselves, their peers, and the association. With reflective practice at the center of professional development, it's no surprise that many are eager to learn and discuss the various ways in which their own histories, experiences, and identities influence their approach to patient and family care.

We will not ignore the reality of systemic racism and will continue to refine the association's programs as we evaluate sustainable solutions to improving access to the industry and supporting the community's professional development. We expect our members to heed the cries of their peers, patients, and families demanding equitable care, greater accountability, and informed practice. We are listening as our community asks itself and one another, "How will I dismantle social injustices like racism and discrimination? What if I say or do something wrong? What can I do to help?" The answer is in the question… seek knowledge of your part, your role. The answer is not only in the "I" but in the "we." Together, we will acknowledge, engage, educate, and connect for the professional development of ourselves, advancement of the child life industry, and improvement of patient care.

Key Takeaways

FROM THE DIVERSITY, EQUITY, AND INCLUSION WORKSHOP

The list below highlights some of the key takeaways from the Fall 2019 DEI Workshop. Since the workshop, ACLP has published the DEI Action Plan designed to incorporate many of the ideas below and leave room for ongoing additions to actions recommended by the DEI Committee, membership, and leaders.

#1

INNOVATION IN EQUITY AWARD

Award given to a clinical program that creates a scaleable way to consistently recruit and select people of color, different ability and/or who self-identify as LGTBQ+ into their internship.

#2

MARKETING CAMPAIGN

Showcase the impact and influence of child life specialist of color on colleagues and patients in a marketing campaign.

#3

ACLP BOARD REQUIREMENTS

Analyze and change any current ACLP Board member requirements that could impede a person of color from serving.

#4

ACLP BOARD NOMINATIONS

Recognize the need to change the formal process of board nominations to include the ability to identify and directly ask individuals that show talent to create a pipeline of applicants.

#5

DIVERSITY LEADERSHIP PROGRAM

Create a diversity leadership program to support individuals from under-represented identity groups to advance into the ranks of leadership in the child life profession.

#6

SEEK DIRECT FEEDBACK

Ongoing, direct engagement with members of color, different abilty, and/or who self-identify as LGBTQ+ to seek direct feedback.

#7

SUPPORT LEADERS' COMPETENCY

Support competency around: performance-review processes, evaluating exit interviews, talent-acquisition strategy, training, development job ladders, and more.

#8

BLACK EXPERIENCES

Utilize data to look big picture at the experience that Black and other unrepresented members have with ACLP and the profession year-over-year.

#9

DIVERSITY OF THEORISTS

Highlight diversity in theorists, theory, and health equity within child life academia to best prepare students for the wide range of patients and families they will serve.

ACLP Staff Reflections

FROM THE *21-DAY RACIAL EQUITY HABIT-BUILDING CHALLENGE*

The Case for Reparations by Ta-Nehisi Coates should be a required reading in schools. His article made me realize, on a deeper level than I had, that slavery didn't end—it evolved. I have a moral responsibility to understand that slavery and oppression can take different forms and that police violence against Black people is modern-day lynching. I took this quote to heart this year: "Reparations would mean the end of scarfing hot dogs on the Fourth of July while denying the facts of our heritage" and spent the day watching *Just Mercy* and *Hamilton*.

– ACLP Staff Member

ACLP STAFF REFLECTIONS

> *Slavery didn't end, it evolved. Jim Crow didn't end, it evolved. Lynching didn't end, it evolved. It's not enough to be quietly non-racist; I need to be actively anti-racist.*

After completing the challenge, I was immediately struck by my ignorance to Black history or really, any history beyond the White narrative, including my own Japanese ancestry. My history classes were filled with lessons on White American history and politics and they glossed over the topics of slavery and oppression. Lessons on slavery, segregation, and the Civil Rights Movement were presented in terms of what had once been and has since been overcome. We were taught that racism is easy to see, feel, and judge. We were quick to claim racism no longer exists because there isn't as much tangible, obvious segregation occurring like the "Colored Only" signs of the 50s and 60s. Does racism no longer exist or has it been replaced by hidden, embedded ways of excluding some while strengthening others? Has there been progress, or have we just figured out a way to be more calculated in our methods?

– ACLP Staff Member

ACLP STAFF REFLECTIONS

> *I'm guilty of ignorance. I can be progressive, educated, and good intentioned, but still be complicit.*

In the *Transformation Podcast*, it was pointed out that Robin DiAngelo, renowned author of *White Fragility*, has no room for White guilt; only White responsibility with which to identify and enact change. We are not interested in enacting the cancel culture and shaming people into action or paralysis. Rather, this process is about acknowledging systems and processes that support the privileged and oppress people of color and dig in to understand what it is about the parts (certification, internship, membership, volunteer engagement) of our system (child life community and professional industry) that reinforce homogeneity.

— ACLP Staff Member

The *Karen Podcast* points out that the architecture of Whiteness is based on the premise that racism does not exist; that we are all equal. This premise supports ongoing avoidance and ignorance to the threats and risks of "living while Black" that our Black neighbors battle every day while we claim we "don't see color." We must be open to discussing all aspects of race especially when the subject arises with children as they develop and make observations about the people around them. We must not avoid, embarrass, or shame our children for asking questions about race. We must normalize our relationship to, engagement with, and communications about race lest we raise children who sense our hesitation, avoidance, or shame and internalize it — reinforcing systemic racism and implicit biases.

— ACLP Staff Member

ACLP STAFF REFLECTIONS

> *I understand micro-agression better and feel more prepared to provide micro-interventions when faced with those situations. Especially when someone says, "all lives matter."*

I Love Thursdays

Teresa A. P. Schoell, MA, CCLS
UR MEDICINE GOLISANO CHILDREN'S HOSPITAL

I love Thursdays.

It's game night, and my son sits in front of the computer, the table speckled with dice. His dark brown curls in neat locs fall like soft ropes around his face. The soft glow of the computer screen highlights his brown skin in shades of cinnamon and toasted pecans. I watch a smile spread across his face, dear to me, as there have been so few of them since quarantine started. This is why I love Thursdays. On Thursdays, he plays D&D over the internet and it's the one time each week when I know he will smile, laugh, and genuinely forget about everything else going on in the world. For a few hours, his universe is goblins, dragons, and fireball spells. He laughs so hard his whole body moves, and the thrill of the battle brings him to the edge of his seat. He is so free, so alive, so happy on Thursday nights.

I sit huddled on the couch in the next room, the lights purposefully off, leaving my face in shadows. I have no poker face, and I don't want him to see my eyes. My chest feels heavy, filled with a pain that I have only a peripheral claim to, but it still makes each breath stab into me, sharp and agonized, tinted with rage. I prefer the rage. It feels so much better than the relentless, devouring terror that lurks beneath, that I pretend isn't there, that is a defining pillar of my motherhood. I look down at my hands, dry and worn from the endless handwashing, but soft and pink underneath. These hands used to be enough to keep him safe.

I am a White mother to a Black son. And I have to tell him.

I don't want to. It's Thursday, and his face is filled with triumph as his clever use of a cantrip spell amuses the dragon and wins his friends a new ally. I have to tell him. Though we haven't yet allowed him social media accounts, he can text with his friends. His social studies teacher talks about current events. I have to tell him. He needs to hear it from me. But I really don't want to. It's Thursday. Thursdays should be sacrosanct, immune to joy-stealing reality. I have to tell him.

I have told him before. I told him the first time in February 2012 when he was only five years old. He stopped wearing the black hoodie from his grandmother. I told him in November 2014 when he was eight years old. He cried when I threw away his foam dart guns. I did, too. I told him twice in July 2016, before he even turned ten. Now I have to tell him again.

But I wait for Friday morning. Thursdays should be sacrosanct.

I knock on his door early in the morning before I leave for work. "I need to talk to you." He looks confused for a moment – not because it's early, he's been awake for almost an hour playing games on his phone as he does most mornings before getting up to tackle the day's school-from-home assignments. He looks confused because I usually just blow him a kiss from the hallway before I head to the hospital for another day of pandemic work as a child life specialist. His look of confusion fades as quickly as it appeared. As I said, I have no poker face.

"His name was George Floyd," I tell him. "He was Black, and he was killed by a police officer." We sit there in an endless moment of silence. I'm ready for tears. I'm ready for rage. I'm ready for sorrow and pain.

"Again?" he asks me quietly. His voice is filled with somber resignation. I am not ready for resignation. I am confused by it. But then I realize. We have normalized the murder of Black people. No . . . *I* have *normalized* the murder of Black people. And I have taught my Black son to do the same.

That singular moment of visceral clarity is carved starkly into my mind. It is the moment when I realized that I am part of the problem. I have always felt a certain pride in knowing that despite the world being racist, I was not. Didn't I rage, and protest, and donate when Trayvon Martin was killed? Didn't I cry, and mourn, and empathize with Tamir Rice's mother? But when the news cycle ended, so did my rage, and my fear, and my attention. I moved on with my normal daily life and taught my son to do the same. I am part of the problem. I didn't mean to normalize racism. I didn't even realize I was doing it.

> *I didn't mean to normalize racism.*
> *I didn't even realize I was doing it.*

I grew up with the colorblind virtue, proudly living a life in which we are all members of the same race, the human race. I studied racism in graduate school, writing my thesis on preventing racism in young White children by engaging them in multi-cultural education and positive interactions with people of color. My White husband and I bought a home in a diverse school district, and chose educational and work experiences that would engage us in daily interactions with people of all races. Our son's birthmother chose us because our profile was the only one with brown faces in any of the photos. Does this sound like someone who is racist?

I thought "racist" was pointy white hoods lit up by torchlight, ketchup bottles emptied on the heads of peaceful protestors, and racial slurs spit from hateful lips. I do none of these things, so I am not racist. I smile and greet my co-workers of color by name every day. I nurture the bond between my son and his birth family, the most beloved Black people in his life. I make sure the toys I use with my patients show a variety of skin tones. I do all these things and more, so I am not racist.

But when a coworker made a racist joke the next week about purposefully inciting violence at a peaceful protest, I didn't say a word. I tell myself I was too shocked to say anything, that I was still gutted from talking with my son on Friday morning, that I was too raw from a weekend of protests usurped by hateful bigots and the ensuing riots and city-wide curfews. But I didn't say anything the next time I saw that person either. My silence validated that behavior. I normalized it. I'm part of the problem.

> *My silence validated that behavior.*
> *I normalized it. I'm part of the problem.*

I have spent a lifetime trying not to be racist. But it is not enough. How could it be? Since earliest childhood I have been steeped in the racist ideas, assumptions, and stereotypes embedded throughout my world. The media I consume is riddled with them, my education reinforced them, and my unwitting actions have perpetuated them. Racist ideas have been ground into my very pores, and I internalized the belief that to call them out is to be "rude" and therefore unacceptable. I joined committees, I led projects, I read books. But it is not enough. I signed petitions, I donated money, I knelt outside my hospital for 8 minutes and 46 seconds. But it is not enough. I know it is not enough, because when my son asked "Again?" I just nodded. And he nodded. Then he got dressed and tackled the day's school-from-home assignments, and I went to work. When I got home from the hospital, we ate dinner and watched the next superhero movie on our list. Just a *normal* Friday.

I have spent my lifetime being not racist, a way of life defined and encompassed by all the racist things I did not do. But now I know that this is not enough. I must be more than the thoughts I don't have, the words I don't speak, and the actions I don't take. This is where *anti-racism* comes in. Being an anti-racist is about reflecting with naked honesty on *all* the thoughts I have, examining the subtle and insidious beliefs that have taken root in my subconscious to influence my reactions and actions without ever recognizing that they are there. It is about scrutinizing my words for bias, unintended meaning, and above all else for the impacts that they may have, large and small. Being anti-racist means recognizing that my devotion to courtesy, my aversion to conflict, and my pervasive desire to be accepted and liked by those around me so often serve as disguises for complicity, validation, and normalization of the unacceptable.

> *I must be more than the thoughts*
> *I don't have, the words I don't speak,*
> *and the actions I don't take. This is*
> *where anti-racism comes in.*

I barely know anything about anti-racism. This is a whole new direction in a journey I've been on my whole life. But here is what I know so far. This is complicated, messy, hard work. And I'm going to make a *lot* of mistakes. My own mind and personal history will be the biggest barriers to my success. They will use every excuse, rationalization, and reframing they can think of to relieve my discomfort, ameliorate my regret, and gently excuse me from the painful obligation of taking ownership of every action, and inaction, I take. I will feel defensive, overwhelmed, and ashamed. And there is no finish line.

But I am not alone. A whole lot of other people are on this journey, too.

The human capacity to adjust, normalize, and move on is deeply embedded, even vital, to our ability to function. As child life specialists, we recognize this human skill as the vital building block for resiliency that it is. But that resiliency can unintentionally prop up systemic racism by

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I Love Thursdays

> *But I am not alone. A whole lot of other people are on this journey, too.*

helping us to move on from tragedy. Time and again, White people have witnessed the horrors of Black people killed by police, expressed our collective outrage, maybe wrote a check or signed a petition, then drifted back to our everyday lives as the momentum faded, the outrage dimmed, and our lives began to feel normal again. But the danger, the fear, and the pain go on for the Black members of our community. They must choose to live in the terror or normalize that threat as a part of their daily lives and accept all the detriment and consequences that normalization brings to their psychosocial and emotional well-being. As child life professionals, charged with the emotional safety of the children we serve, we know the devastation and damage that brings.

So, what is different this time, with the death of Mr. Floyd? Beyond the data, the disparities, and the news cycle, something is different for White people this time. The difference is COVID-19. The White members of our community are all experiencing first-hand a threat that lasts beyond a single news cycle. We are feeling the daily impacts of a danger that lingers, a threat that pervasively and insidiously seeps into every aspect of our lives. Every time we leave our homes, we must consider the threat of the virus. We must take precautions. We must change our behaviors and activities in ways we do not want. And we must sit with the daily reality that even if we do everything in our power to protect ourselves, and our love ones, it may not be enough to keep us safe.

The pandemic has given White people a touch point for emotional connection, by providing an opportunity to empathize, even a tiny bit, with the experiences of the Black members of our community. The ongoing impacts of COVID-19 on our lives force us to experience, and remember, what living with a daily threat feels like, deep in our bones, over unending days, and weeks, and months.

This virus won't last forever. We can't let racism, either.

When an RN Needs Help at Home… Child Life is MY Hero

Kevin Xuereb, MSN, MSEd, RN, ACCNS-AG, CCRN
NEW YORK PRESBYTERIAN WEILL CORNELL HOSPITAL, NEW YORK, NY

I am writing this letter to the greater child life specialist community. Recently, there has been an extraordinary amount of attention given to nurses around the globe for their work during the COVID-19 crisis. Every time a bright light is shone on an object, it creates shadows elsewhere. Too often child life specialists are cast in the shadows of the hospital world. As a father and a nurse, I wanted to highlight a time when I needed a child life specialist to help me during my moment of crisis. The child life team at New York Presbyterian Weill Cornell certainly delivered.

I have been a nurse at New York Presbyterian Hospital for 13 years. Most of my time there has been spent on the Burn Unit caring for both pediatric and adult patients. As a burn nurse, I developed a profound and deep respect for our child life partners. Conducting routine wound care on a pediatric patient can be emotionally exhausting for both the patient and the nurse. Child life helps to lift that burden and create a more comfortable and emotionally tolerable environment. For a short time as the Manager of Burn Outreach, I teamed up with the Burn Unit child life specialist, Bailey. Bailey and I conducted the school reentry program for school-aged burn survivors on their return to the classroom. Nurses are always taught to be a patient advocate, but child life also acts as their confidant, cheerleader, and shoulder to cry on.

It was these attributes that helped me during the COVID-19 crisis. In mid-March, our hospital tried to triple our ICU capacity and double our ICU staffing by training several hundred nurses to handle the new volume. During this time, it was decided that all pediatric patients were to be moved to our sister hospital several miles north on the island of Manhattan. When the children left the hospital, I felt like we as a hospital community lost a small part of ourselves.

As a father of four children (ages two-12), there were some added pressures at home. My wife Maureen is a schoolteacher, and we tried to talk openly, honestly, and age appropriately about what was going on around us, without being too frightening (that was not easy). The uncertainty of the situation was compounded by the loss of people we knew to COVID-19. The strain of having a dad who worked in the ICU was wearing on the family. The fear of contaminating my family had me socially distancing from them as well. I kept my distance by staying alone in my room and wearing a mask at home, and those important hugs were few and far between. At work, the stress was always at the forefront, "Is my mask on right? Did I touch my face just now? How long did I wash my hands for?" During a routine morning, I ran into a friend who was a director of nursing. She asked how everything at home was, and I was honest. I said, "Not great. The kids aren't doing too well, they are all worried about me getting sick." She suggested I reach out to child life.

> *During a routine morning, I ran into a friend who was a director of nursing. She asked how everything at home was, and I was honest. I said, "Not great. The kids aren't doing too well, they are all worried about me getting sick." She suggested I reach out to child life.*

Without pediatric patients to work with, child life specialists took on the role of good will ambassadors bringing a morale boost to the hospital staff. When others would not go within a mile of a COVID-19 unit, they battled on with their red wagons and supported the frontline and nursing staff. They gave us snacks and kept us hydrated. They made encouraging signs for the units and a series of inspirational quotes in sidewalk chalk surrounding the hospital. My personal favorite was a little fish resembling Dori from *Finding*

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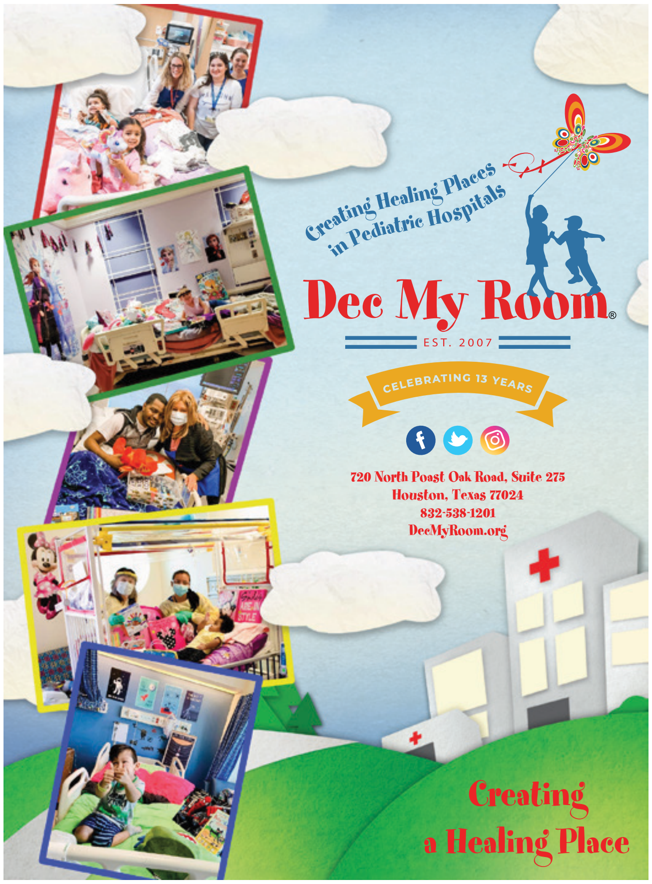
When an RN Needs Help at Home… Child Life is MY Hero

Nemo saying, "just keep swimming." They were tirelessly cheerful, and I do not know how they did it.

> *Walking into their workroom was like meeting a room full of friends you didn't know you had yet.*

The child life specialists also provided personal support in the way of information for health care workers. They were there when I asked for help in providing support for children, both professionally and personally. Walking into their workroom was like meeting a room full of friends you didn't know you had yet. Bailey had provided coloring sheets to help the children understand what personal protective equipment was and why we wear it. She suggested a workbook for children to help work through their anxieties. Finally, Bailey showed me the book *The Invisible String* by Patrice Karst. I ordered it right away and received it within a few days. As parents, my wife and I cried as we read it to our kids. The book helped my whole family understand the love we share with each other and that even though I have to go work at the hospital, and even though I was keeping my distance from them, we were all connected by the invisible string of love.



As I write this letter, we are 10 weeks into our quarantine. Having four children in close quarters for 10 weeks often has us feeling like lion tamers, trying to feed the kids so they will remain calm and not turn their hungry attention on the two helpless parents before them. We are still working on our anxieties, using the workbook, talking with the kids, spending as much 1:1 time as we can with each of them. It may appear like a small offering to suggest a book. As health care workers, we hear all the time about how small gestures can have profound results on our patients. The time I spent with Bailey and her team will always have special meaning to me. As a nurse, a father, and a friend, when I needed a best friend, a cheerleader, or a shoulder to cry on…I too turned to my child life specialists. In a city and a country that bangs pots and pans to recognize health care workers and health care heroes, know that my heart beats a loud drum for all of you, not just at 7pm, but always (roughly 60-100 beats per minute).

Child life specialists are real life angels that spend every waking moment focusing on improving the lives and experiences of hospitalized children and those that work with them. When the children left the hospital, I felt us "lose" something. It wasn't really about the kids, but the laughter. The laughter of a child that echoed through the hallways. A laugh that was initiated by the kindness, generosity, love, and overall silliness that only child life can provide. The staff working at the bedside needed those laughs, love, and support too. My friend Bailey and all the child life specialists helped restore the soul of a hospital when we needed it the most. You are all too often overlooked and in the shadows. I wanted to let you know for all the work you have done in the past, in crisis, and in the future, for every smile you put on a child, a parent, or a coworker, know that there are nurses out there supporting you too. We love you and will gladly sing your praises from the rooftops, and our hearts beat a drum of love and support for you always.

With Greatest Love and Appreciation,

Kevin Xuereb
MSN, MSEd, RN, ACCNS-AG, CCRN

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Scenes from the Life:

HOW COVID-19 AFFECTED CHILD LIFE PRACTICES IN PEDIATRIC EMERGENCY DEPARTMENTS THROUGHOUT NEW YORK CITY

Lauren Keyes, MA, CCLS
MOUNT SINAI KRAVIS CHILDREN'S HOSPITAL IN NEW YORK, NY

Hilary Woodward, MS, CCLS
NEW YORK-PRESBYTERIAN MORGAN STANLEY CHILDREN'S HOSPITAL AT COLUMBIA UNIVERSITY MEDICAL CENTER IN NEW YORK, NY

Kymme Napoli, MS, CCLS
BELLEVUE HOSPITAL CENTER IN NEW YORK, NY

Stephanie Mejia, MS, CCLS
HASSENFELD CHILDREN'S HOSPITAL AT NYU LANGONE HEALTH IN NEW YORK, NY

Taylor Brower, MS, CCLS
THE BROOKLYN HOSPITAL CENTER IN BROOKLYN, NY

Whitney Henderson, MS, CCLS
MAIMONIDES MEDICAL CENTER/CHILDREN'S HOSPITAL IN BROOKLYN, NY

COVID-19 hit New York City (NYC) quickly and forcibly; the city became the epicenter of the pandemic. Certified Child Life Specialist (CCLS) roles were pushed to rapidly adapt to the new requirements of the disease. The first confirmed case of COVID-19 in New York City was on March 1, 2020. In this article, six CCLSs who work in pediatric emergency departments (PEDs) throughout NYC share their COVID-19 experience. Interviews were conducted virtually in June 2020.

How did your interactions with patients and families in the emergency department change during the COVID-19 pandemic?

Lauren: Throughout this time, our core responsibilities felt challenged by outside factors. Most PED patients were isolated while being tested for COVID-19, and child life could not physically enter rooms to preserve personal protective equipment (PPE) and minimize risk of exposure. As an alternative, we used Zoom on tablets placed in isolation rooms for introductions, procedural preparations, and to aid in guided alternative focus during procedures. We developed personalized coping kits based on needs and interests for staff with PPE to give their patients. These included single-use art supplies, coping materials, activities to do at home, and developmentally appropriate information about COVID-19.

Hilary: Our entire team needed to minimize direct contact with patients and families. I learned to introduce child life services, begin my assessment, and provide coping support from outside the plexiglass door via newly installed phones. This way of working posed challenges; we learned to maximize what we had to provide the safest care possible. The restrictions provided opportunities to enhance family autonomy by guiding and offering suggestions, rather than providing direct care.

Kymme: When COVID-19 hit, our hospital had to adapt to the influx of patients and demand for PPE. How would my role—to provide psychosocial support, normalize the environment, and provide preparation—look during COVID-19? We utilized give-away items that families could use both during the visit and at home. I put together info sheets about coping and utilized coloring booklets made for COVID-19 and quarantine. I created laminated procedural prep and support info sheets and placed them in exam rooms to minimize contact with patients. I called and spoke with families about their medical visit and helped them process COVID-19.

Stephanie: To prepare for the potential surge of patients, the PED became a respiratory unit for adult patients with COVID-19 symptoms. I converted our child life cart to only the basics and one-time use items. Many families came in nervous of potential COVID-19 exposure, and anxious that they were going to "catch it" during their visit. I found myself supporting parents during this new transition through explanation and validation. Moreover, I supported staff who felt overwhelmed by transitioning into a new space. Soon after, child life was not allowed in the room to preserve PPE. I bought a bubble gun to distract patients from outside the door and worked with nursing staff to determine appropriate items for their patients, providing an activity packet to help normalize the environment and promote positive coping.

Taylor: We initially did not think that pediatrics would see any impact from COVID-19. Once the adult emergency room and COVID-19 tent were full, the hospital decided pediatrics was to be partitioned into two areas: to conserve PPE, it was decided that child life would remain on call for traumas or bereavements in the PED but not be present in the physical emergency room. Recognizing the need for education, normalization, and preparation, our team started exploring how to provide child life services in unconventional ways. The first step was to work with staff to provide resources and materials for distraction. Next, I created laminated COVID-19 "prep posters" for the isolation area to educate, prepare, and distract patients. Staff were given developmentally appropriate craft/activity kits and COVID-19 coloring sheets to hand out for an additional layer of familiarization and support from child life.

Whitney: We worked to minimize changes and maximize safety for our patients. Pediatric traumas were brought to the PED instead of the shared trauma bay, and visitors were limited to one parent/guardian. I provided "COVID-19 Materials," including information sheets for patients and families in multiple languages, and single-use toys and materials. I provided materials to help reduce fear related to masks for children. To normalize the environment, I purchased a bubble gun, utilized wipeable glitter wands, and printed coloring sheets with characters wearing masks. Nurses brought in materials I provided to prevent excess exposure. I validated parents and patients' anxieties about COVID-19 and exposure. I remained working in the ER and emotionally supported adult patients with COVID-19.

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Were you deployed to a different unit or role during the COVID-19 pandemic?

Hilary: The adult palliative social workers asked for support from other psychosocial professionals across campus, and I signed up. During these shifts, I phoned recently bereaved families to check for needs and offer support and resources. In addition to this, I received referrals from medical staff to have end of life discussions with families. Some of those calls felt sad, yet familiar: "Our patient's wife has been struggling to tell their kids that he has COVID-19; he may die tonight -can you help her tell the children?" Before each call, I took a deep breath and reminded myself that if all else failed, I could always listen. I was grateful to have a thorough resource guide from the social workers, interpreters who remained steady through emotional conversations, and a team I could debrief with whenever needed.

What, if any, additional responsibilities did you take on during the COVID-19 pandemic?

Lauren: We noticed a need to support staff and provide coping techniques during this difficult time. Starting with PED staff, we facilitated hands-on activities, such as making stress balls to utilize for coping and stress release. To expand support into the Adult ED, we developed staff coping kits featuring stress balls, bubbles, adult coloring, information on healthy coping, and free resources for health care workers. In addition, we posted positive messages throughout the ED, and provided opportunities for staff to process feelings including facility dog visits, sessions with our PED Music Therapist, and art kits assembled by our Art Therapists. Child life placed posters in patient rooms for staff to display a photo of themselves without PPE to humanize "the face behind the mask." Additionally, we created posters featuring staff with and without PPE on to destigmatize potentially frightening equipment. Along the way staff began to affectionately refer to us as "staff life," a reference to the way that we shifted our practice to address current needs.

Hilary: Our pre-existing simulation team walked through our new resuscitation protocol for presumed or confirmed COVID-19 to optimize our process. As more of us took on adult work, impromptu debriefs became a near-daily occurrence. Members of our team faced the deaths of family members, friends, and colleagues. Others dealt with their own illness, the illness of family members, the challenge of living apart from families to protect loved ones, and myriad other pandemic-related difficulties. Given this context, I continue to serve on an interprofessional committee to steer weekly wellness initiatives in our PED alongside two adult psychiatrists.

Kymme: I joined the hospital's emotional response team, Helping Healers Heal (H3), providing weekly wellness rounds to the ED and radiology units. During rounds, I educate staff about H3 services and share information about additional mental health resources available. I encourage dialogue about processing the pandemic, discussing positive coping strategies, resilience, gratitude, mindfulness and creating self-care plans. Most importantly, I provide an active and empathic listening ear.

Stephanie: I used this time to build rapport with my team and staff who worked shifts in the "COVID-19 area." My job became focused on helping my colleagues remain positive. Staff expressed being overwhelmed by seeing so many people sick and dying and being scared to bring anything home. The child life department and I tried to find ways to lift the spirits of our nursing staff and increase staff morale. We created appreciation kits, identified ways to destress in the breakroom, and ways to decorate your PPE.

Taylor: Staff coping needs rose and we became "staff life, adult life, or hospital life." My clinical work evolved into working with donations to help provide meals, coffee, and other goods to hospital staff. In doing this we created a "staff wellness cart" that checked in on the coping needs of our colleagues on the front line. We would reinforce positive coping supports, encourage practicing coping mechanisms, and aid in development of these skills. We supported families who lost members of all ages, staff who lost family and friends, and staff members who cared for patients lost to COVID-19. Our child life team has been preparing to support staff with PTSD and another potential COVID-19 wave. We are still working to secure donations for self-care kits. We are still having tough conversations to begin healing and working tirelessly with our team to de-stigmatize the hospital where so many lives were lost.

Whitney: I found ways to provide psychosocial support for families by sitting with adult patients with COVID-19 and providing comfort items. I offered support for children whose parents were hospitalized, being aware that they were actively exposed to the virus. I supported staff by bringing down a comfort cart, hanging signs, doing sidewalk chalk, and making a morale boosting sign. We did psychological first aid and self-care for staff in the break room, like making hand scrubs and rock painting. I helped travel nurses find materials and find their way around the ED. I responded to adult bereavement referrals and adult codes. I compiled bereavement packets/bags for different age groups, worked 1:1 with newly diagnosed oncology patients, and made our playroom into a studio to broadcast into each room via Zoom.

COVID-19 changed history and the face of the world, and while a vibrant NYC came to a halt, its hospitals roared into action. Child life found itself playing an altered but important role in supporting patients, families, and hospital staff.

ALPHABET 2.0

W is for Work:

FROM BURNOUT TO BALANCE

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As a child life specialist and health care provider, it is common for us to hear the buzz words 'burnout' and 'self-care.' If I were in a room right now and asked, "How many of you have heard about burnout and thought it could never happen to you?" I am sure some of you would be nodding your heads and laughing. I would have been too. I was only in my first job as a child life specialist and doing what I truly believed was my calling in child life, end-of-life support for children and families in the hospice setting, when I experienced burnout. Do not get me wrong, I love working with families facing end of life, and it is a huge part of what I still do today. The difference is the realm in which I do this work, how I do this work, and the personal and professional growth from my experiences to know how to advocate for myself. As I sat down to write this article and reflected on my experience with burnout, I realized that I was not able to fully process this experience until several years later. Now that I am five years out of that situation, I am hopeful that sharing my experience with burnout and the lessons I learned will help others within our field.

> *As I sat down to write this article and reflected on my experience with burnout, I realized that I was not able to fully process this experience until several years later. Now that I am five years out of that situation, I am hopeful that sharing my experience with burnout and the lessons I learned will help others within our field.*

To start, we need to understand what burnout is and what it can look like in helping professionals. Maslach and Jackson (1981) define burnout as "a syndrome of emotional exhaustion and cynicism." Burnout is recognized as a common phenomenon among those who work in health care, due to the significant emotional toll that arises as we continue to give of ourselves to others. When developing the Maslach Burnout Inventory scale, Maslach and Jackson (1981) identified three factors impacting burnout: personal accomplishment, emotional exhaustion, and depersonalization. These dimensions encompassed aspects like anxiety, tension, behavioral shifts, frequent complaining about clients, fatigue, increased anger, and even job performance. In the following lessons, I will walk through each of these three aspects, explain more about what burnout looked like for me, and reflect on my personal journey of overcoming burnout.

Lesson 1: I'm Not a Tightrope Walker

I think we can all agree that there are times when our census becomes too much. This could be a smaller number of patients with extensive psychosocial needs that take a majority of your time, a high number of patients that have you running from room to room without the opportunity for a break, or even a combination of the two. Maslach and Jackson (1981) discuss how "lowered personal accomplishment" is a common aspect of burnout within helping professions. They also address how this aspect of burnout can involve an individual having a negative view towards their job performance. I remember a week where I had three patients die within a two-day span. While it was common for me to experience multiple deaths in one week, this week was different. I felt an exponential amount of guilt over the services I was unable to provide for these families leading up to those moments. When I was hired, my position involved one-third of the state I was living in, which made my farthest patient no more than 90-minutes away. However, that quickly changed. Within four months, I was now covering half the state, and my farthest patient, at that point, was 2.5-hours away, one-way. I had about twenty patients on my list, and I could not keep up. Of the three patients that died that week, I had only met with two of those families one time. They had been on service for about a month, and I had only seen them once. I had every intention of seeing them again because I knew their time was short, but other patients' end-of-life needs had taken precedence. I felt incredibly guilty about not being able to serve these families in a way that, I believed, they deserved, and I believed I had failed them. In hindsight, did these families know any different? No, but I did. I knew they were not getting what they should have, and I found myself in the back of a funeral home more and more often. Families were receiving hand/footprint keepsakes I had made rather than having the opportunity for memory-making and legacy work prior to their child's death.

Additionally, I was trying to balance unreasonable work expectations outside of patient care, both within my scope as a child life specialist (i.e., budgets, supply purchasing, professional presentations, bereavement camp) and externally as a member of a growing organization (i.e., re-creating our program's website, helping with marketing efforts, assisting with scheduling and planning of "lunch and learns" about the services our team provided to area referral sources). I did not know how to speak up for myself. I was the new child life specialist to the team, and I believed that saying something would be complaining. I thought I was being a team player by staying silent and "just handling it." I could not keep up and felt like I was walking a tightrope. One wrong move and everything would come crashing down.

Organizational variables, such as "role demands that are inconsistent with either the helper's abilities, goals, values, and/or beliefs" can attribute to burnout within child life specialists (Holloway & Wallinga, 1990). From my experience, role conflict greatly impacted my experience of burnout. The demand was too much, which resulted in the loss of myself. Anything that had to do with me as a person, or my life outside of work, kept falling away just so I could stay balanced on that thin little wire called work. I think this is something we, as child life specialists, can often fall prey to at work. We wear so many hats and are helpers through and through, so we naturally want to be able to meet every expectation put before us. The reality? We cannot always do it- and that is okay! We are not tightrope walkers in a circus (well, some of you might be), and it is okay to stand up and say something when you need help. It is important to be able to recognize when work becomes too much and to put yourself first. In my next job as a child life specialist, I was incredibly blessed by a manager who taught me how to balance a work load, verbalize when I needed help, and who advocated for us to prioritize work-life balance. Now, I better understand the value of debriefing with colleagues or even acknowledging when you feel the need to talk to a professional. Personally, I knew that I needed help and chose to see a licensed professional counselor for the next two years. It was very helpful because I not only learned better coping strategies, but I also learned how to recognize these signs in myself earlier, which now helps me to avoid reaching the point of burnout again. It was a lot of really hard work on myself, but I am a better professional because of it.

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Lesson 2: Don't Drink the Tea

When people talk about implementing acts of self-care, you might hear preferences like yoga, working out, happy hour with friends, reading, bubble baths, eating healthy, date nights, or traveling. Maslach and Jackson (1981) share another aspect of burnout in helping professionals, which is "emotional exhaustion- feelings of fatigue and depression coupled with depleted emotional resources." Often, self-care is recommended to help alleviate part of the exhaustion that comes

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W is for Work: From Burnout to Balance

with the emotional work we do as child life specialists. While working in hospice, I ran. I tried to eat healthy. I engaged in things outside of work that were important to me, such as volunteering and being involved with my sorority. I thought I was doing all the right things, and to an extent, they were good things for me. But they were not enough. I was working 12+ hours a day, and even though I tried to take that time back when I could, there were some weeks that it just did not happen. The same week we had three deaths in two days, we also had our annual bereavement camp weekend. I clocked so many hours that week that I was able to take the entire next week off and still got paid overtime. When camp was over, I hopped in my Ford Escape and left to see my parents in Tennessee. I had not planned on going home after camp, but that week was my last straw and I ran. After a week at home, I did not want to go back. I realized I needed to find a new job, and so I tearfully headed back to figure out my next steps. I cried most of that nine hour drive, and I think that was one of the first times I had cried during my time in that role.

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When it came to taking care of myself, the stress of my job was overpowering the small acts I incorporated on a weekly basis to try and balance my life. I was engaging in the acts of self-care, but I was not truly acknowledging and coping with the emotional weight of my job. In 15 months, I gained 60 pounds. Two of my three meals a day were fast food in my car. The more stress I experienced, the more my body lived in a 'fight or flight' mode, which is shown to increase cortisol in the body, and overexposure to cortisol can result in increased appetite (Lindberg, 2019). For me, fulfilling that increased appetite came in the form of sweet tea from a certain fast-food restaurant. When I felt stressed, I would hop in the drive-thru and order a sweet tea. Tired? Same thing. Hungry, bored, angry, or emotionally drained? You guessed it - get the tea. Two weeks before I left my hospice role, I was diagnosed with pre-diabetes. After evaluating my diet and exercise, the doctor told me that if I would quit drinking the sweet tea, I would probably drop my fasting glucose back to a normal level, and fortunately I was able to do this within a few months.

For me, do not drink the tea means do not allow your body to become physically overwhelmed by the physical stress, emotional burden, and pure mental exhaustion of work that you lose your health. Physical health is a good way to monitor how you are handling stress, especially when it comes to the work environment. Looking back, I should have also seen these signs months in advance. No matter how much I ran, how many protein shakes I drank, or how much salad I ate, the scale continued to rise. After starting my new position and befriending the dieticians across the hall from my office, I learned that I was utilizing food to cope and was stuck in a never-ending cycle of stress eating. With support, I was able to overcome the physical deterioration I had experienced as a side effect of burnout, and I now understand how to take care of myself in a physical sense.

Lesson 3: Watch Out for Snapping Turtles

Speaking of counseling and coping, another contributing aspect to burnout, is "depersonalization- treating people like objects or becoming negative or cynical about clients" (Maslach & Jackson, 1981). As the weeks went on in the job, I became increasingly cynical. I would read emails where others would share about situations they were experiencing and see it as someone trying to put the spotlight on themselves, manage themselves up, or gloat. I watched things go on within the organization that did not align with my personal and professional beliefs and values, and I did not trust those around me. While there had been some specific situations that led to those feelings, overall, I became reactive in every sense of the word. I should have seen it months before, but I was blind to knowing how to recognize these changes within myself and had become a human version of the snapping turtle.

If you know anything about common snapping turtles, you know that they typically do not attack unless pro-

Me and my previous child life team on my wedding day

voked or they are experiencing feelings of threat. What does a snapping turtle have to do with this, you ask? I remember a moment when our pediatric social worker asked me about a visit I had facilitated with one of our patients. I was quick to defend my intervention and validate how it was appropriate, rather than hearing what she was asking and giving her what a colleague of mine calls 'generous assumptions.' Reflecting on that situation, I believe she was trying to express concern for me and the late hours I was working, rather than being critical of me working late to meet a family's needs. Another interaction I remember is a staff meeting where we were having a team debriefing. There was a lot of built-up tension among the team, and it was an opportunity for us to express our feelings in a safe environment with a mediator. I do not remember what was said exactly, but what I do remember is what happened when I finally spoke up. Over a year of unexpressed anger and emotions exploded out of my mouth as tears ran down my face, and I told the team I was done. I revealed that I had an in-person interview for another job later that week, and no matter what happened, I was leaving. This was not my finest moment, professionally or personally. This was not me at all, and I am still mortified by it over five years later. Becoming a snapping turtle was my big, red flag moment of realization. I was done. I was burnt out. I could not take it anymore, and it was time to step away.

> *Becoming a snapping turtle was my big, red flag moment of realization. I was done. I was burnt out. I could not take it anymore, and it was time to step away.*

Where was I going to go from there?

I knew I needed the boundaries that a hospital setting would provide: a way to clock in and clock out in order to truly leave work at work, not having to live in my car, and definitely not with a phone that stayed on 24-hours a day, seven days a week. I needed a way to rebuild myself as a child life specialist, but I still wanted to be able to do a significant amount of grief work in my next role, since that was my passion. Through this really hard time in my life, I found my love for working with well children of seriously ill adults. I was very lucky that my next job allowed me the opportunity to do that exclusively, but within the boundaries of a hospital. I came into that role as a broken and hurting child life specialist. My new child life manager exhibited a lot of patience and understanding to help me grow from my past. When I left that role a few weeks ago for a new opportunity, I

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W is for Work: From Burnout to Balance

laughed as I apologized to her for all that I had put her through my first few years on the team. I am sure I was a nightmare, but the reality is, burnout can leave you in a bad place. If you do not put in the work to change, it can also be easy to stay in that place. In addition to valuing the boundaries of a hospital setting, I have learned a great appreciation for having a family of child life specialists who are willing to put in the work with you. They challenged me to grow, and in that process, we grew as a team. I developed many skills in the areas of communication, emotional intelligence, secondary traumatic stress, vicarious trauma, self-care, how to function within a team, and the list goes on. The growth I experienced during that time was a season of rebuilding and re-establishing myself as a child life specialist. It is the reason I was able to recently make my next career move, and I am forever indebted to those that were involved in the process of putting this humpty dumpty back together again.

For those reading this and who may relate to one or more of the things I talked about, I hope you know you are not alone. I share this experience because I believe that it is not only important for us to continue educating our field on burnout and the importance of self-care, but to acknowledge that this is a reality: there are child life specialists out there who have hit this breaking point, and you can come back from it. My experience was hard, and it took a lot of time and effort to truly find myself within child life again. Would I change what I went through? I do not think so. This is a part of my personal and professional journey, and plays a significant part in who I am today: a child life specialist who now feels confident enough to stand up for herself, recognizes when she needs a break, and knows how to incorporate boundaries that help her maintain the ability to do what she loves.

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BEYOND THE CLASSROOM

Views of Emerging Professionals

Creating a Student Journal Club:

CHILD LIFE JOURNALS AND JOURNEYS

Delanie Urbanovsky, MS
CHILD LIFE STUDENT AT TEXAS WOMAN'S UNIVERSITY

As a child life student based in Beijing, China, my quarantine experience began two months earlier than the rest of my child life peers in North America. From late January 2020 until May 1, 2020, heavy restrictions were enforced by police across the city of Beijing due to the spread of COVID-19. While the isolation from friends, family, and activities was challenging, I struggled most with the progress towards my career goals being paused. I knew that in North America the rest of my cohort was racking-up precious volunteer hours, while the hospital where I volunteer was on government lockdown. I missed seeing those children and the feeling you get when you know you are making a difference.

First official meeting was awesome!! We loved meeting you all!!

First official meeting of Child Life Journals and Journeys

To help curb this feeling of being stalled in my goals, I decided to use my time in quarantine to start a journal club for aspiring child life specialists. I was first introduced to the concept of a journal club during my practicum at Children's Memorial Hermann in Houston, Texas. One member of the Child Life/Expressive Therapies Department chose an article to read and discuss. I was hooked right away. I still have the original article that we read together and have referred to it during my later child life endeavors. Although reading an article from a peer-reviewed academic journal might not be everyone's first choice for light reading, I found that the stimulating conversation over lunch with friends made for such an enriching experience.

My first course of action in creating my own journal club was to see how receptive people would be to such an idea. In February, I reached out to several child life students I knew and posted on the Association of Child Life Professional's student forum. Once I gathered a small, enthusiastic group, I created a GroupMe group text message so that we could determine how best to proceed from there. It was determined that to grow the group size, the link should be posted on the same forum thread and sent out to student members of the Texas Association of Child Life Professionals (TACLP). From that link share, our participation grew to 19 individuals, and I was shocked to see that so many people wanted to read research with me. To familiarize ourselves with the technology, we decided to conduct a test meeting at the beginning of April. That first meeting had a total of five participants. During the meeting, we discussed an article which emphasized the importance of research in our field and brainstormed ways to grow and expand our group. We decided that utilizing various platforms on social media would be the most effective way to spread the word about our group. This utilization of social media was a huge success as we soon had almost 100 members and we are still continuing to grow. Our first official meeting took place at the end of April. That meeting was a lively discussion amongst 20 participants and the group officially became titled Child Life Journals and Journeys.

Screen shot of a typical Child Life Journals and Journeys meeting

Our current operations are thus: Members use a sign-up sheet maintained in Google Docs to determine who will choose the article each month. The link to the article is shared in the GroupMe calendar and participants are asked to read it prior to the next meeting. On the last Thursday of every month, we have a Zoom video conference meeting to discuss our thoughts, perspectives, and ideas on what we have read. The beginning of the Zoom session is an introduction of the article by the member who selected it; then we use the “breakouts” feature in Zoom to analyze the article in small groups of four to five people so that everybody can have a chance to speak and be heard. After 30 minutes of small group discussion, we rejoin the main Zoom session and share what we discussed together. As the facilitator of the meeting, I pop into the breakout groups and assist with adding probing questions and listen for key points to bring to the full group once we reconvene.

Child Life Journals and Journeys is a place for future child life professionals to share and discuss research to promote evidence-based practice. My goal for starting such a group is to give my peers a strong foundation in research upon which they can confidently build their careers. As Child Life Journals and Journeys continues to grow and develop, I quickly realized that I could not manage this group size on my own. Several group members have stepped up into leadership roles to help make sure everything runs smoothly. Currently, our administration is comprised of the following “teams”: appreciation, merchandise, newsletter, professional collaboration, social media, scholarship, and therapeutic Thursdays, each of which is led by different volunteers. We have lots of exciting projects on the horizon including guest speakers, a collaboration with the Society for Research in Child Development, and therapeutic Thursdays where our team leader will share an evidence-based therapeutic activity with the group. We hope to be ready to sell merchandise by the time of publication, and plan to use the proceeds to set up a scholarship fund that would be awarded to outstanding members.

One of my favorite things about this group is the sense of community that it brings with my peers. In such a competitive field, it is incredible to see students encouraging each other, giving advice and support, and uplifting complete strangers. I believe this cultivation of community really speaks to the kind of people who are drawn to this profession. It has been a joy to see people expand their interest in research. Research is so important to validate our field and to provide quality care to patients and families. I would love to see Child Life Journals and Journeys outlast my career as a student and hope to one day turn it over to the next generation of child life students.

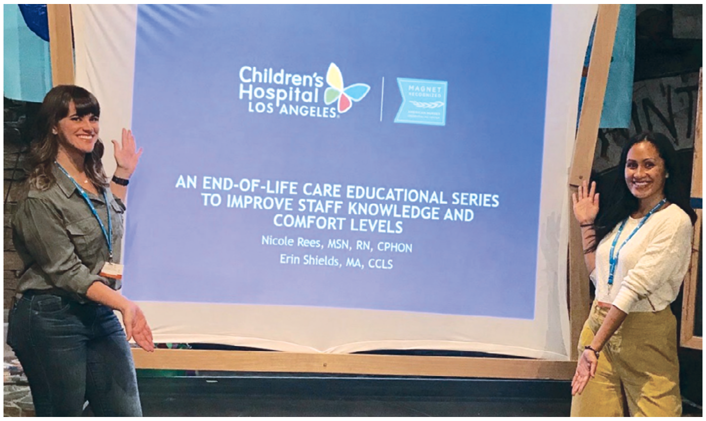
RESEARCH CORNER

Erin Shields, MS, CCLS II
CHILDREN'S HOSPITAL, LOS ANGELES, CA

Improving Comfort Levels Around End-of-Life Care and Conducting Research in the Clinical Setting

In the pediatric oncology setting, the number of hours spent closely monitoring patient status and coordinating with the medical team at end-of-life (EOL) can leave nursing staff vulnerable to a range of emotions, often comparable to those feelings experienced by the family. During the spring of 2017, I was approached by one of my nurse colleagues, Nicole Rees (MSN, RN, CPHON), with the idea of implementing a multi-modal education series to help increase nursing staff's understanding and comfort level when providing care at EOL. Health care providers go through extensive education and training; however, nothing quite prepares you for the emotions that arise during highly emotional encounters at the bedside. A reasonable connection might be made that if someone does not feel prepared (informed, educated, and seasoned in how to address challenges and emotions at bedside), it could negatively influence their ability to adapt and provide adequate care at EOL. Nicole's review of current literature on these factors was the driving force behind our desire to launch a research study at our hospital to answer the question of whether the implementation of an EOL care educational series could improve nursing EOL care practices.

Our quasi-experimental study took place between September 2017 and May 2018. The multi-modal education series was offered to nursing staff (RNs, LVNs, and Care Partners) on the inpatient hematology oncology units, as well as the bone marrow transplant unit. The educational series included training in the following areas: EOL symptom management, child life services, supportive care resources, COMFORT™ communication, and an End-of-Life Nursing Education Consortium (ELNEC) course. To assess RN comfort level, a survey was distributed to nursing staff before and after the series was completed.



Nicole and I presenting research at the CACLP Conference in the Fall of 2019.

Based on the research findings, we learned a few things and were able to justify changes to practice and implement these modifications on our unit. Our results were consistent with suggestions of current literature and demonstrated a need for continued EOL education for nurses regardless of their years of experience. Considering these findings, one of the topics from our series, the ELNEC course, will continue to be offered annually at our institution. Based on the suggested need from the survey responses, additional focus on spiritual, cultural considerations, and communication strategies will also be added to this course. Our research manuscript has been submitted for publication and is currently under review. Additionally, a review of our research and findings will be presented as a poster at the 2020 Association of Pediatric Hematology/Oncology Nurses Conference, and we have plans of seeking other opportunities to disseminate our results on other platforms.

At EOL, a patient's family, friends, doctors, and nurses are not the only people in the environment experiencing stress, anxiety, and anticipatory grief. Other members of the team (physical therapists, occupational therapists, speech therapists, respiratory therapists) who may have spent hours at the bedside are subject to experiencing a level of grief. For example, child life specialists, activity coordinators, and child life assistants all form relationships with patients and families and often spend a lot of time with EOL patients and siblings. Thus, additional training and support for child life staff on how to cope with anticipatory grief, and how to interact with children and families, could produce similar results in improving their comfort level as well as their ability to provide optimal services and support at EOL. While there is not a lot of published research specific to child life specialists, we can and should make connections to justify the need for future projects and studies to improve patient care and support for child life professionals.

While not directly addressed in our research, we identified and presented these clinical implications for child life professionals at the California Association for Child Life Professionals (CACLP) conference in the fall of 2019. In the same ways that nursing staff and care partners voiced a desire to learn more about how to support patients at EOL (strategies for communication, increased knowledge, cultural considerations), we made parallels to perceived experiences of child life specialists and activity coordinators at our institution. Like nursing, despite undergraduate and graduate degrees, child life specialists can complete training in the classroom and at the bedside (in their internship) and enter the workforce with minimal to no hands-on experience supporting families at EOL. I hope to explore the potential clinical implications for child life professionals during a future study.

Reflections on Conducting Research in a Clinical Setting

Nicole and I learned a lot through this research process. One of the first things we learned was how to utilize existing resources. We applied for, and were awarded, grant funding through the Research Council at Children's Hospital Los Angeles (CHLA). We were also lucky to have access to the Institute for Nursing and Interprofessional Research (INIR) at CHLA. With the support of the INIR programming, we were able to attend workshops and gain access to mentors and other team members. One INIR workshop that was helpful in the early stages of our research was the Evidence-Based Practice (EBP) workshop. This workshop was a full-day review of EBP practices and strategies for rating and reviewing articles. Towards the end of our educational series, Nicole and I were able to attend a second INIR workshop that focused on manuscript writing.

In addition to the education and resources provided in these workshops, the INIR introduced Nicole and me to another invaluable tool – our biostatistician Paula Murray (PhD). I can humbly say that Nicole and I would not have been able to fully explore and understand our research findings without the support and guidance of Paula. Through conversations with Paula, she explained how to use data analysis tools, such as ANOVA and R software, to interpret and analyze our survey data. From the research study to manuscript finalization, Paula continued to be an essential resource and team member on this project. Paula continually guided us in our understanding of the data, ensuring that the data and results were being accurately described and easily accessible to our (future) readers.

Over the last three years, I learned so much about the research process, tools available to me at my institution, and about myself. The biggest, "Ah-hah!" realizations for me and Nicole were rooted in the need to be flexible and to accept that we were both learning through this process. For example, IRB approval is not a quick turnaround. We learned in these early stages that we need to be flexible and that we may need to adjust, and readjust, our timeline throughout the process… and that's okay. I think removing the pressure of being "perfect" early-on set us up for realistic expectations through the following phases of series implementation and reviewing results. I think one of the biggest barriers for people considering research is that it is too hard. If you have any takeaway from reading this, I hope it is this: You can do it if you acknowledge and accept the learning curve. It can be overwhelming at times, but if you break it into small attainable tasks and goals, as well as utilize your resources (your peers, coworkers, support staff) while remaining flexible, it can be done! It may take three years, as it did for us, but it can still be done, and it can still be impactful.

I feel that I experienced a lot of professional growth as the project reached each milestone or challenge. I remain proud of the hard work, collaboration, and learning that took place, for us as researchers and for our nursing staff. As a Certified Child Life Specialist, I was humbled and pleased to see that the child life course in the series was received well by staff. I felt validated and reassured that my multi-disciplinary team saw value in child life services and found the tools and strategies helpful. I also felt motivated, and continue to feel motivated, to explore different ways of incorporating similar models and supports into practice for future interns, students, coworkers, and myself.

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Myringotomy Tubes

Krista Dolan
STUDENT, BANK STREET COLLEGE OF EDUCATION, NEW YORK, NY

Ear tube placement is a routine childhood surgery placing small tubes (also called myringotomy tubes, tympanostomy tubes, ventilation tubes, or pressure equalization tubes [Ben-Joseph, 2019]) in the eardrum to help drain fluid from behind the eardrum. Because young children's ears are still growing, it is not unusual for this fluid to build up, causing repeat ear infections, hearing impairment, and pain. Although this is a common outpatient procedure, it requires anesthesia, therefore holding the same psychosocial risks to both children and parents as a more complex surgery. Additionally, the level of understanding and preparation a child has about this specific procedure may influence how they cope with a potentially stressful medical experience. The open-ended play of loose parts preparation allows for problem-solving making it ideally suited for children and families as they cope with health care experiences. By taking a developmental-interaction approach and providing a supportive relationship for a child to learn and express themselves through play, children are better able to understand and cope with medical trauma, feel their self-esteem is supported, engage in emotional expression, and experience internal motivation (Luongo & Vilas, 2017). The developmental-interaction approach recognizes the influence of materials, ideas, and people on creating a meaningful experience coupled with an ideal learning environment that promotes the interconnection of cognition and emotion.

Although the most common age for ear tube placement is one to three years, this preparation is designed for an older child (four to eight years old). Many older children also get tube placement (either initial or repeat), and this loose parts project is intended to scaffold and build on their existing knowledge for improved understanding and coping and to promote mastery. In instances when this is a repeat procedure, many children may not remember the initial placement or procedure and may fear bodily harm and loss of control (Children's Hospital of Philadelphia, 2015; Rollins, Bolig, & Mahan, 2018).

Figure 1
Materials needed.

List of Materials:

- Surgical gown, cap, and gloves (for the child to wear)
- Empty paper towel or toilet paper roll (ear canal)
- Medical glove or balloon (eardrum)
- Rubber band
- Piece of paper (ear speculum - holds the ear canal open)
- Medical tape
- Surgical scissors
- Straw (ear tube)

Instructions:

1. Before you begin, it is important to demonstrate how sound travels through a paper towel roll. You can do this by covering the end of the roll by the child's ear to show how covering the roll muffles sound. This demonstrates what it is like when fluid is trapped behind the eardrum.

2. Using the surgical scissors, cut down one side of a medical glove (or balloon).
3. Place the opened glove over one end of the paper towel roll.
4. Secure the glove with the rubber band.
5. Form the piece of paper into a funnel and secure with medical tape.
6. Place the funnel at the opposite end of the tube.
7. Cut the paper towel roll so that it is short enough for the scissors to reach the balloon through the funnel and paper towel roll (might take a few tries).
8. With the funnel in place, reach through both the funnel and the roll with the scissors and cut a small hole in the glove.
9. Place the straw through the hole.
10. Trim the straw leaving just a small amount outside of the balloon.

This loose parts activity provides the opportunity for young children to gain understanding about this procedure, express feelings and concerns, and experience a sense of empowerment and mastery of this medical experience while helping them gain a sense of control and greater competence (Vilas, Koch, & Passmore, 2014). A more detailed preparation would be appropriate for an older child, including education and information about how our ears hear. With a younger child you will need to assess and determine whether the child would benefit from this deeper description and learning, or if they may be confused by a detailed explanation that could potentially increase their anxiety. Explanations should always be age-appropriate and can be guided by the child's questions.

Figure 2
Step 6

Figure 3
Step 9

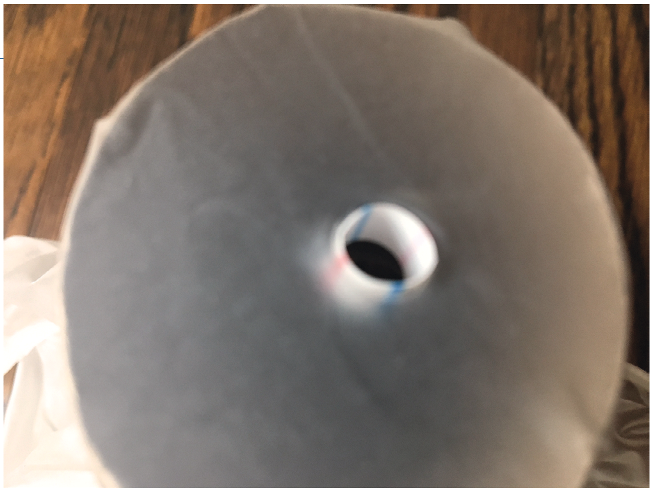

Figure 4
Step 10

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SPECIALIZED RESOURCES

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

Resources for Working with Nonverbal Children with Autism Spectrum Disorder

Michelle Badejo, CCLS

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Children who are nonverbal can be a vulnerable population in the health care environment. Child life specialists can play a significant role in providing quality communication, advocating for more diverse modes of communication, and striving for positive health care experiences for all children. Since communication includes much more than speech alone, it is helpful to have a greater knowledge base about alternative ways to communicate with children. The following article includes some resources to consider when working with children who are nonverbal. While children may be nonspeaking for a multitude of reasons, the resources found in this article will mainly focus on nonverbal learning disorders such as Autism Spectrum Disorder (ASD) but could be applied to other nonverbal patients as well.

BOOKS

- **Stewart, K. (2007). *Helping a child with nonverbal learning disorder or Asperger's Syndrome: A parent's guide* (2nd ed.). New Harbinger Publications Inc.**

  This book is an introduction for parents or professionals working with children who have nonverbal learning disorders. It offers specific strategies for intervening and helping children to cope with challenges such as communication and social skills.

- **Crissey, P. (2018). *Beyond words: Using paralanguage to communicate effectively.* AAPC Publishing.**

  Facial expressions, body language, and tone of voice are all part of communication and sometimes referred to as paralanguage. This book for professionals offers an overview of paralanguage as well as curriculum and activities to help professionals teaching and working with children who are nonverbal.

JOURNAL ARTICLES

- **Riosa, P., Muskat, B., Nicholas, D., Roberts, W., Stoddart, K., & Zwaigenbaum, L. (2014). *Autism comes to the hospital: Perspectives of child life specialists.* https://www.researchgate.net/publication/268143636_Autism_Comes_to_the_Hospital_Perspectives_of_Child_Life_Specialists**

  In this article, child life specialists have been recognized as valuable health care professionals who work with children who have ASD. Child life specialist were found to possess a variety of useful and appropriate skills when working with this population. These skills include rapport building, proactive communication, and patient advocacy.

- **Batool, A., Jaehoon L., Devender, B., Youngmin, K., & Griffin-Shirley, N. (2019). Practitioners' perceptions of the picture exchange communication system for children with Autism. *Disability and Rehabilitation.* https://www.tandfonline.com/doi/full/10.1080/09638288.2019.1620878**

  Practitioners report both confidence and success while using the picture exchange communication system (PECS) to improve communication when working with children with ASD; however, it is noted they expressed that PECS was time consuming.

- **Liddle, M., Birkett, K., Bonjour, A., Risma, K. (2018). A Collaborative Approach to Improving Health Care for Children with Developmental Disabilities. *Pediatrics.* https://pediatrics.aappublications.org/.**

  This article discusses "adaptive care plans" (ACP), and how child life specialists may use them to create partnership between caregivers and the healthcare team. The goal of an ACP is to provide a more proactive and positive health care experience for children with developmental disabilities.

DOWNLOADABLE RESOURCES

- **The National Child Traumatic Stress Network. (2004). *Facts on traumatic stress and children with developmental disabilities.* https://www.nctsn.org/resources/facts-traumatic-stress-and-children-developmental-disabilities**

  Statistical information about the incidence of traumatic experiences for children with developmental disabilities and special considerations for therapeutic interventions when working with these children.

- **Autism Canada. (2020). *Physician handbook.* https://autismcanada.org/resources/physician-handbook/**

  A guide useful to any health care professional working with children who have a nonverbal learning disorder. Especially helpful are the tip sheets about hospital visits for children with ASD and learning disorders beginning on page 31.

- **AssistiveWare B.V. (2020). *Quick communication boards.* https://www.assistiveware.com/learn-aac/quick-communication-boards?utm_source=website&utm_medium=pdf&utm_campaign=communication-boards**

  Printable communication boards that may be used on the go or when tablets are not available.

- **Autism Speaks Inc. (2020). *ATN/AIR-P Parent's Guide to Blood Draws.* https://www.autismspeaks.org/tool-kit/atnair-p-parents-guide-blood-draws**

  This guide is a resource for health care professionals working with children who have ASD. It offers strategies and information to manage pain, provide distraction, and use visual cues.

- **Vanderbilt Kennedy Center (2011). *Visual Supports and Autism Spectrum Disorders.* https://vkc.vumc.org/assets/files/resources/visualsupports.pdf**

  This guide is a resource around the topic of using visual supports for patients

who have ASD. It offers background on what visual supports are, why they are important, how to use them, and additional resources on ASD. More visual supports for medical professionals from Vanderbilt Kennedy Center can be found at: https://vkc.mc.vanderbilt.edu/vkc/triad/services/visual/

WEBSITES

- **Autism Canada. (2020). *Other Therapies.* https://autismcanada.org/living-with-autism/treatments/related/**
  In addition to information about living with ASD, at autismcanada.org you will find an overview about the positive benefits of complementary therapies such as music, art, and recreation when working with individuals who have ASD.
- **AssitiveWare B.V. (2020). *Learn AAC.* https://www.assistiveware.com/learn-aac**
  AssitiveWare.com is a website dedicated to augmentative and alternative communication (AAC) resources. Here, professionals can learn more about AAC, how it decreases vulnerability for nonspeaking individuals, and how to use AAC in medical setting.

APPS

- **AssistiveWare. (2020). Proloquo2go (Version 7.2.5) [iOS] https://apps.apple.com/us/app/proloquo2go/id308368164?mt=8**
  Proloquo2go is an augmentative and alternative communication app that allows nonverbal children to communicate needs and create sentences by tapping on symbols. Proloquo2go can be helpful when working with nonspeaking individuals who have ASD, Cerebral Palsy, or speech impediments such as dysarthria. It is customizable and may be used with both younger and older individuals.
- **Good Karma Applications, Inc. First Then Visual Schedule HD. (Version 2.27). [iOS] https://apps.apple.com/us/app/ftvs-hd-first-then-visual/id624035410?ls=1**
  Users of this app may create customizable daily schedules that are accompanied by illustrations. Video may also be added to each event in the schedule to demonstrate the specific steps involved in each task. Illustrations and visual aids make this app a meaningful way to communicate with both nonverbal children and verbal children alike.

SOCIAL STORIES

- **ABA Educational Resources. (2020). *Social Stories.* https://www.abaresources.com/social-stories/**
  Social Stories are short, simple, and illustrated scenarios that may be used to exchange information with someone who has a nonverbal learning disorder, such as ASD. Similar to prep books, social stories can be personalized to include a specific place or individual(s). They use visual supports to show a step by step sequence of events and may be reviewed numerous times prior to hospital visits and during the visit as needed. They can be used to describe events, activities, expectations, and social norms. There are several free social story guides and other resources listed at abaresources.com.
- **University of Rochester Medical Center (2020). *Developmental & Behavioral Pediatrics: Social Stories.* https://www.urmc.rochester.edu/childrens-hospital/developmental-disabilities/services/visual-supports.aspx**
  Golisano Children's Hospital at the University of Rochester Medical Center has a variety of online social story examples available, using PECS symbols as the visual aids.
- **Rady Children's Hospital – San Diego (2020). *Autism Discovery Institute: Social Stories.* https://www.rchsd.org/programs-services/autism-discovery-institute/hospital-visit-tips/social-stories/**
  Rady Children's Hospital provides several sample social stories for specific procedures, as well as a template to customize your social story. Rady Children's Hospital includes social stories for EEGs, pre-op, radiology, and more.

OTHER RESOURCES

- **Therapy in a Bin. (2020). *Stages Language Builder: Emotion Cards.* https://www.therapyinabin.com/products/stages-language-builder-emotion-cards/**
  Help children identify and communicate emotions with this set of 80 illustrated cards. Featuring women and men from various cultural backgrounds depicting five basic emotions – happy, sad, angry, surprised, and disgusted, these cards may be used when working with nonspeaking children to help communicate what they are feeling.
- **American Sign Language University (2015). *ASL first 100 signs.* http://www.lifeprint.com/asl101/pages-layout/concepts.htm**
  For individuals who communicate primarily through sign language, it can be a comforting gesture when a caregiver uses sign language to communicate with them. While a medical interpreter should always be sought, learning a few signs may demonstrate willingness to care and aid in building rapport. This video demonstrates 100 common signs that children may use to communicate with their caregiver. Also included is a practice activity/test. In addition to these basic words, you can also use the side bar to learn how to sign other helpful words like "hospital" and "doctor".

For children who have ASD, sensory issues and difficulty communicating needs only adds to the stressors of the hospital environment (Autism Speaks Autism Treatment Network, 2018). Unfamiliar situations may cause high levels of anxiety and stress for a child with ASD that might lead to challenging behaviors (Myles & Hudson, 2008). Child life specialists can help provide a more positive health care experience for children who have ASD by taking time to understand the child's unique needs and communication preferences (Myles & Hudson, 2008). This can be done by working with caregivers to discover what communication, sensory, or safety needs are most appropriate for their child, and communicating these needs to the multidisciplinary team (Autism Speaks Autism Treatment Network, 2018).

***Michelle Badejo** is a child life specialist at the Children's Hospital of Philadelphia. Prior to becoming a child life specialist, Michelle worked as a pediatric hospice and respite nurse. Combining both nursing and child life experience, Michelle continues to be an advocate for children's health and well-being. Michelle can be reached by email at badejom@email.chop.edu for any inquiries about this article.*

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ACLP Calendar

OCTOBER

1-31 Additional October dates for *Child Life Professional Certification Exam* administration testing window*

9 Applications due for *International Scholarships* for the 2021 Child Life Annual Conference

16 Applications available for the 2021 winter/spring *Diversity Scholarships*

18 Deadline to submit transcripts and other documentation for review in time to register for the November *Child Life Professional Certification Exam*

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

31 Deadline to apply to *recertify through PDUs*

NOVEMBER

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

16 Applications due for 2021 winter/spring *Diversity Scholarships*

DECEMBER

20 Deadline to submit transcripts and other documentation in time to apply for the *2021 Summer Internship*

31 Last day to *reinstate lapsed CCLS credential*

JANUARY

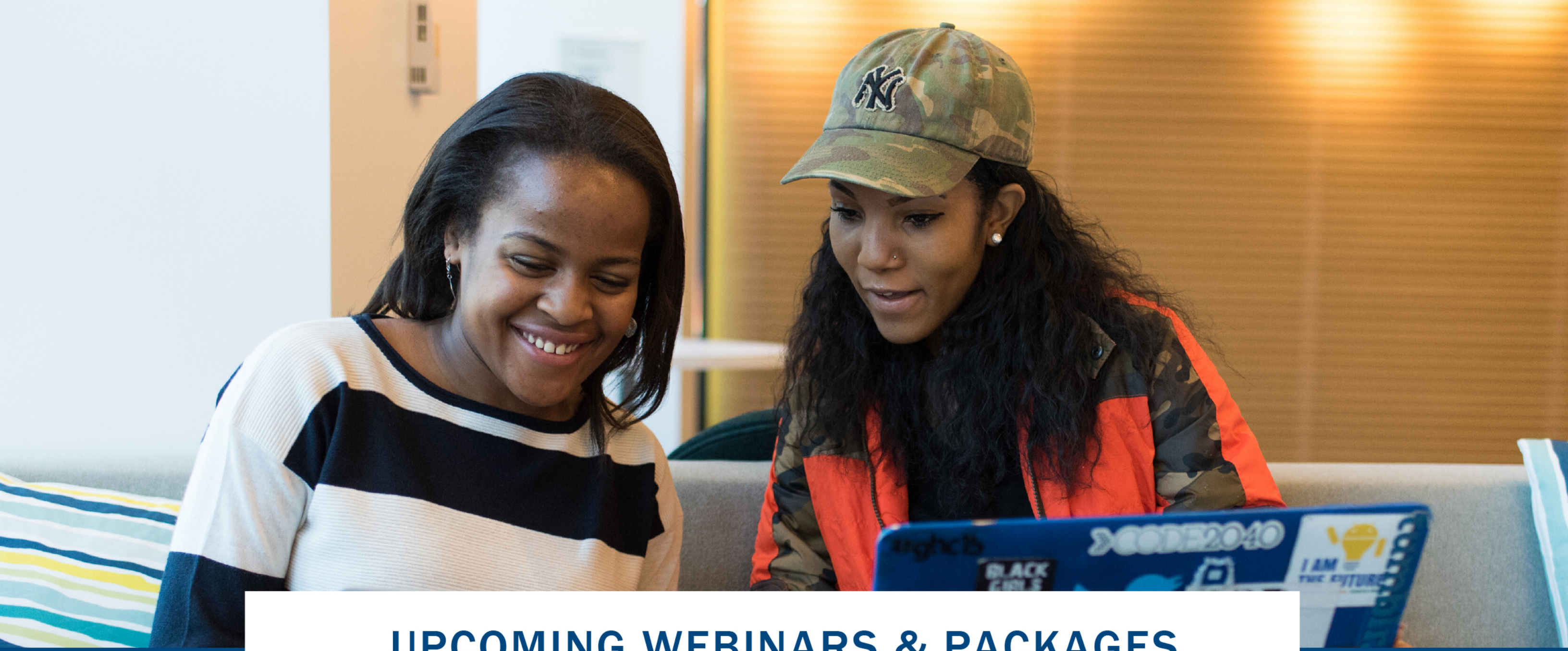
1-31 Start planning your Child Life Month events and activities for March!

1 Submission deadline for ACLP Bulletin for consideration in the Spring 2021 issue

5 Application deadline for the *2021 Summer Internship*

31 Deadline to pay *2021 certification maintenance fees*

*In response to the global coronavirus pandemic, the traditional November testing window will be expanded to include October 1, 2020 - November 15, 2020. Candidates are encouraged to test earlier within this testing window because of the predicted second wave of coronavirus cases and the potential for the closure of in-person testing facilities. Candidates must register and pay for the exam through the ACLP website a minimum of 5 days prior to the desired test date.



UPCOMING WEBINARS & PACKAGES

WEBINARS

October 6, 1pm EST
Social Inclusion for Children in Healthcare

October 14, 2pm EST
Won't You Be My Neighbor: Diversity in the Workplace

October 19, 11am EST
You're From Where? Supporting Children from Diverse Cultures
FREE for members

November 4, 1pm EST
Proactive & Preventative Strategies for Use with Patients with Behavioral Health Needs

November 11, 1pm EST
The ABC's of Understanding Emotional Responses

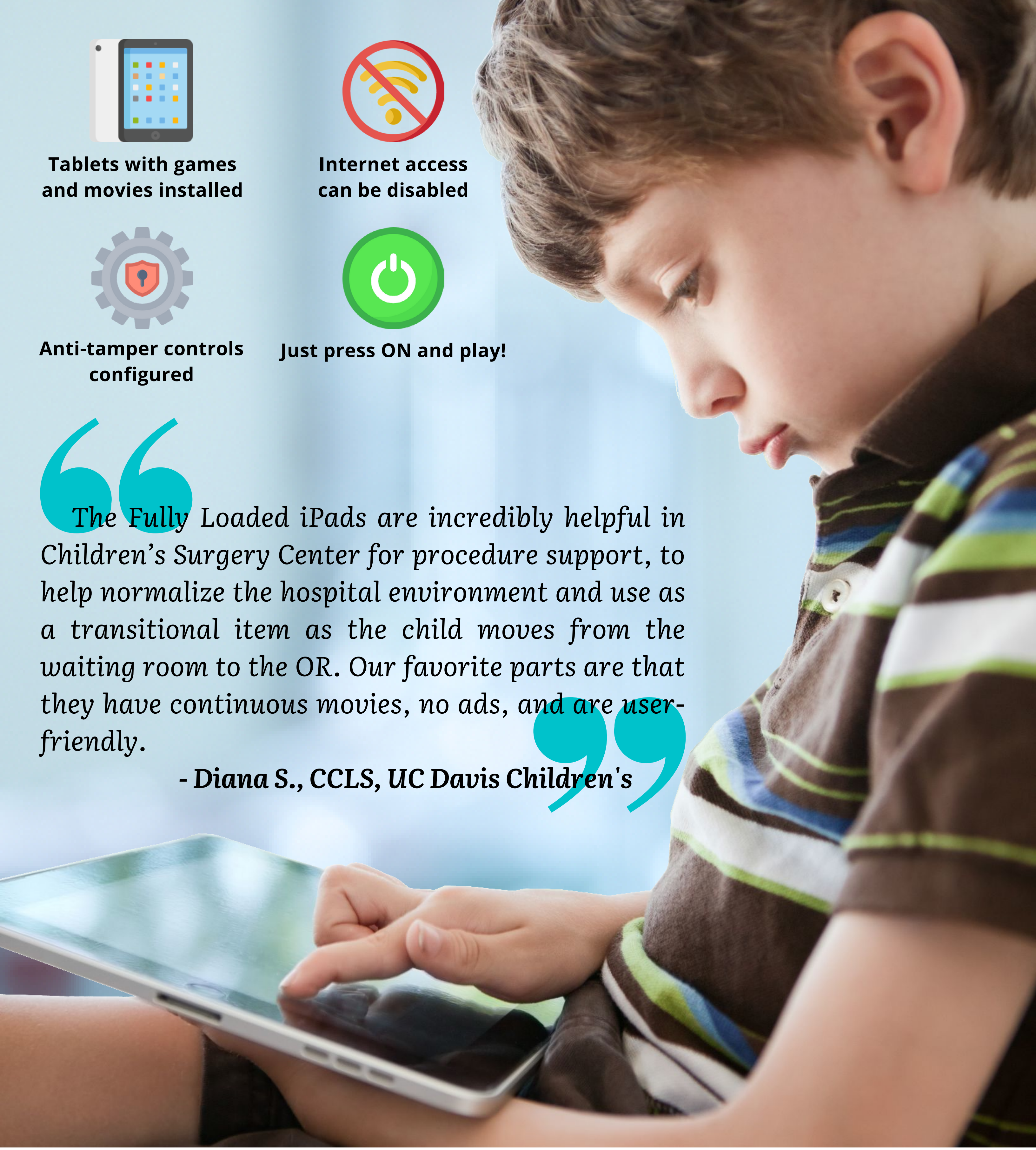
PACKAGES

Choose Your Own PDU Bundle
Are you in need of PDUs in a certain domain? Build your own 4-webinar package based on the content and domain you are most interested in for $99.

2020 Child Life Virtual Conference On-Demand Content
Purchase all the on-demand content from the 2020 Child Life Virtual Conference. This includes over 40+ PDUs for $299. On sale September - November.

To register for a webinar, log into your online learning dashboard at education.childlife.org.

Questions? Email webinars@childlife.org



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>
> **- Diana S., CCLS, UC Davis Children's**

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