

# ACLCP Bulletin

A PUBLICATION OF THE ASSOCIATION OF CHILD LIFE PROFESSIONALS

FALL 2024 | VOL. 42 NO. 4



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Defining Your Theoretical Orientation

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Published quarterly in February (Winter issue), May (Spring Issue), August (Summer issue), and November (Fall issue). For more information on submitting articles, please see [Submission Guidelines](#) in the ACLP Bulletin section of the ACLP website.

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# CEO Shares

**By: Alison E. Heron, MBA, CAE**

Dear ACLP Community,

As we embrace this season of gratitude, I want to take a moment to express my heartfelt appreciation for your unwavering commitment to supporting children and families with compassion and expertise. The specialized training and knowledge you bring to psychosocial care truly set you apart in our field, and I am genuinely thankful for your dedication to equipping families with the tools they need to navigate life's toughest challenges.

I am proud to share that our continued pursuit of clinical excellence has been recognized by the National Commission for Certifying Agencies (NCCA). The Child Life Certification Commission's (CLCC) Child Life Specialist credential program earned accreditation in September. This achievement highlights the rigorous standards met by the CLCC, reinforcing the professional caliber of Certified Child Life Specialists (CCLSs) worldwide —over 6,000 individuals proudly hold this certification.

In October, child life leaders gathered for the

22nd annual Child Life Leader Networking Retreat & Conference in Scottsdale, AZ. This event provided an invaluable opportunity to enhance leadership skills, build supportive networks, and discuss initiatives to further our profession. I am grateful to all who participated and engaged in meaningful discussions; your involvement will undoubtedly have a positive impact on your teams.

Thanks to the generosity of our partnership with Disney, we have launched several successful initiatives this year, including the new Child Life Program Needs-Based Grant. With 64 members applying, we are excited by the creativity of the proposals and look forward to announcing the winners in late 2024-early 2025.

As we transition into 2025, we will unveil our 2025-2027 ACLP Strategic Plan to guide the Board of Directors, committees, and staff for the next three years. This plan prioritizes strengthening our identity and belonging, partnerships and collaborations, and excellence in professional practice and training. Through these efforts, we aim to elevate our profession and enhance support for children and families. We look forward to sharing this strategic plan, goals, and objectives with you at the start of the new year.

Registration for the 2025 Child Life Conference will open in early January, and I hope you will join us from May 22-25, 2025, in Los Angeles, CA. Our annual conference is a wonderful opportunity to reconnect with peers, earn PDUs, and stay updated on the latest in our field—mark your calendars now!

Thank you for walking alongside us this past year. Our achievements are made possible by dedicated volunteers, engaged members, and individuals like you. Let us enter 2025 with purpose and ambition, committed to excellence in every aspect of our profession.

Alison E. Heron, MBA, CAE, CEO

A handwritten signature in black ink that reads "Alison E. Heron". The signature is written in a cursive, flowing style.



## **EMERGE Conference: A Learning Opportunity**

One of the most humbling experiences for me this year was the opportunity to speak at the Emergency Medicine Education & Research Global Exchange (EMERGE) Conference, hosted by The Aga Khan University (AKU) Medical College in Pakistan. The theme, Rethinking Emergency Care Science, brought together professionals from around the world to explore the future of emergency medicine, and I was honored to give the keynote address. My presentation focused on emotional safety, leadership, equity, and inquiry in emergency medicine education—topics that are not only central to our work but also deeply aligned with the values of our association.

The conversations that followed were eye-opening, reminding me of the universal need for emotional safety, particularly in high-pressure settings like emergency medicine. I also had the privilege of co-leading two workshops with Dr. Jabeen Fayyaz from The Hospital for Sick Children in Toronto. Together, we explored how simulation can be used to improve emotional safety, and we received positive feedback from the attendees who found emotional safety a new concept. It was truly a learning experience for me, one that reinforced how essential emotional safety is to pediatric healthcare, no matter the context.

What stood out to me most at the EMERGE conference was how eager everyone was to embrace emotional safety as a priority. The openness and generosity of the attendees, combined with their willingness to explore new ideas, reminded me how much we all share in the desire to create safer, more supportive environments for children. It was a privilege to be part of such an inspiring exchange of knowledge and to bring these lessons back to our work at home.

# President's Perspective

**By: Sarah Patterson, MSc, CCLS**

As fall arrives with a few months left in the year, I reflect on the incredible work our community has done to center emotional safety in our everyday practice. It has been a season full of learning, collaboration, and growth, and I feel truly grateful to be part of an association so deeply committed to the emotional well-being of the children and families we serve. The progress we've made in 2024 sets a strong foundation as we move into 2025, and a new strategic plan, and I want to take a moment to highlight some key experiences and initiatives that have shaped our journey.

## Supporting Emotional Safety Through Child Life Disaster Relief

This year also brought a profound reminder of the importance of emotional safety in times of crisis. As hurricanes swept through various regions, families and children were left grappling with loss, fear, and uncertainty. In response, our association supported the Child Life Disaster Relief (CLDR) organization in their efforts to provide emotionally safe care to children affected by these disasters.

CLDR's work, offering therapeutic play and emotional support to children in disaster-stricken areas, is a powerful example of how emotional safety can be a lifeline in the most challenging of circumstances. ACLP's donation to CLDR felt like a small but meaningful way to contribute to this critical mission. Their work continues to inspire all of us to think more deeply about how we can support children not just in routine care, but in moments of great vulnerability.

## Looking Forward to 2025

As we move toward 2025, I am reminded that the journey toward fully embedding emotional safety in every facet of pediatric healthcare is ongoing.

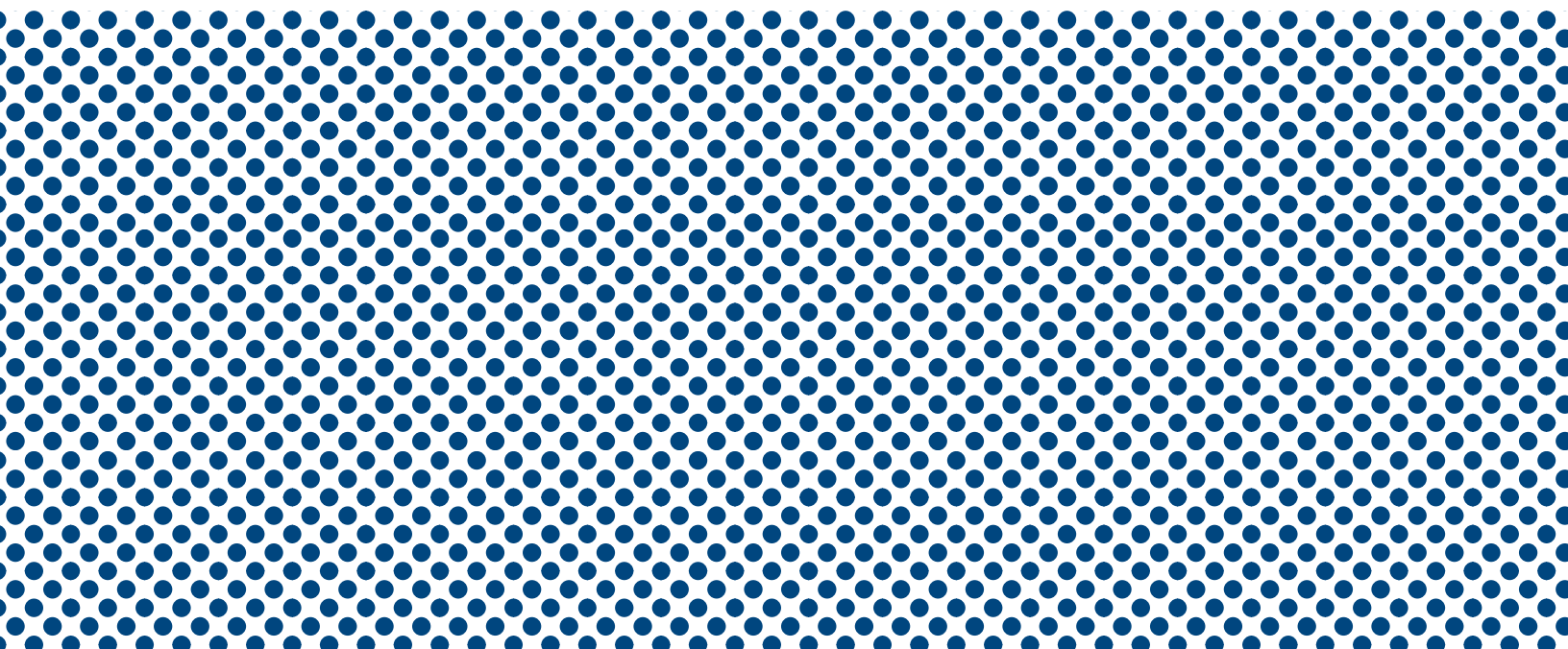
There is always more to learn, more to share, and more we can do to ensure that children feel safe, supported, and understood. I am continually inspired by the dedication of our members, who have made emotional safety a priority in their own organizations.

In the coming year, we plan to build on the progress we've made by working with several healthcare partnerships, advocating for emotionally safe policies, and continuing to elevate emotional safety globally. None of this work is possible without the collective efforts of our community, and I want to thank each of you for the contributions you've made to this mission.

Emotional safety is not just a goal—it's a responsibility we all share. I am honoured to continue this work with you and look forward to what we can accomplish together in 2025. Thank you for your ongoing dedication and commitment to the emotional well-being of children and families. I am deeply grateful to be part of such a caring and passionate community.

Warmly,

Sarah Patterson, MSc, CCLS  
President, Association of Child Life Professionals





# From the Executive Editor

**By: Morgan Morgan, MS, CCLS**

As a child life specialist, I find optimism in knowing that I am part of a community that is working to create spaces where every person, regardless of race, gender, ability or any other identity, feels included and valued. Despite the overwhelming sense of divisiveness I feel following the recent elections, I hold fast to the idea that there are people working to build these ideals in themselves and the children we work with every day.

As healthcare workers and advocates for children, we realize that political changes will have massive impact on our lives and the lives of those we serve. Regardless of the outcome of these elections, our work represents a desire for

progress, inclusivity, and the commitment to nurturing our shared future. Just as we advocate for children's emotional and developmental needs, so too must we advocate for a society that values care, kindness, and justice. Together, we can create a world where every child is supported, heard, and given the tools to thrive. As child life specialists, we must navigate the delicate intersection of theory, practice, and advocacy, knowing that the work that we do is making a difference in the future of our world.

This issue brings together a variety of articles that reflect the breadth and depth of our profession, reminding us that every action, every voice, and every story has the power to make a difference. Each of these articles challenges us to think critically, creatively, and compassionately about the children and families we serve.

Angeles Nunez, MS, CCLS, CPMT introduces milk therapy as innovative ways to use breastmilk for non-nutritive purposes, exploring how this familiar yet often misunderstood resource can support infant well-being beyond nutrition. Understanding the therapeutic and emotional benefits of breastmilk reminds us that even the smallest acts of care have profound effects on health outcomes.

In "Fear to Familiar" Maryam AlBahar, MS, CCLS describes her experience publishing children's books and sparking a health literacy program in the Middle East, speaking to the importance of representation, storytelling, and cultural sensitivity. Sharing the healthcare journeys of children in their native language with familiar cultural markers opens doors to broader conversations about access, equity, and how we can ensure that all children, regardless of their background, feel seen and understood.

An anonymous author reminds us of the importance of using our advocacy skills for our own needs in the workplace in "Do I Get to Have Sensory Needs as a CCLS?" As child life professionals, we know the power of a sensory-friendly space or the calming effect of a sensory

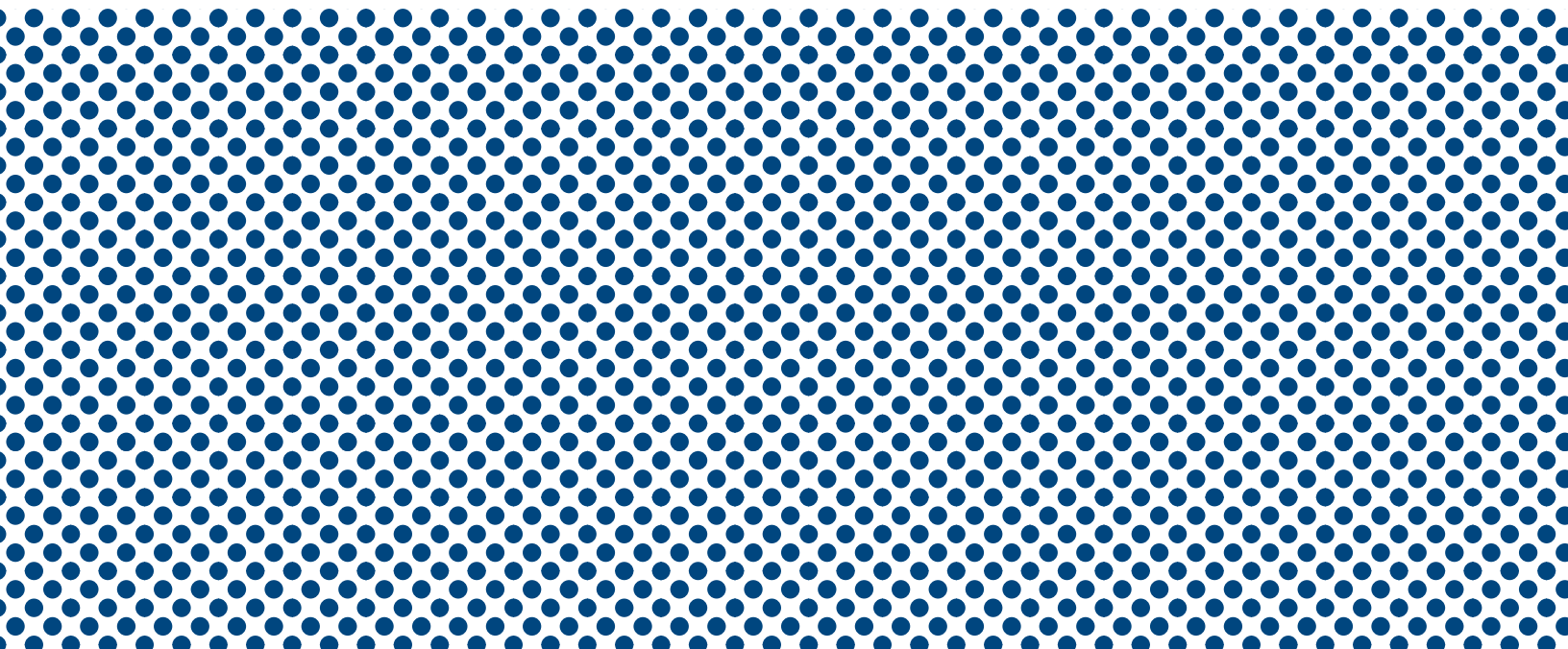
tool in reducing anxiety and increasing a child's sense of control. Advocating for the needs of ourselves and our colleagues requires us to push for thoughtful accommodations.

In their article "Defining Your Theoretical Orientation", Kathryn Cantrell, PhD, CCLS and Ashley Blondino remind us of the importance of expanding the theoretical framework of our profession. As we grow as a profession, an evolving and maturing understanding of theory helps us elevate the impact we have on the emotional, developmental, and psychological well-

being of the children in our care.

Let this issue remind us that our work, while focused on individual care, is part of a larger movement toward systemic change. Let us continue to advocate, support, and nurture—because in doing so, we are shaping the future, one child at a time.

With hope and optimism,  
Morgan Morgan, MS, CCLS





# WELCOME TO THE BOARD ROOM

**By: Alisha Saavedra, MA, CCLS**  
**ACLP Board of Directors, Immediate-Past President**

Following the most recent board meeting in August, it is my pleasure to share some key updates about passed motions regarding bylaws and the nomination process for selecting the 2025 incoming board members.

## BYLAWS

ACLP's bylaws are the framework for guiding the board's actions and decisions, including its composition of roles and responsibilities. With the continued delineation of ACLP and the Child Life Certification Commission (CLCC), feedback from the CLCC's governance audit advised that revisions be made to the bylaws to meet the NCCA National Commission for Certifying Agencies (NCCA) standards. It was brought to the board's

awareness that bylaws do not typically reflect specific designations for board seats, such as the CLCC chair and Canadian liaison from the Canadian Association of Child Life Leaders (CACLL), both of which are non-voting seats. Inclusion of the broader community, reflecting a DEI lens, was also shared. The board discussed the current bylaws and proposed changes for consideration.

Subsequently, the following motions were made by the Executive Committee of the board in October:

A motion was passed to revise the ACLP bylaws by removing the specified board seat for the Child Life Certification Commission (CLCC) chairperson from the ACLP Board of Directors positions, effective January 1, 2025.



A motion was made to remove the specified board seat for the Canadian Association of Child Life Leaders (CACLL) from the ACLP Board of Directors positions, effective January 1, 2025. Motion passed.

Additionally, having an ACLP liaison on the CLCC commission as a non-voting seat may create undue influence and a conflict of interest. To provide greater clarity and eliminate any perceived influence between both organizations, the ACLP liaison commission seat will be removed, effective January 1, 2025.

## MOTIONS

A motion was brought to the floor to approve the 2025-2027 strategic plan framework changes with edits. The motion was approved. The consent agenda for the August board meeting included meeting minutes and five committee charters for review, listed below. While the previous meeting minutes listed have been reviewed and finalized, they must be voted on for final approval by the full board. There were no items on the consent agenda that were requested to be removed, hence all items were adopted into the consent agenda for a vote. A motion was brought to the floor to approve the consent agenda with edits to the charters listed. The motion was approved.

- President Meeting Minutes
- Executive Committee Meeting Minutes (May and July)
- May Board Meeting Minutes
- Community Based Practice Charter
- Education and Training Charter
- Finance Charter
- Governance Charter
- Patient and Family Experience Charter

## THE NOMINATING COMMITTEE AND SELECTION OF NEW BOARD MEMBERS

The process of selecting new members for the ACLP Board of Directors is a critical task that ensures the continued success and governance of our organization. This committee is charged with overseeing the selection process in its entirety, from review of submitted candidate applications to submitting a final candidate slate for ACLP membership vote. Here is a brief overview of how our nominating committee operates to select incoming board members.

## REVIEW OF THE BOARD MATRIX

Prior to the call for applications, open positions and the strategic board composition matrix are reviewed to identify potential gaps from current board members term ending May 2025. This includes looking at identifiers such as geographic location, role e.g., academician, clinical staff, leadership and management, years in the field, race and ethnicity, gender, etc. The nominating committee leadership is provided with this information and works with staff to devise a timeline to put out the call for applications. This year, nominating committee is seeking applicants for the positions of President-Elect, Treasurer, and (2) Directors. To foster the most diverse representation on the board, applicants who are CCLS with 6-10 years of experience, male, non-binary/non-gender conforming, of racial diversity, from Southwest, West & International locations, and/or work in a community-based setting, are encouraged to apply. While applicants from these groups are encouraged, this is not a requirement to be considered. The call for board applications launched on September 10th, and applications remained open for one month. The closing deadline was extended by one week to encourage those interested in the Director and Treasurer position.

## ANTI-BIAS TRAINING FOR THE NOMINATING COMMITTEE

During the May 2024 board meeting, a motion was brought to the floor to approve funding and support for continued anti-bias training for the nominating committee members provided by an outside DEI consultant. Current committee members have completed the first of a two-part anti-bias training course. This training is required to be able to serve on the committee and must be completed to access any applications for review. The second half of the training will be completed in December prior to conducting board candidate interviews.

## USING NEW TECHNOLOGY FOR APPLICATION SUBMISSION

Application submissions have also transitioned to a new online platform. Current committee members have completed training on the new technology and will be using it to review applications during this cycle. This new platform enhances fairness by supporting redaction of applicants' personal information, thus reducing bias, and minimizing undue influence during the initial scoring process.

## NEXT STEPS

Once a pool of applicants is established, it is the committee's responsibility to complete a review process that includes scoring a rubric for each candidate. This rubric has been previously reviewed through a DEI lens. Application materials include a completed application, self-assessment, current resume/CV, board composition matrix form, professional letter of reference, and signed supervisor approval form from their employer. Based on this initial review phase, the committee will determine which applicants will be extended an invitation to interview in January 2025. Applicants who are not selected to move forward in the process will be notified by email and provided feedback.

We encourage all members to participate actively in the nomination process when it is time to vote, helping to shape our future leadership. If you feel inspired, perhaps you will consider joining the board in the future!



# MILK THERAPY

## As an Intervention for Parental Bonding and Legacy Building

By: Angeles Nunez, MS, CCLS, CPMT

Earlier this year, I was sitting in a family meeting for a family whose two-week-old infant was admitted to the PICU for heart failure. I was there to provide emotional support for the family while they were given the news that their baby was in the final stages of heart failure and actively dying. During this meeting, the first concern the mother voiced in this moment of distress was, "What do I do with my milk?" This was my first realization that not only would this mother grieve the loss of her baby but she would still need to go through the weaning process for her milk for weeks or even months after the loss of her baby as a constant reminder. The medical team offered to provide information for our local milk bank if she was interested in donating, and I provided the family with a list of resources for jewelry keepsakes including websites for milk jewelry. This experience changed my perspective on infant loss and parental bonding during this critical time.

In the hospital, families of infants and toddlers are often grieving for various reasons even when the patient is medically stable. They may be grieving the circumstance, the unexpected, the missed milestone or simply grieving the loss of time spent at home with their loved ones. During my experience working with families of newborns and infants, families grieve when their baby can't breastfeed especially if they are continuing to pump. These experiences led to my research into the benefits and alternative uses of breast milk and I came across Milk Therapy



### What is Milk Therapy?

Milk Therapy is the use of breast milk for non-nutritive purposes (Kaminska-el-hassan, et al. (2019). This means finding alternative uses for breast milk when baby hasn't finished the bottle, milk has expired, milk has been left out, there's no more room in the fridge or when the baby is unable to nurse due to NPO status or intubation. The application of breast milk on a mother or baby's skin or hair can provide moisture and prevent itching, irritation and dryness. From a child life perspective, the process of utilizing Milk Therapy can also promote parental bonding and legacy building. It can create a sense of connection with the baby while recognizing and memorializing the caregiver's journey.

## Benefits of Milk Therapy

Breast milk has both anti-inflammatory and anti-bacterial properties, containing vitamins, minerals, and antibodies and is considered a natural medicine that can be beneficial when used beyond a food source (Kaminska-el-hassan, et al., 2019; Demirtas & Yalcin 2022). Breast milk contains components such as stem cells and a substance called erythropoietin which may promote the growth and repair of skin cells (Kaminska-el-hassan, et al. 2019). In addition, the fat content in breast milk can help with moisturizing, and the fatty acid components can help to lock in moisture. Examples of how Milk Therapy can be utilized are as a face wash, hair wash or in a milk bath, with just a few drops of fresh or frozen breast milk. Milk Therapy can be utilized as a way to feel connected

to your child but also as a form of self-care.

The use of Milk Therapy or the topical application of breast milk has been used for decades across cultures, often passed down from generation to generation as a tradition and as a natural or home remedy (Kaminska-el-hasan, et al. 2019). As researchers begin to take a closer look at the components of breast milk and breast milk used for non-nutritional purposes, an increased interest has been seen in how breast milk can truly be used as a natural medicine for infant, mother and for tertiary persons.

In multiple studies, the topical application of breast milk has been found to be beneficial as a natural medicine when used for minor problems such as rashes, eczema or sores, dry or cracked nipples from breastfeeding/pumping (Kaminska-el-hassan, et al. 2019; Demirtas & Yalcin 2022). A few studies show that breast milk improved atopic eczema and diaper dermatitis with similar results as 1% hydrocortisone (Kaminska-el-hassan, et al., 2019).

*\*Disclaimer: Do not apply to open wounds and always speak to a healthcare professional before trying a new healthcare routine\**



## Child Life Interventions

A few months into my research and creation of materials for Milk Therapy, a 5-month-old baby that had been in the PICU since birth, started to medically decline. Her mother had been actively pumping with the hopes that her baby would someday be discharged home and be able to breastfeed. I already had good rapport with this family, and I had shared some Milk Therapy techniques with the mother as she shared her struggles in pumping multiple times a day, running out of freezer space and worries of if her freezer stash of milk would expire before the baby could use it.

I shared Milk Therapy techniques to support bonding and connection such as making breast milk soap and including breast milk in self-care routines such as face washes and showers/baths. Later, the mother brought in bars of soap to show me all that she had made. She was excited to share that she had started leaving

her nightly pumped bottle in the shower for her and her husband to use and that she was now mailing bars of soap to her cousins and aunts in another country who suffered from different skin conditions including eczema and skin discoloration.

This mother shared that it gave her a sense of purpose during the difficult hospital days, especially when she went back to work when the baby turned 4 months old. This mother shared the difficulty of being away from her baby during the day, being unable to feed her baby and needing to pump multiple times throughout the day to keep her milk supply in case her baby ever needed it. She shared that finding an alternative use for her breast milk not only gave her a sense of purpose but helped her feel close to her baby. Her husband agreed that using his wife's breast milk in the shower, to wash his face and hair, helped him feel close to the baby and closer to his wife.

Once the baby began to medically decline, the mother shared with me that she would start the weaning process as well, to have one less thing to grieve when her baby was gone. She continued to make soap and even began to share with friends and coworkers who were interested. The mother was distraught that she had worked so hard for her milk supply and her baby was never able to eat. During the baby's last week, as she continued to decline, I advocated to the medical team how important breast milk was for the mother and the attending agreed that the mother could place some milk on the baby's lips. The mother was so happy that she could share her milk and this moment with her baby. With emotional support from her husband and myself, she used her finger to share some milk with the baby and the baby made eye contact and began to suckle, looking like she enjoyed it. It was such a special moment for the family that I was able to capture in photos and videos and something that the medical team had said they had never heard requested before. It's a small thing to advocate for but it made such a difference in this family's life that since this experience, I've advocated for it a few more times with other babies whose families found this important, and almost every time it has been deemed appropriate by the team and counted as

a special moment for the family including photos and videos that they will never forget. Along with other memory making keepsakes, the mother chose to have milk jewelry created.

Milk Therapy as an intervention for parental bonding has become a quality improvement project at my hospital to better support our patients and families throughout the hospital system but especially in the PICU, NICU and mother-baby unit. My team, including myself as a PICU child life specialist, a lactation consultant, a PICU attending and a NICU fellow, are currently working on educational brochures to provide in mother-baby admission packets as well as to provide at bedside during interventions and during bereavements across the hospital system.

We hope to gain data from surveys given prenatally during birthing classes and tours and surveys sent out postpartum to assess knowledge of Milk Therapy as well as use and results. Our goal is to educate families on the benefits of Milk Therapy and to add to the limited research out there on the benefits of alternative uses for breast milk. We also hope to initiate the first look at how Milk Therapy can be utilized for parental bonding and legacy building for both healthy and hospitalized children.



## Conclusion

As child life specialists, we have a unique role in providing support during families' most difficult times. Some of my best interventions have been created by recognizing what the family deems important and following their lead, getting creative and finding the best way to meet their needs. In the PICU, it can be difficult for families to bond with their intubated and sedated infant while also recognizing that the mother is in their postpartum period as well, often moving from the mother-baby unit straight into their child's hospital room. Sharing the knowledge of Milk Therapy and how it can be both physically and emotionally beneficial for the baby and for the mother can be a tool that can support bonding and healing process throughout hospitalization and/or through grief.

**For additional information and links to resources, please contact Angeles Nunez, MS, CCLS, CPMT directly: [aenunez9@gmail.com](mailto:aenunez9@gmail.com)**

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# FEAR TO FAMILIAR:

## Helping Kuwaiti Children Understand Hospital Experiences through Stories

By: Maryam AlBahar, CCLS MS

As a child life specialist, I set out on an exciting mission to spread healthcare awareness among children in Kuwait through two children's books I authored about the hospital experience. Written in English with plans for an upcoming Arabic version, these books feature Arabic names and culturally inclusive elements, making them relatable to children in Kuwait and the greater Middle Eastern region. The primary goal of these healthcare storybooks was to familiarize children with the hospital environment and the various experiences and equipment they may encounter. By presenting these scenarios in a relatable and accessible manner, the books aimed to help children feel more comfortable and less anxious about medical settings.

The first book, *Dalia the Bear Goes to the Hospital*, talks about a young bear who wakes up one day and doesn't feel very well. To her surprise, when her mother takes her to the hospital, the doctor tells her she needs to spend the night! Dalia shares what she does while in the hospital, including meeting the child life specialist that works there. The second book, *My Hospital Senses: What I See, Hear, Smell, Taste, and Feel at the Hospital*, follows a dog named Max on a tour of the hospital. Max explains our different senses and what they might pick up in the hospital. Collaborating with UK-based children's book artist Hannah Wood, the books were brought to life with captivating illustrations. Printed in Kuwait, they were specifically designed for children aged



Elementary students at Bayan Bilingual School reading *Dalia the Bear Goes to the Hospital* during their 'We Love to Read' week.



6-9, although they were also suitable for slightly younger and older audiences.

The inspiration for these stories came from my experiences working in local government hospitals. Families often avoided open conversations with their children about medical procedures like shots, blood draws, or hospitalization, fearing it would upset or frighten children. This reticence may be influenced by factors such as a tendency to shield children from discomforting topics, education levels among nomadic and undocumented families, and a lack of awareness. It also stemmed, in part, from a lack of culturally relevant resources—many books addressing visits to the doctor or hospital were primarily from Western perspectives and didn't resonate fully with Kuwaiti families.

Creating these books was challenging. From drafting the story and sketches to finding the right illustration artist and printing company, every step required careful consideration and numerous revisions, with a sprinkle of imposter syndrome, funding delays, and more. Choosing the right characters, images, colors, sizes, paper thickness and then printing and fine-tuning the text and font size were all part of the journey. Another challenge I faced was after publishing on Amazon. Friends gave me feedback to trim the text for young readers, so I pulled the books, creating a shorter version that eventually got printed in Kuwait. I also battled Amazon Kindle sizing and formatting issues, which are ongoing. These hiccups were a big learning curve and a lesson in focusing on regional publications before making them available elsewhere. Despite these obstacles, the thought of helping kids kept me focused and motivated, in addition to the support of my incredible cheerleaders, Boston-based CCLSs Dr. Claire White and Leah Terril.

Several months after publishing, a friend's child fell ill, and she reached out to me about talking to her child about her hospital experience. My children's books on hospital experiences, crafted with culturally inclusive elements and Arabic names, were warmly received by both adults and children in Kuwait, where I had been sharing them as needed. It indicated a growing receptiveness

to preparation and education among newer generations. This notable shift towards greater openness and honesty in discussions, spurred by younger parents gaining awareness of the importance of effective communication strategies, has led to more engaging and informative conversations with children about hard topics such as healthcare, preparing them to face challenges with resilience and regulation. I realized that because the available healthcare storybooks were primarily Western-based, I needed to push past my self-doubt to share my book with the community that was now more prepared to receive it.

I wondered how I could effectively reach a large population of children, and this question sparked the idea for the school campaign. I reached out to educators and administrators, providing copies of the books for story time sessions in elementary schools across Kuwait. I explained that by presenting healthcare topics through engaging stories, children were empowered to understand and cope with medical experiences, fostering cooperation and future medication compliance. After an initial period of silence from schools, the response came flooding in all at once and was overwhelmingly positive. Schools eagerly accepted the offer and happily incorporated the books into their weekly reading sessions and libraries.

Educators were eager to incorporate the books into their curriculum, recognizing the value of healthcare literacy, and the feedback from both adults and children was remarkable. Teachers reported enthusiastic engagement from students, captivated by the stories and illustrations. Parents contacted me to share exciting comments and reactions from their children. The books will hopefully be utilized as valuable educational tools, initiating discussions about healthcare topics in a fun and accessible manner and, equally as important, fostering empathy and understanding among classmates, particularly those with chronic illnesses or medical conditions. By sharing stories of characters facing similar challenges, children can empathize with their peers and gain a deeper understanding of their experiences. Photos of teachers, parents, and children enjoying the books

were shared, which helped to spread the word about the importance of healthcare literacy for children.

The reaction from children and teachers were ones of excitement and joy. Kids like Ibrahim exclaimed, "Oh wow, there's a lady in a hijab!" Fatema, who said, "Her name's Dalia!" and "The images and colors are so fun," highlighted the books' cultural resonance and visual appeal. Eleven-year-old Farrah provided insightful feedback to her mother via a message from her reading time at school: "I liked (Dalia the Bear) because it teaches other kids do not panic when they get sick or when they can't go to places (out with their friends) and sort of not get scared of the doctors cause they're gonna help you feel better, so you can go to your friends' houses again." Surprisingly, younger children were also drawn to the books, with a few 3-5 year-olds jumping into reading groups and photo opportunities to point at one of the colorful images on the page. One such preschooler would rush to take a book from the older children and ask for "Dalia!"

Miss Sara Hussein, a Reading Teacher at Bayan Bilingual School, commented, "I'm thrilled to share that our students have thoroughly enjoyed diving into the books. The stories have captivated their imaginations and sparked their love for reading in truly remarkable ways...(and) will not only enrich our 'I Love to Read' week but will also leave a lasting impression on our students, inspiring them to continue exploring the wonderful world of literature."

The positive reception and impact of the campaign highlight the potential for using storytelling as a powerful tool for healthcare education among children, allowing us to break down barriers and normalize conversations about healthcare topics. By introducing these subjects in a familiar and engaging format, the books encourage children to speak about their own experiences and ask questions in a comfortable and supportive environment to help build a future where healthcare literacy is a priority. As local children learn to trust adults and information, they become more receptive to interventions by healthcare teams and child life specialists in

hospitals, fostering a positive and supportive healthcare environment for young patients. Another goal for these children's books is to reflect the profound impact of the child life profession on young patients' experiences, highlighting our contributions to their emotional well-being. I want to inspire fellow Child Life Specialists to publish literature that supports and empowers children during their hospital journeys.

The books are now in the libraries of numerous elementary schools and preschools in Kuwait and a regional bookstore chain. Whether we practice in the field or not, our passion as child life specialists for helping children and families truly enables us to accomplish tasks we never dreamed of. I hope to expand this initiative by reaching more schools in Kuwait and the greater MENA region. For educators interested in participating in future story time sessions or receiving copies of the books for their school libraries, I invite you to reach out. Together, we can continue to make healthcare topics engaging and accessible for children, empowering them to navigate medical experiences confidently and resiliently.



A child admitted into a local hospital reads *Dalia the Bear*. The story follows a young girl bear who wakes up feeling ill one morning and needs to be admitted into the hospital. There, she meets a CLS who explains the hospital experience for her.

# DO I ALSO GET TO HAVE SENSORY NEEDS AS A CCLS?

By: Anonymous

Neurodiversity is a topic that's having a big moment in mainstream society these days. Attention-deficit/hyperactivity disorder (ADHD) in particular feels like an increasingly common diagnosis, both in children and adults. ADHD, by definition, is an "ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (U.S. Department of Health and Human Services, 2023). The main symptoms of ADHD include inattentive behaviors, hyperactivity and impulsivity. Adult ADHD is a similar yet different diagnosis and the symptoms "may not be as clear as [in] children. [Hyperactivity] may decrease, but struggles with impulsiveness, restlessness and difficulty paying attention may continue" (Mayo Foundation for

Medical Education and Research, 2023). When I was in school and thought of a kid with ADHD, I thought of a boy running around a classroom who needed to be reminded to sit still. It never even occurred to me to think about that boy growing up and being an adult. This article details my personal experience learning about ADHD as an adult, getting diagnosed and learning to accept my new normal.

There has been a documented recent rise in ADHD diagnoses in recent years. This is in part due to "changing diagnostic criteria and increasing awareness of the disorder in marginalized populations, especially individuals of color and females" and an increase in public knowledge "through the media and [particularly] social media" (Abdelnour et al., 2022).

Part of the boom in mainstream interest in neurodiversity is the reason I went to get diagnosed. I had seen all the TikTok videos and, irony of all irony, was getting a master's degree in developmental disabilities. I spent time in school learning how to break down a child's individual needs, particularly learning and sensory, and build accommodations tailored to them. I felt like I was continuously hearing about ADHD and seeing videos of other people getting an adult diagnosis. So I took my concerns to a psychiatrist and waited for them to tell me that I was just overreacting or projecting. But my intuition was correct. And I didn't really know where to go from there.

There are so many positives to the unique way my brain works. I am, by nature, a loud



person with a tiny attention span and a million creative ideas. That tiny attention span makes it incredibly easy to relate to my younger school age patients, and create coping plans that benefit them. Building rapport is almost always a breeze because one of my biggest strengths is being able to ramble on about something completely random and constantly switch topics on the fly.

All those crazy ideas turn into exciting projects that might just solve a problem our department didn't know could be solved. I thrive on seeing a lot of patients and having many things to do, and getting to organize everything in my head as if it were a game. I can see the school aged kid for an IV prep then jet off to the teenager appendectomy prep then talk to the mom crying that her child is being admitted all while wondering if the nurses are ready for that original IV and if I have the right stress ball in my pocket.

I have a unique understanding of my patients and their potential triggers, and it's all thanks to my sensory needs. I am fortunate to be in the perfect unit for me where I get to do a plethora of things at once and use my crazy brain in a pattern that it thrives in.

Where I trip up is the interpersonal relationship of it all and what to do when I am escalated. How ironic, I teach kids de-escalation plans when I can't even sit down and think of my own. I am the first one to advocate for a sensory break or different approach for a patient, but the last one to advocate for myself. If I didn't keep my email open in front of me, I would never remember to answer one. In emotionally charged situations, I can be sensory overloaded. When people are yelling at each other, I can take things personally and get worked up.

I don't always know how to verbalize the emotions that I am having in an appropriate way. I talk over people because my mind is already ten steps ahead. When I am sensory overloaded, I freeze. Or cry. And I don't want to be that person. But I'm terrified that I will never be able to be "accommodated" that way that little boy might be in school. What if I tell my boss that I need certain accommodations? And what if they think less of me for it?

Sensory issues are a part of ADHD that I am ashamed to say I really didn't know much about. I knew about hyperactivity and impulsivity but that's where my knowledge fell short. Once I went to school and learned about the sensory issues that could be attached, I gained a better understanding of, not only my patients, but of all these things I'd thought everyone dealt with. The flickering light makes it hard for me to remember how to spell certain words. The song playing in my head makes it hard for me to focus on a conversation. My intern chewing gum next to me while a song was playing on the computer making it so I couldn't read the screen.

I can't process conversations auditorily as well as I can visually. I really need a minute or two to be able to understand what someone is saying to me to be able to respond correctly, but it feels like my mouth talks before my brain has time to think. I grew up believing that kids with sensory issues had to have autism which is a terrible misconception to have. Neurodiversity is a broad spectrum and being able to work with everyone on every part of that spectrum will only help this field in the long run.

We, as child life specialists, have extensive training in "typical" developmental level and behavior for children of all ages. Some of us choose to take classes on "atypical" development or on neurodiversity. Some hospitals have



programs dedicated to our neurodiverse and sensory population. I find that navigating through life as an adult with ADHD has made me look back on all my child life knowledge and classes, trying to figure out how to apply that knowledge to and advocate for myself.

In a perfect world, all my colleagues would have knowledge about how neurodiversity could present itself in adults. Seeing an overwhelmed colleague would lead to a pause, thinking “Maybe it’s not just that person’s personality” or “Maybe they aren’t overly emotional.” Maybe our world isn’t set up for adults with impulsivity and emotional reactivity issues. Maybe the “staff” part of our hospital is a sensory nightmare. All ADHD, and neurodiversity, presents differently so I don’t want to make blanket recommendations. But these are a few things that would help me and my personal brand of ADHD.

As child life specialists, we are set up to be able to provide the best of care for our patients, no matter their neurodiversity. Our background knowledge gives us unique insight into how to utilize different coping mechanisms for

patients. My hope is that we can further apply that knowledge into how we treat adults and colleagues who are also on the neurodiversity spectrum.

The first step is providing enough resources and sensory friendly environments where these staff members feel comfortable coming forward with their diagnoses and ideas for accommodation. There is already a great article in the Bulletin called “[Supporting Autistic Child Life Students](#)” by Mary Ann Gill which sheds light on how child life professionals can support autistic colleagues, and has applicable knowledge onto colleagues with other types of neurodiversity.

I love our field and work, but I also see the unequal juxtaposition of professionals who are supposed to be advocates for those with all levels of developmental ability and sensory needs, and the feeling that we ourselves need to be neurotypical and perfect. I feel the weight of it every day and I am terrified I will never be a good enough child life specialist to overcome it.

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## Accommodations Ideas

- **Visual information processing:** Options for visual aides should be present in all meetings, including written itineraries prior to meetings. Different people process information differently. Providing visual aides prior to the meeting allows time to think and process potential ideas or questions to feel like I can contribute appropriately. Providing visual information during the meeting (such as a projected itinerary) allows for a wider variety of learners to learn in real time.
- **Sensory breaks:** The option to get up and walk away from an overstimulating situation could be a real option, even as a 5 minute break to fix my sensory overload. It can be embarrassing to feel like I can't conduct myself "properly" for an adult, or that my feelings and behaviors make me "not professional."
- **Sensory-friendly seating:** The need for different seating options doesn't end just because those of us over the age of 18. Sometimes sitting "properly" in a chair can make me feel fidgety or uneasy. Sitting with my feet up makes me feel more contained and hits on my need for proprioceptive input, or "a sense of body awareness" and "controlling force of pressure" (Centre for Autism, 2024). The feeling of being contained makes me able to focus better on my work. Other options can include being able to sit on the floor when overwhelmed or on a backwards chair to be able to lean more of my body on the chair.
- **Multiple smaller breaks:** One long break can actually feel more like work to me. I don't like to sit still for that long and find myself feeling less at ease than before, sometimes ending my break early because I am so antsy. I prefer to split my hour break into three different twenty minute breaks to both break up my long day and help myself feel more rested.
- **Meeting reminders:** I will look at my schedule for the day and then immediately forget I have a meeting in five hours. To combat this, my coworkers know to send my meeting invites to my google calendar so I can have my phone give me a 15 minute alert before the meeting starts. Personally, I also have this connected to my smart watch because there is too much visual noise with alerts on my phone. I can get distracted with texts and other meetings later in the day when looking at my phone. The watch only shows one notification at a time.
- **Earplugs:** Sometimes the amount of noises or different conversations can overstimulate me. I find it hard to focus when certain noises or music is playing, alongside other conversations. ADHD can "affect executive function and attention" which increases difficulty for "process[ing] sensory input, including sounds, [making it difficult] to interpret sounds" (Medical News Today, 2024). I would love to wear earplugs made for noise reduction, not full noise cancellation, but I fear judgment and misunderstanding from coworkers.



# TIMELINE OF CHILD LIFE DEVELOPMENT in Saudi Arabia

وادة  
عبدالرحمن  
Abdulrahman's Oasis  
جمعية حياة الطفل  
The Child Life Foundation



2022 - 2024

<p><b>Dec 2022</b></p> <p>Established Abdulrahman's Oasis (AO)</p>	<p><b>Jan 2023</b></p> <p>Launched Child Life Services at King Fahd Medical City (KFMC) with Sanad Foundation</p>	<p><b>Feb 2023</b></p> <p>Recruited local Child Life assistants at KFMC</p>	<p><b>Mar 2023</b></p> <p>Started the first Child Life awareness campaign in public spaces</p>
<p><b>Jan 2024</b></p> <p>Signed an agreement with NGHHA to introduce Child Life services in the children's hospital</p>	<p><b>Dec 2023</b></p> <p>First cohort enrolled in the Child Life higher diploma program</p>	<p><b>Nov 2023</b></p> <p>Approved Child Life higher diploma and master's programs at Alfaisal University (aligned with ACLP certification requirements)</p>	<p><b>May 2023</b></p> <p>Designed AO Child Life clinical training handbook</p>
<p><b>Mar 2024</b></p> <p>Established the AO Child Life volunteer program</p>	<p><b>Apr 2024</b></p> <p>Launched the first AO therapeutic playroom at KFMC</p>	<p><b>May 2024</b></p> <p>Participated as a Thought Leader sponsor at the ACLP Child Life conference.</p>	<p><b>Jun 2024</b></p> <p>Published an article on the impact of the Child Life profession in Saudi Arabia</p>
<p><b>Oct 2024</b></p> <p>Signed an agreement with Riyadh Second Health Cluster to expand Child Life services across all pediatric wards and outpatient services</p>	<p><b>Sep 2024</b></p> <p>Achieved a governance compliance score of %99.30</p>	<p><b>Agu 2024</b></p> <p>Signed a collaboration agreement with ChildKind International to enhance pediatric pain care standards in local hospitals</p>	<p><b>Jul 2024</b></p> <p>Introduced Child Life services at King Abdullah Specialized Children's Hospital (KASCH)</p>
<p><b>Oct 2024</b></p> <p>Signed an agreement with Sanad Foundation to train and recruit 22 child life specialists</p>	<p><b>Oct 2024</b></p> <p>Signed an agreement with the Saudi Commission for Health Specialties to set up training and education programs on Child Life and Emotional Safety for all healthcare professionals</p>	<p><b>Oct 2024</b></p> <p>Signed an agreement with Johns Hopkins Aramco to introduce Child Life services and establish a Child Life center of excellence</p>	<p><b>Dec 2024</b></p> <p>Graduate the first cohort from the Child Life higher diploma program</p>

# DEFINING YOUR THEORETICAL ORIENTATION

By: Kathryn Cantrell, PhD, CCLS & Ashley Blondino  
Texas Woman's University

Child life specialists use developmental, psychological, and family systems theories to inform their work. A solid theoretical foundation can help child life specialists regularly draw from theories at all stages of the clinical cycle. A theoretical orientation is a tool that organizes a specialist's thinking and decision-making and allows them to predict how children and families might grow, learn, and cope with challenges.

At its core, it is a set of theories (think Piaget's cognitive developmental theory or Bowen's family systems theory) or theoretical concepts (think temperament or coping) that a child life specialist knows so well, they can easily recall and use them in their daily practice, like a toolbox to enhance their work. Every child life specialist's theoretical orientation will be unique to their clinical style, their setting, and the needs of their patients and families. In this way, a theoretical orientation is a collaboration, shaped by the children and families a specialist supports. In this article, we hope to help you define your own, unique theoretical orientation.

## How to Assess a Theory's Usefulness

It is important to evaluate theories when applying them to make sure they are helpful and not harmful. We find Redmond (2015) helpful for evaluating theories. Redmond (2015) outlines central traits to consider when assessing theories: Precision and clarity, comprehensiveness, testability, usefulness, importance, simplicity, fruitfulness, contextual/culturally relevance, plausibility/believability, and language dynamic.



These traits can be found in Table 1 where they are each described. Depending on where a specialist is working and the population they are supporting, some of these traits might be more relevant than others.

For instance, a specialist working in a fast-paced setting like the ER will likely appreciate theories that are easy to remember and quick to implement. These would be theories that are straightforward and effective in their language. On the contrary, a specialist serving historically underserved communities might gravitate towards theories that are culturally and contextually relevant. It can be helpful to start by looking closely at your setting and population. What stressors do your families encounter? What aspect of development are you most concerned about? More questions are outlined in Table 1.



**Table 1**  
**Redmond's (2015) Features to Assess Theory**

<b>Theory Features</b>	<b>Description</b>	<b>Key Question</b>
Precision and Clarity	The theory's ability to describe a lived experience with specificity.	Does the theory clearly explain a lived experience in a way that aligns with my clinical observations? In a way that aligns with patients' stories?
Comprehensiveness	The theory's ability to consider an entire domain of development.	Does this theory consider all of development? Or fully consider an aspect of development that is central to my setting and population?
Testability	The ease at which the theory's concepts can be measured empirically.	Can features of this theory be tested or assessed using research methods? How could I measure improvement?
Usefulness	The theory's practicality in a specific setting and its ability to support the clinical cycle.	Does this theory help me make clinical decisions about interventions and evaluations? Does this theory help me develop assessment questions?
Importance	The theory's value to the community where it is being used.	Does this theory consider aspects of the lived experience that are important to the patients and families I work with? Is the theory well discussed in the community or setting?
Simplicity/Parsimony	The ease at which the theory's concepts can be easily understood and remembered.	Is the theory easy to remember? Is it easy to teach to patients and families? Or medical teams?
Fruitfulness	The theory's ability to inspire additional work.	Has the theory led to contemporary ideas and sub-theories? Are these new ideas relevant to my work?
Contextual/Culturally Relevant	The theory's ability to consider the patient and family's surroundings.	Does the theory consider a patient and family's context and culture?
Plausible/Believable	The ease at which the theory aligns with the user's own observations.	Do I believe in this theory? Does it align with my lived experience?
Language Dynamic	The ease of the theory's jargon.	Does the theory's jargon help me remember and use the theory? Or does it make it less accessible?

## Putting Together Your Theoretical Orientation

Theory guides every stage of the child life process: from assessment to planning, intervention, evaluation, and re-assessment. In some cases, a specialist might use one theory throughout all these stages. For example, a specialist might use Bronfenbrenner's (1979) ecological theory to understand how a family copes and then use the same theory to guide their interventions and evaluations. However, this may not always be the case. Sometimes the theories that help a specialist assess a family might not be the best fit for preparing interventions. Too, the orientation might integrate concepts from several theories or just a couple, depending on the environment.

There is no perfect number of theories to use; rather, what works best for the families is the most ideal combination. Each child life position is unique, and the theories that work for one setting might not work for another. During assessment, a theoretical orientation could help a specialist choose the right questions for family interviews or identify which behaviors to concentrate on when observing play. When curating an intervention, a theoretical orientation might guide the goals and objectives of the programming. For evaluation, it could direct the kinds of questions asked to see if the intervention met its goals.

Our community relies on traditional developmental theories like Piaget's cognitive development theory (1936) or Erikson's psychosocial development theory (1950) (Brown, 2014; Turner 2018). Although these theories are clear and significant, they frequently neglect the impact of culture and context (Koller & Wheelwright, 2020). Many of the classic theories were developed by studying White children from upper-middle-class backgrounds. While the theories have been thoroughly tested, they may not accurately represent the diverse experiences of all families. Depending on your specific role and the population you support, different theories might be better suited to meet your clinical needs.

Your theoretical orientation will change depending on what helps you understand the children and families you serve. As such, it is

## Figure 1

Example 1: When working with youth and young adults with HIV in an outpatient clinic, my theoretical orientation reflected the interventions I used most often. I regularly provided diagnostic education related to HIV and antiretroviral medication. Too, I provided emotional support to young adults integrating their HIV diagnosis into other elements of their identities. Lastly, I worked closely with families who shared an HIV diagnosis and worked with them to consider ways the entire family could support positive health behaviors. When doing this work, I relied on cognitive theory (Piaget) to inform my education choices, intersectionality (Crenshaw) and identity theory (Erikson, Arnett) to inform my work with young adults, and family systems theory to inform my work with entire family units (Bowen).

Example 2: When working with adolescents in a community setting providing in-home child life services, my theoretical orientation reflected the setting where I conducted my work. Being invited into someone's home allows for observations of a family's close bonds (Bowlby), how the system functions together (Bowen), and how they cope as a unit (Lazarus & Folkman). Too, I would learn about the family's immediate neighborhood and surrounding community (Sociology of Childhood) and interact with other systems like the patient's school or church (Bronfenbrenner).

Example 3: When working with children and adolescents receiving radiation therapy, my theoretical orientation reflected the learning and coping needs of my patients. When conducting simulations, I would consider the best language choices for teaching (Piaget), how repetition supports desensitization (Pavlov), what rewards might motivate my patient (Bandura, Skinner), and how best to intervene with my patient's secondary appraisal of stress (Lazarus & Folkman). I was also curious about my patient's primary attachment figure (Bowlby) and how they could support the patient through the experience.

helpful to remain knowledgeable of traditional developmental theories while also learning about contemporary theories that might be more contextually relevant. Reading updated editions of our seminal texts (Hollon et al., 2018; Turner et al., 2018; Pearson, 2017) and noticing the theories other specialists are citing in the *Journal of Child Life* are two ways to remain current in your theoretical knowledge.

Over time, as you support different families and face new challenges, the theories you depend on will likely evolve too. Some theories that you have depended on may fade out of relevance as children and families continue to cope with global warming, gun violence, and lack of access

to affordable housing and food. Table 2 provides questions to help you tweak your theoretical approach for your specific setting as you grow into your role.

It is important to remember that your theoretical orientation is an adaptable concept that grows with you and your role. It should support your work, not restrict it. On days when your orientation feels like it might be falling short of your community's needs, consider revisiting Redmond's (2015) ideas for recommendations. To learn more about evaluating theories, we recommend reading Redmond's article here: <https://dr.lib.iastate.edu/entities/publication/6159f22b-c094-49eb-9b97-94b45cc8d1e0>.

**Table 2**  
**Questions for Theoretical Approach Consideration**

1. What are common stressors in this population or setting?	These variables may lead to specific theories that can help with a specialist's assessment process. For example, if working with a population where medication adherence is a common concern, behavioral theories may help the child life specialist assess areas to intervene.
2. What is the developmental scope of this setting or population?	Working in the NICU, the theories specific to socialization and learning may be less helpful. Instead, it might be more beneficial to consider theories centered on relationships and systems like attachment and family systems.
3. What domain of development is most often assessed?	Depending on the nature of the setting and population, the child life specialist may focus on specific domains more than others. For example, a specialist working in a procedure setting might focus their assessments on a child's previous coping history and cognitive development instead of asking questions about their early attachment style or friendships.
4. What is the pace of this setting?	The pace of the setting can also determine the theories that are most appropriate for a theoretical orientation. Working in an environment that moves quickly, it may be most helpful to rely on theories that are parsimonious and easily recalled like stage theories.
5. What regional or future stressors might impact this population?	Some specialists may find that their theoretical orientation changes based on their setting's geography, regional politics, or local events. For example, when a community is coping with gun violence, a specialist may notice that their orientation shifts.

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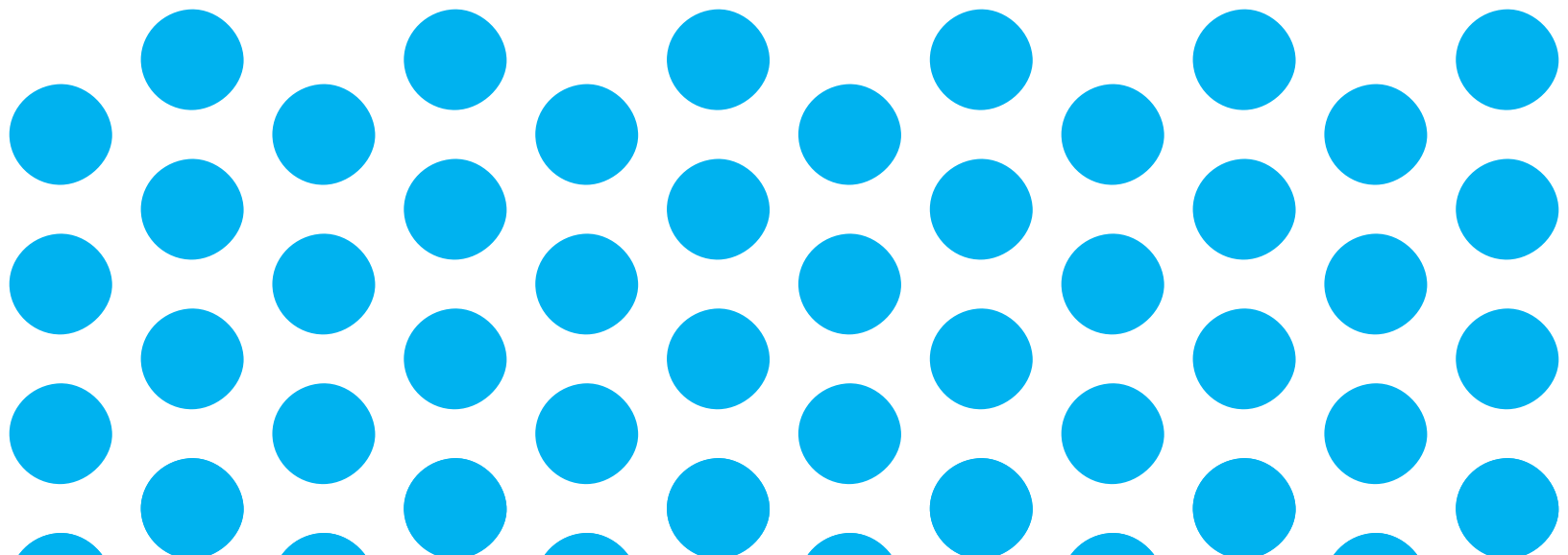
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# BOOK REVIEW:

## The Child Life Chronicles: Stories from the Field

By: Laura Gould, CCLS, MS

The Child Life Chronicles: Stories from the Field is a collection of case studies from individual child life specialists that highlights cases that define each practitioner's career. This collection, edited by Christen Bradbury, CTRS, CCLS, highlights cases from around the world and discusses unique cultural, emotional, and medical needs and how child life collaborated with families to provide a needs assessment and interventions to meet each child's developmental level. The book serves as an opportunity for current child life specialists to reflect on their assessment and intervention skills and provides insight to those outside the field on the job of a certified child life specialist in various settings.

Each story begins with the author's name, years in the field, country where the intervention took place, and themes including possible triggers for a potential reader, such as gun violence or death of a child. Before beginning, some stories also note vocabulary that may be unfamiliar for some readers depending on the country of the author and reader; for example, in the United Kingdom a cannula is an intravenous catheter which in the United States is commonly referred to as an IV. Each case includes the setting, background on the patient (with names changed), target concern, developmental considerations, planned intervention, a narrative of the event and finally a reflection by the clinician on their experience.

This book did not simply highlight the cases where child life specialists were confident in their interactions but also shared those scenarios that make clinicians step outside of their comfort zones and grow. One example is in the chapter

"A Quiet Place to Say Goodbye;" Sarah Hall, CCLS details her first experience providing bereavement support- difficult work. While each patient, family, practitioner, and scenarios are unique, many child life specialists can relate to many case scenarios presented. In "Blood Draw to Triumph," Christen Bradbury discusses working with a young patient with needle phobia. She recognized that a child life specialist will not be available for every lab draw or injection, but developing a coping plan includes teaching interdisciplinary team members, caregivers, and the patient.

The Child Life Chronicles: Stories from the Field should become a staple for learning and reflective practice in the child life field both for seasoned



and aspiring child life specialists. This book allowed for a natural break between chapters for the reader to stop and reflect on their own practice. The editors excelled at choosing stories covering a broad spectrum of child life's role. Stories included supporting procedures such as an MRI, lab draw, and operating room preparation. Other stories included supporting siblings during trauma and bereavement support, and others detailed therapeutic activities, play, and diagnostic education. Belinda Hammond, EdD, CCLS, CIMI expands child life outside of the hospital walls to school reintegration in "Confused Classmates," but it would be great to read about more case examples outside of the traditional hospital setting.

Students could utilize this text as an introduction to the field to understand child life's role and feel validated in knowing child life specialists self-reflect and continue to expand their skills. The assessment piece provided is helpful to understand insight into each child life specialist's decisions in what interventions to provide. However, most of the developmental theories come from American or West European, white, male psychologist such as Erik Erikson, even when the scenarios discussed may be occurring in South Africa. It would be helpful to learn if other theories are used and how development may

look different in varying parts of the world. The background of the child life specialist may also be helpful to take into consideration. This book provides knowledge about the role of child life to interdisciplinary staff who may not know when and how to utilize child life as there is such a range from assisting with pokes, coping with trauma and health care environments, and bereavement support. Lessons can be derived from the book such as when to collaborate. It may be helpful to delve into interdisciplinary collaborations with social work, nursing, technologists, physicians, medical assistants, and ways roles overlap and the uniqueness of child life's role.

This book is now available in paper and e-book formats. One suggestion is that it become an audiobook. As it becomes harder in busy lives to find time to pick up a book, it would be great to see this book transformed into an audiobook with each other's voice reading each chapter to hear their emotions behind their words. I found this book inspirational and was in awe of the amazing work other child life specialists are doing worldwide.

## References:

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Bradbury, C. (2023). *The Child Life Chronicles: Stories from the Field*.

# SPECIALIZED RESOURCES:

## Supporting Children Through a Port Access

By: Nicolle Bengtson, CCLS

As a child life specialist who has worked in a cancer center for over a decade, I have been able to witness the resilience of patients and their families going through one of the hardest times of their lives. I have provided support to families during the initial diagnosis all the way through the end of therapy. Throughout their treatment process, the patient will have to endure a number of difficult medical procedures, countless visits to the hospital, sedation, taking harsh medications/ treatments, and many physical changes within their bodies.

### What is port access?

At Texas Children's Hospital and other institutions, many children being treated for cancer will get a port-a-catheter surgically placed. This device is placed under the skin and is accessed with a needle at each visit. This allows patients to receive their treatment in a quick, safe, and efficient way. A large portion of my role as a child life specialist in the cancer center is providing education, preparation and support to patients for their frequent port accesses.

Once a child has a port-a-catheter placed, each time they come to the hospital for treatment they will have their port accessed. The procedure is sterile, so everyone in the room will have to wear a mask. The patient will need to remove their shirt or wear a shirt where the chest is exposed so the port site is easily accessible.

Once the patient and family are situated the nurse will begin the cleaning process. Once

the port site is cleaned and dry the port will be accessed with a needle. There are often options to help with needle pain which may include lidocaine cream or numbing freeze spray. After the needle is inserted into the port-a-catheter, the site will be covered and dressed with a bandage to keep the area clean and sterile. The nurse then can collect bloodwork from the port and is ready for the patient to receive treatment.



### Tips for Supporting a Patient During Their Port Access:

- Set-up the room for success
- Develop a coping plan with patient
- Provide medical play preparation before or after procedure
- Advocate for comfort positioning or desired position
- Provide distraction/support during procedure
- Provide procedure narration throughout
- Assisting patient in returning to baseline
- Post procedure education
- Develop a follow-up plan for future visits

### Explaining a port-a-catheter to patients and their families

When educating a patient and their family, I use the Medikin port doll to explain the port as I feel like it gives a very realistic visual in a non-threatening way. It is a great resource for patients of all ages. It can be utilized during a medical play session to let the patient explore the port and real medical supplies that will be used during their port access. For the preschool and school-aged patients I like to engage the patients in medical play utilizing real medical supplies to allow them to feel more comfortable with their port and the port access process.

When preparing a patient or their family, I often start by explaining that a port-a-catheter placement is a surgery where a small circle device is placed under the skin. When providing the patient with preparation, I use the following script: "This is a surgery where the doctors will give your body something that will help you through your cancer journey. It is a quick surgery where you will be asleep the entire time. The port is very helpful to have because it allows the doctors to give you

medicines in a fast and safe way. It is different than an IV because you can get stronger medicines without having to feel or taste them and it can be used for a longer period of time. After the port surgery you may feel sore for a week or two, but the soreness will slowly go away. Once your port site has healed you can do everything you did before having a port including swimming or taking a shower. When you leave the hospital, your port will be de-accessed and then re-accessed each time you return. You will keep the port placed until you are finished with your treatment."

Another resource I have found to be helpful for all ages is to provide patients with a port shirt. This can help alleviate the stress of removing their shirt and promotes privacy.

As a child life specialist, I have found that utilizing the resources around me can be one of the biggest tools to helping families cope with what they are going through. Getting a port-a-catheter placed is often one of the first moments that makes their cancer journey feel real. I feel so lucky to be able to work with these patients and families and get to share some of the amazing resources that are available.



## Port Shirt Resources:

- Comfy Cozy: [comfycozys.com](http://comfycozys.com)
- Zip with Us: [Zip With Us](http://ZipWithUs)
- Luke's Fastbreak: [LUKE'S FASTBREAKS - #BeStrong #NoMoreHospitalGowns](http://LUKE'S FASTBREAKS - #BeStrong #NoMoreHospitalGowns) ([lukesfastbreaks.org](http://lukesfastbreaks.org))

## Education and Preparation Resources:

- Medkin--port doll: [Neuro-Oncology • Oncology-Hematology | MediKins by Legacy Products](http://Neuro-Oncology • Oncology-Hematology | MediKins by Legacy Products) ([legacyproductsinc.com](http://legacyproductsinc.com))
- Kelsey's Dream: [Hopper the cancer crusher: Hopper | Kelsey'sDream](http://Hopper the cancer crusher: Hopper | Kelsey'sDream) ([kelseysdream.org](http://kelseysdream.org))
- Aflac ducks: [My Duck - The Aflac Childhood Cancer Campaign™](http://My Duck - The Aflac Childhood Cancer Campaign™)
- Gabe's Chemo Duck: [My Duck - The Aflac Childhood Cancer Campaign™](http://My Duck - The Aflac Childhood Cancer Campaign™)
- Shadow buddies: [Oncology Port-A-Cath Buddy — SHADOW BUDDIES](http://Oncology Port-A-Cath Buddy — SHADOW BUDDIES)
- American Childhood Cancer Organization: [Cozy Cat and Medical Kit: Cozy Cat Stuffed Animal - ACCO](http://Cozy Cat and Medical Kit: Cozy Cat Stuffed Animal - ACCO)

