"THEY'RE FINE" – ARE THEY?:

Advocating for Adolescents in Family Planning and with Suicidal Ideation

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Throughout the years, the role of child life specialists has evolved beyond the playroom and into various clinics, community-based programs, and other nontraditional settings where patients need further support for experienced traumas. Advocating for child life services has brought forth much reflection on assessing our role in these moments and providing the best care possible for the patients and families we work alongside. With all this in mind, we would like to share our experiences advocating for child life services even when others have questioned our inclusion and involvement.

Case 1: Katie's Work with Adolescent Patients in the Dilation and Evacuation Clinic

After working for multiple years at various stand-alone children's hospitals, I ventured to work within a larger adult hospital. With that transition came a lot of learning, lessons, and reflection. I began working with adult nursing staff who are sometimes required to work with pediatric patients with little to no training in pediatrics. One early morning shift, I was notified of a pediatric patient at the hospital for a dilation and evacuation procedure. According to the nurse at the bedside, this fourteen-year-old patient was having a hard time coping and was alone, fearful, and withdrawn. This nurse expressed concerns and asked for help.

As I approached the adult unit where these procedures are performed, I received comments from various staff before entering the patient's room that included asking why a child life specialist was supporting a pediatric patient for an "adult choice." I remember feeling perplexed and shocked. I smiled and responded that my job was to help all pediatric patients cope with the various stressors of the hospital, especially patients who may have limited psychosocial support. However, as I turned the corner, I reflected- Am I qualified to help this patient? Is this within my scope of

practice? Am I doing something not in agreement with our child life standards of practice? I don't remember reading any articles recently about child life support for this procedure.

I then found a fourteen-year-old girl sitting alone on the exam bed, head down, fidgeting with her hands with a wide-eyed affect streaming across her face. After I introduced myself and my role within the hospital, this patient began to confide in me her various concerns. She talked about how she was feeling nervous as she had never been in the hospital or had an IV before. She had questions about how the anesthesia works and expressed concerns about waking up in the middle of the procedure. Her thoughts and concerns were on target with any other fourteen-year-old that I prepare for surgery every other day at work. At that moment, I realized at baseline that this was a scared teenager -without a fully developed prefrontal cortex and not an adult (Arain et al., 2013). She needed preparation and psychosocial support regardless of her reasons for being here. It is not my place to judge or deny my skillset to this patient due to any circumstance that brought her into my patient census that day. I continued to prepare and support her through an IV placement, discussed her concerns with her care team regarding her procedure, and advocated for her needs throughout her visit.

Throughout my time at this institution, I have continued to advocate for the opportunity for patients having dilation and evacuation procedures to have further child life support regardless of what others may think is "right" or within my "role." I believe the role of any child life specialist is to help others cope with the various stressors of hospitalization. As our field continues to expand and evolve into various settings, roles, and clinics, I think it is easy to revert to what we know to be "safe" and "known." However, if we continued with that thought process throughout time, child life specialists may not even exist today. I can't tell you how often I get told, "We need this for adults" when working with families… if we can laugh and agree with those statements, why deny our skillset to those in need regardless of the situation that brought them into our clinical world? I will continue to advocate for patients who exhibit the highest need for developing a coping plan with the various stressors associated with hospitalization and hope more discussions may be had within our community regarding these "nontraditional" cases.

Case 2: Barbara's Work with Adolescents Admitted for Suicidal Ideation

There are a multitude of services child life specialists provide in several different departments. This complicates the job, particularly when some child life services are more recognized than others. Child life specialists navigating this disparity may feel self-doubt as "untraditional" or less utilized services get questioned or challenged. One of those instances for me was during an interaction with a thirteen-year-old girl admitted for suicidal ideation in an adult unit.

As I was passing the patient's room, I noticed a sign on the door stating, "No visitors." I checked in with the nurse to gain more information about this patient, as it is part of my job to understand better what intervention and resources I might be able to offer. The nurse looked at me and said, "You don't need to go in. She can't have anything fun." I was puzzled by her response but continued to listen. She elaborated, "She's here for suicidal ideation. She can't have anything that she might use to harm herself. Plus, we don't want to reward her behavior and make her stay in a fun place, or else she will continue to come back." I shared that I did not intend to bring anything into the room without first collaborating with her. My primary goal was to introduce myself and assess the patient's needs. At the end of our conversation, the nurse informed me that I could go into the patient's room but that the patient would not need anything from me.

As I walked away, several questions quickly came to mind: Should I enter the room? The nurse said I didn't need to go in but knew I could offer something. Providing child life services doesn't mean that it is always something physical. Is interacting with a hospitalized child who is here for suicidal ideation within my scope of knowledge and expertise? Is my presence as a child life specialist appropriate in this situation? I spent about an hour with the thirteen-year-old patient, building a therapeutic relationship, introducing long-term coping strategies, and ensuring the patient felt heard and seen. I realized that patients admitted with psychiatric needs could be easily forgotten; however, at the end of the day, they are still children. As child life specialists, our roles may differ daily depending on the population, setting, timing, etc. This varying role that child life specialists convey may create space for confusion amongst staff. Some might only see part of what we do, causing them to have a misrepresentation of what we can offer. In my case, the adult nurse appeared to associate child life specialists as entertainers and the "fun" person. However, as the ACLP (2023) states, "Child life specialists are trained professionals with expertise in helping children and their families overcome life's most challenging events." On this day, I was utilizing my expertise to help advocate for further psychosocial support for this patient on what many would consider to be the most challenging event of this patient's life thus far.

Concluding Reflections

Without a doubt, every child life specialist will have a moment when others may question their role or involvement with a certain patient population. When that time comes, having a moment of doubt within yourself and potentially your role in the situation is normal. However, remember to take those moments with stride and use them as learning opportunities to reflect. We became interested in the field of child life because we want to help people. We want to empower others to obtain coping skills and utilize our techniques within and outside of their time with us.

If the field of child life continues to expand into various roles, settings, and patient populations… how do we continue to support one another? How do we continue to advocate for one another? How do we provide opportunities for growth and sharing perspectives?

These experiences showcase the constant need for education with the healthcare team to further understand our role within various settings. Furthermore, we need to have the confidence to advocate for ourselves and demonstrate that we are educated and qualified professionals who will help patients cope with some of life's most challenging moments.

The following are reflection questions that helped us in these moments described above:

1. Take a moment to pause and breathe: How is this situation making me feel? Why do I feel this way?
2. Remember your purpose: What is the goal? Why are you here and involved in this case? Why were you called or notified about this case?
3. Consider other perspectives: Who are you collaborating with? Are there shared/common goals? What is their expertise? How can you work with this person to address a gap in care? What is their communication style?
4. Advocate for yourself: What qualifications do you have to provide a certain service? What is your educational background? What other similar experiences can you relate this to? What evidence or ACLP guidelines can be utilized to demonstrate certain expertise?
5. Advocate for your patient: What does your patient need from you in this moment? How do you meet this patient's unique needs while working alongside the rest of the multidisciplinary team?
6. Take time to process: Is there a mentor or someone on your team you can debrief with about this experience? Is there an opportunity for clinical supervision where you can gain other perspectives on the situation? How might you use this experience to improve the care you provide to your patients and/or communicate your role with others?

References:

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