The Integration of Child Life in the Medical Diagnosis Camp Setting

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Abstract

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The Integration of Child Life in the Medical Diagnosis Camp Setting

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The purpose of this study was to research the impact that a Certified Child Life Specialist (CCLS) have on medical diagnosis camps. CCLSSs are health care professionals who primarily work in the hospital setting with children and families to help them cope with challenges related to hospitalization, their diagnosis, and psychosocial issues.

Medical diagnosis camps are therapeutic recreation driven youth development programs that are unique in that they serve medically fragile children and their families. Qualitative research was collected from two different demographics of child life professionals: CCLSSs who have worked full-time as a CCLS at a medical diagnosis camp, and CCLSSs who have volunteered their time at medical diagnosis camps. Currently, there is not much overlap between these two worlds, as diagnosis camps are often seen as an “alternative setting” for CCLSSs. This study’s findings will illustrate the need for CCLSSs in the camp setting and offer suggestions as to how to integrate them.
Dedication

First and foremost I would like to dedicate this thesis to my family. Without your constant love and support I could not have completed this. Mom, thanks for still reading my papers even though I am a grown woman.

I would also like to dedicate this thesis in memory of Paul Newman. Thank you for impacting so many lives including mine.

Finally, I dedicate this in memorial to Joan Jurich. You have left a handprint on my heart. You are missed.
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Chapter 1: Introduction

Background Information

According to Bethell (2011) there are over 14.16 million children who have been diagnosed with a chronic illness out of the estimated 73.76 million children in the United States. Within the field of medicine, there has been much improvement in the treatment of these diagnosis, including early detection and advanced treatments that allow children with a range of diagnoses to live into adulthood (Lotstein, McPherson, Strickland, & Newacheck, 2005). Having a chronic illness can be a cyclical process, meaning sometimes children will be symptom-free for a period of time then without warning another occurrence of their disease can take over (Boekaerts & Roder, 1999). Having a chronic illness can be a very challenging lifestyle for both children and families.

The role of a CCLS is to help patients and families cope and endure the everyday stressors that can arise from being in a hospital or other healthcare setting (Child Life Council, 2015). The goal of CCLS is to target and foster the proper development of infants, children, adolescents, and young adults, while educating patients with coping skills to withstand challenging hospital as well as other stressful life experiences (Perceley, 2014). With a background in child development, CCLSs are able to use play, preparation activities, education, and self-expression activities to allow children and families to become familiar and more comfortable within the healthcare setting (Child Life Council, 2015). CCLSs are present in a hospital or healthcare setting. There are more possibilities for the expansion and presence of CCLSs, and one possibility is at a medical diagnosis camp.
According to the American Camp Association, there are 142 camps in the United States that serve children and families with different diagnosis and disabilities (American Camp Association, 2015). Medical diagnosis camps, also known as therapeutic camps, grant a wide range of children with chronic medical diagnoses exposure to social and recreational activities while still assuring a medically safe environment (Burns, 2014). These camps allow children to feel a sense of normalcy in a world that can often feel uncertain.

For both campers and families, there can be much anxiety and stress when first arriving at camp. Typically children manifest feelings of depression, anxiety, nightmares, and physical complaints such as headaches and stomachaches caused by separation from family and home systems (Thurber, 1995). Child anxiety and parental anxiety can coexist. If parents tend to be overprotective in their mannerisms (e.g. “be careful, you’ll have an accident”), the perceived threat can manifest itself and grow to be seen on a larger scale (Kingery, Peneston, Rice, & Wormuth, 2012). The feelings that can arise from this anxiety can greatly affect children’s camp experiences. Having a professional staff member in the camp setting for children to discuss these feelings is necessary.

**Statement of the Problem/Significance of Study**

At this time, there is not much information on the integration of CCLS into the medical diagnosis camp setting. The purpose of this study was to understand the role of CCLSs in the medical diagnosis camp setting, and to determine whether the integration of this role is possible or necessary.
A child going into the camp setting for the first time can have a variety of psychosocial stressors. Leaving their parents and attending camp for the first time can seem daunting. Children may experience homesickness and feelings of anxiety (Kingery et al., 2012). These are feelings that are already layered on top of the stressors and anxiety that come with having a chronic illness. If these feelings are not addressed they can become internalized and, children can become withdrawn, aggressive or even tearful (Kingery et al., 2012). CCLSs have the knowledge and tools available to help children and their families cope with and eliminate these intense feelings.

**Delimitations**

Delimitations of this study include CCLSs with a minimum age of 22, working full-time for at least 1 yr within a medical diagnosis camp setting, and CCLSs who have volunteered within a medical diagnosis camp setting.

**Limitations**

As previously mentioned, CCLSs are not fully integrated into the medical diagnosis camp setting so the sample size was relatively small.

**Definition of Terms**

For the purpose of this study, a medical diagnosis camp is defined as a camp that is an overnight camp; meaning that the campers stay for more than one night. Campers are identified as those who have been diagnosed with a medical illness, their siblings, and/or their caregivers.
The CCLSs who participated were considered professionals or volunteers who have been a part of at least one overnight medical diagnosis camp session for a minimum of 1 year.
Chapter 2: Review of Literature

Child Life Profession

CCLs are trained professionals who have been educated in child development as well as family systems; they encourage effective coping while using play, preparation, education, and self-expression (Child Life Council, 2015). Compared to many different career fields, the profession of child life is still relatively new. The Child Life Council, the organization that oversees the profession and certification process, is 34 years old as of 2016. The American Academy of Pediatrics discusses many aspects of the specialty of child life, from where it started to how far it has come. Emma Plank is known as the "mother" of the child life profession; in 1955, she began the first child life program at Cleveland City Hospital, now known as Metro Health Hospital in Cleveland, Ohio. Along with originating the first program, she authored *Working With Children in Hospitals*, a pivotal book which has helped educate professionals as well as families on working with the unique population of children in the hospital (Percelay, 2014). From that one hospital, the child life specialty has expanded to over 400 programs in North America and to many other alternative settings (Percelay et al., 2014).

In order to become a CCLS, there are a number of requirements. By the year 2022, all CCLSs will be required to have a master’s degree. With these educational and professional standards articulated by the national Child Life Council, the goal is to assure that all CCLSs are skilled in successfully interacting with infants, children, youth, and families in a productive and developmentally friendly manner (Child Life Council, 2002, as cited in Turner & Fralic, 2009). There are four essential components that CCLs are
required to know: assessment, planning, intervention, and evaluation (Turner & Fralic, 2009). Assessment is considered to be one of the most basic roles of a CCLS. An assessment can be collected through interview as well as observation (Turner & Fralic, 2009). Based on the assessment, the CCLS can make a plan to identify the kind of intervention most likely to benefit the child. There are many types of interventions: medical play, preparation, self-expressive activities, and diagnosis education, to name just a few. To review/see what could be done differently next time or to see whether or not the intervention was successful makes up an evaluation. These four aspects help the CCLS fully and completely serve their patients and their families.

Originally, this profession had the stereotype of being “play ladies,” but today has grown to have many integral components, mentioned above, which are necessary to having a successful hospital experience for children, families, and staff. Play is still an important part of the profession. Play is a universal language for children, but playing intentionally/therapeutically allows CCLSs to hone in to achieve developmental breakthroughs even during stressful times throughout a hospitalization (Koller, 2008). Beyond helping children understand the stressors in the hospital, CCLSs also use medical play to help children understand medical procedures. Play can let a child feel safe, in what otherwise could be a threatening environment.

**Patient and Family-Centered Care**

Within the philosophy of the specialty of child life is the belief of patient and family-centered care (PFCC). A CCLS approaches the family as a holistic family unit. This compliments patient-centered, or patient-focused care which, “enables healthcare
organizations to work collaboratively with patients and their families to enhance and improve their care experiences” (Shaw, Pemberton, Pratt, & Salter, 2014, p. 20). During the hospital stay families will endure many choices and hardships, and CCLSs act as advocates for those families. The CCLS is there to think about the details that families may be forgetting about due to stress. A CCLS is there to allow the family to be in control and make decisions and work to create/implement a productive plan of care (Bell, Johnson, Desai, & McLeod, 2009). Figure 1 displays components of PFCC and how, when executed with patients and families, possible positive results occur. When working at camp or within the hospital it is important to be able to effectively work with both the patient and the family. This chart shows vital parts of PFCC and how the CCLS can give satisfaction to not only the family but also the staff.

Advances in Pediatric Health Care

When evaluating the impact of the CCLSs in the medial diagnosis camp setting, it is important to focus on the camp participant themselves. Around the United States, there are over 14.16 million children who have been diagnosed with a chronic illness, out of the estimated 73.76 million children in the United States (Bethell et al., 2011). Although this is a large number, there has been much advancement in treatments, early detection and the overall healthcare system. With all this improvement, it is estimated that a vast majority of children with chronic conditions will live into their adult years (Lotstein et al., 2005).

Health care, in general, has improved greatly, but more specifically it has improved for children with chronic illness. Near the end of the 1970s, the growing struggles for families and children facing these diagnoses was starting to be recognized; at that time, only care that was provided in hospitals or other institutions was covered by insurance. This meant that patients typically could not stay assimilated to their homes or their communities, and it was a challenge to find the services they needed within a manageable distance (McPherson et al., 2004). Illnesses not only affect the child, they impact the entire family unit. Not only will the family system have to adjust to the ordinary developmental milestones, they will also have to adjust to this new diagnosis and the challenges the diagnosis presents (Hicks & Davitt, 2009). This is why more hospitals are transitioning to a PFCC model. Medicine is trying to become more cost effective for patients and families, which is a reason that medicine is going beyond acute care and moving into the more home-based health care model (Myers, 2013). Trying to
go beyond in hospital care and make it more humane for people facing chronic illnesses is a goal of medicine.

**Common Stressors for Pediatric Patients with Chronic Illnesses**

**Coping and control.** Having a chronic illness can be cyclical, meaning children will be symptom-free for a period of time then without warning their illness can reoccur (Boekaerts & Roder, 1999). Coping with chronic illness is the first major stressor. Not only do these children have to deal with everyday issues that include social, academic, and family issues, they are now exposed to regimented treatments, restrictive diets, medical procedures, and frequent hospitalizations (Hampel, Rudolph, Stachow, Laβ-Lentzsch, & Petermann, 2005).

Because a child loses his or her sense of control when diagnosed with a chronic illness, he or she can be at risk for developing psychological problems like depression (Pinquart & Shen, 2010). The severity of the depressive symptoms can be determined by the specific diagnosis, these depressive symptoms are most common in: chronic fatigue syndrome, fibromyalgia, migraines, cleft lip/palate, and epilepsy diseases (Pinquart & Shen, 2010).

**Social stressors.** Beyond the medical aspect, how their peers react to the diagnosis can also have a large effect on depressive behavior. The children who have chronic illnesses may look different and have to miss more school which in turn may cause them to experience peer rejection (Sandstrom & Schanberg, 2004).

**Medical.** Being in a medically intensive situation can bring its own form of stress. The chart below allows CCLSSs to look at developmental age and see what common
stressors are associated with each group. With this information, the CCLS can create appropriate and therapeutic interventions. Table 1 illustrates the stressors for each age group, to further understand the hospitalized child’s experience.

Table 1

_Breakdown of Hospital Stressors by Developmental Age_

<table>
<thead>
<tr>
<th>Age</th>
<th>Hospital stressors</th>
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<tr>
<td>Neonates (0 to 30 days)</td>
<td>• Startles to loud noises and sudden movement</td>
</tr>
<tr>
<td></td>
<td>• Blinks in response to bright light</td>
</tr>
<tr>
<td></td>
<td>• Impaired basic needs</td>
</tr>
<tr>
<td>Infants (birth to 12 mnths)</td>
<td>• Separation from parents</td>
</tr>
<tr>
<td></td>
<td>• Impaired basic needs</td>
</tr>
<tr>
<td></td>
<td>• Stranger anxiety</td>
</tr>
<tr>
<td>Toddlers (1 to 3 years)</td>
<td>• Separation from parent and fear of abandonment</td>
</tr>
<tr>
<td></td>
<td>• Stranger anxiety</td>
</tr>
<tr>
<td></td>
<td>• Unfamiliar environment</td>
</tr>
<tr>
<td></td>
<td>• Loss of autonomy and mobility</td>
</tr>
<tr>
<td></td>
<td>• Change in routine</td>
</tr>
<tr>
<td></td>
<td>• Back-laying position frightens toddlers</td>
</tr>
<tr>
<td></td>
<td>• Respond fearfully to sudden movements or loud noises</td>
</tr>
<tr>
<td>Preschoolers (3 to 5 years)</td>
<td>• Separation from parent</td>
</tr>
<tr>
<td></td>
<td>• Heightened fears (pain, strangers, medical equipment)</td>
</tr>
<tr>
<td></td>
<td>• Feels loss of protection and a sense of abandonment</td>
</tr>
<tr>
<td></td>
<td>• Misconceptions develop from lack of understanding</td>
</tr>
<tr>
<td></td>
<td>• Unable to distinguish between fantasy and reality</td>
</tr>
<tr>
<td></td>
<td>• Loss of competence &amp; initiative in developmental tasks</td>
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Table 1, Continued

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Stressors</th>
</tr>
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</table>
| School Age (6 to 12 years) | • Loss of bodily control  
                         | • Enforced dependence  
                         | • Loss of competence  
                         | • Fears body mutilation and deformities  
                         | • Fears loss of bodily functions and/or body parts  
                         | • Fears pain  
                         | • Fears death  
                         | • Fears anesthesia |
| Adolescent (13 to 18 years) | • Lack of trust  
                         | • Loss of independence and control  
                         | • Threat of change in body image  
                         | • Restriction of physical activities  
                         | • Loss of peer acceptance and/or fear of rejection  
                         | • Threat to bodily competence  
                         | • Threat to future competence  
                         | • Fear of death |

*Note.* Attributed to “Children’s Hospitalization and Other Health-Care Encounters,” by J. Rollins, 2005, in J. A. Rollins, R. Bolig, and C. C. Mahan (Eds.), *Meeting children’s psychosocial needs across the health-care continuum*, pp. 22-25, Austin, TX, Pro-Ed.

**Family Stressors for Children with Chronic Illnesses**

**Caregiver/parent stressors.** Hearing a child diagnosed with a chronic illness can be stressful, and caregivers need to know the appropriate amount of information in a timely manner. Having too much or too little information can cause distress amongst the family (Kolbrun Svavarsdottir & Olafia Sigurdardottir, 2013). Beyond these feelings of distress can come feelings of guilt; guilt because they could be starting to resent their ill child, or guilt because of the person they are becoming from the stress situation (Erel-Brodsky, 2014). When the normalcy of the family system has changed uncertainty can cause excess stress, but with help from a psychosocial team there can be a relief from
some of the uncertainty that the families face that may help the family get back some form of normalcy (Mullins, Molzon, Suorsa, Tackett, Pai, & Chaney, 2015). In a study that measured the anxiety and depression in parents with a chronically ill child, researchers compared two groups of parents: 1) the parents with an ill child and 2) a reference group, people with healthy children. The results showed that specifically mothers who have a chronically ill child report higher levels of anxiety and depression (Oers et al., 2014). Finally, managing finances is a significant stressor that can impact the caregiver greatly from driving to doctor visits, affording medication, and short-term or long-term hospitalizations can be very high in cost. Beyond that, trying to get adequate coverage from insurance companies can often be stressful and frustrating. With all these financial burdens increased stress between the caregiver and healthcare provider can occur (Pediatric Psychosocial Issues, 2014).

**Sibling stressors.** Having a sibling who is ill can cause much confusion and emotional turmoil for the healthy sibling. There can be a lot of anxiety associated with being the healthy sibling, including worries of a sibling dying or having to return to the hospital, fear that they will become ill too, worry about family finances, and pressure to be a “good” child to help with their parents emotions (Lane, & Mason, 2014). Although the sibling may be healthy, their lives can become overrun by treatment and hospital visits (Havermans et al., 2011). The age of the sibling also plays an important factor, as older siblings show lower self-esteem when coping with a sibling who is diagnosed (Havermans et al., 2011). Figure 2 illustrates how every part of the sibling’s life is different, and how these differences can cause the stress/anxiety mentioned above.
The chart below spells out three main stressors socioeconomic, illness-related, and psychosocial and their subfactors. This chart clearly separates and explains the factors and how they fit into each category. Although CCLSs are trained in knowing different contextual stressors and how they will impact the sibling this chart explicitly shows it. This can be helpful for the CCLS working within the camp specifically during siblings camp.

Medical Diagnosis Camps

According to the American Camp Association (2015), there are 81 overnight camps that serve children and families who have disabilities or special needs. Some specific diseases/illnesses that fit into the category of diagnosis and special needs are as follow: asthma/respiratory ailment, blood disorders, cancer, HIV/AIDS, and hemophilia just to name a few (American Camp Association, 2015). For these camps therapeutic recreations are the core of their programming and the primary goal is to normalize the diagnosis for the campers (Hunter, Rosnov, Koontz, & Roberts, 2006). They help improve the psychosocial functions by the programs they run, and how they intentionally run the programs. When planning a program, camp directors have goals in mind, goals which address specific changes they wish to see occur in the campers (Sibthorp, 2003).

The Stressors of Camp for Families and Child

The stressors between parents and their children can be interchangeable when there is high parental anxiety before camp the child’s pre-camp anxiety is higher which can lead to homesickness (Kingery et al., 2012). This precamp stress is not biased to gender, with higher rates of parental anxiety it was found that boys are more effected, showing significantly higher rates of homesickness then girls (Kingery et al., 2012). Figure 3 displays the difference that boys and girls felt in response to parental anxiety. The knowledge from this chart can give the psychosocial team insight to certain behaviors.
Children who had parents with negative expectations of camp actually benefited most from camp. It is also possible that these parents with the negative expectations could have caused more anxiety to their children before coming to camp. (Simons, 2007).

**The Influence of Camp**

Camp has an influence on three very crucial parts of children’s lives: their physical, social and psychological well-being. Activities at camp typically involve physical activity. Findings from a study on children with Cystic Fibrosis who attended a four-week summer camp found that campers reported improvement in their well-being, experienced less physical breathlessness, higher energy, lower fatigue, and increased appetite (Blau, 2002). The campers’ duration of physical activity outcomes from camp are equal if not greater than before they experienced camp (Blau, 2002).
Socially, camp can be a positive place for children of all ages to meet developmental milestones. Children with a chronic illness who have attended summer camp have seen a rise in self-worth as well as social acceptance (Alison, Negley, & Sibthorp, 2013). Camps provide this increase in social understanding by fostering social situations which allow campers to grow as leaders as well as feel a sense of independence (Thurber, Scanlin, Scheuler, & Henderson, 2007). At camp, children are able to form a network with children facing similar diagnosis, as having that ability to have a meaningful interaction is critical.

There has been much research done evaluating the psychosocial impact of camp. Aspects of human development such as personal identity, interpersonal, physical and cognitive abilities, positive values, perceived social skills, and spirituality all showed improvement after attending summer camp. (Simons et al., 2007). It is important to understand how these psychosocial impacts are achieved, though, beyond the therapeutic programming camp can also be a psychosocial intervention that lowers the burden of the disease and helps the campers to feel more supported (Moola, Faulkner, White, & Kirsh, 2014).

It is not always just the child who benefits from a summer camp experience, as research results showed that parents had lower separation anxiety which could lead to less overprotectiveness, which will allow more independence from the child (Simons, 2007). The positive outcomes from camp, for all, are clear.
Integrating Child Life into Medical Diagnosis Camps

At this point, there are two publications on the CCLs and our integration into the camp setting. First is from Child Life Beyond the Hospital, a book that looks at and describes the role of a CCLS in “alternative settings,” including hospice, schools, funeral homes, dentist offices, and human service agencies. The other article being a thesis called Child Life Specialists in the Camp Setting: an Exploration of Presence, Roles and Perspectives, this thesis looked into the health-related quality of life and how CCLS can impact that within the camp setting. A very important aspect to evaluate is what role a CCLS would play in the medical diagnosis camp setting. Hicks and Sweeny (2008) detail the inner-workings of the two full-time CCLs at Camp Sunshine. From the camp’s perspective, the CCLs help in various aspects of camp, including planning/implementing programs (Hicks & Sweeny, 2008). At camp, children can begin to learn more information about their illness, which could be frightening. Having a CCLS present can help clear up any misconceptions that may arise (Hicks & Sweeny, 2008).

Finally, a CCLS could be utilized to lessen the stress of being separated from caregivers (Hicks & Sweeny, 2008). Some children have never been away from their caregivers for an extended period of time, so camp could increase homesickness and separation anxiety (Hicks & Sweeny, 2008). Having a CCLS perform early intervention by prepping the child for camp and the experiences they will have away from their families may lessen the stress once the child arrives (Hicks & Sweeny, 2008).

A second publication examined how CCLs can improve the health-related quality of life of the campers (Geisse, 2013). Results of the study found that CCLs
could help campers with their psychosocial/emotional development specifically in the realm of empowerment by building campers sense of autonomy. They build this autonomy by allowing the campers to have opportunities to engage in self-exploration thereby promoting self-esteem and confidence (Geisse, 2013).

Integration of the Ecological Theory in Camp

Bronfenbrenner’s ecological theory examines human development by considering the entire ecological system. This theory believes that each person’s system has five different levels: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The interactions between these systems are what influence that person’s development. In the microsystem are activities, social roles, and interpersonal relations experienced by the person who is developing (Bronfenbrenner, 1994). The mesosystem is where two or more influences in the microsystem link or interact. In the exosystem, two or more linkages or processes occur between different settings. At least one of these linkages, though, must be an indirect influence in the person’s life (Bronfenbrenner, 1994). The macrosystem looks at the culture and subculture of the person’s environment; the beliefs, attitudes and values that the person is surrounded by. Finally, the chronosystem looks at the passing of times and the events that occur during the time that may influence the developing person. It is thought that if one thing changes in any of the systems, it will influence the rest.

When children go to camp for the first time there are a lot of different factors which influence and shape their experience. As previously mentioned, parental anxiety can be easily transferred to the campers. This can often be seen through homesickness
during the camper’s experience (Kingery et al., 2012). CCLSs are trained to work with both the camper and his or her entire family system. The ability to see all the levels of the child’s ecological system and how interact with each other is vital. Closely evaluating these interactions of the systems can give the CCLS greater insight as to why the camper may be feeling anxiety or homesickness. These levels can also show us why some campers are braver than others.

**Integration of Vygotsky’s Sociocultural Cognitive Theory in Camp**

Sociocultural Cognitive Theory focuses on how culture can affect/shape the developing person. Vygotsky states cognitive development stems from social interactions and from guided learning within the zone of proximal development as children and their caregivers co-construct knowledge. The zone of proximal development, simply put, are the skills that are too difficult for a child to master on his/her own (Mahn, 1999). These can be achieved with help and encouragement of a knowledgeable person. This knowledgeable person can be an adult and adults can transmit their culture's tools of intellectual adaptation that children internalize (Mahn, 1999).

This theory focuses on how culture can affect/shape the developing person. Vygotsky states cognitive development stems from social interactions and from guided learning within the zone of proximal development as children and their caregivers co-construct knowledge.

In regards to camp, the culture is vastly different than one the campers may have experienced before. Limitations are seen as barriers that are needed to be broken. With the social interactions had at camp with both campers and staff alike the camper who is
being immersed in a new culture can experience a shift of ideas/possibilities on what is achievable. The staff is trained to have the same mind-set of supporting and encouraging safe, but limit breaking fun. Imagine if the staff had the guidance of a CCLS to give the lens of what a child experiences in the hospital. A CCLS could emphasize the importance of control and give the reasoning behind it. With this guidance from a knowledgeable person, the CCLS, the campers could have a whole new outlook.
Chapter 3: Methodology

Participants

Qualitative research was used to gain information from CCLSs who have either worked full-time, a minimum of 1 year or have volunteered at a medical diagnosis camp. Participants were required to be over the age of 22 years. Both men and women were invited to participate. The participants listed above were required to be certified by the Child Life Council or be in the process of being certified. The participants were required to have attended one full overnight medical diagnosis camp session. The voluntarily based survey was sent out via Qualtrics to CCLSs via the Child Life Council forum and Facebook. The survey included questions specifically designated for the different professionals filling it out.

Recruiting of Participants

The participants were recruited via professional networking as well as postings within the American Camping Association forums and the Child Life Council forums to recruit interested CCLSs (see Appendix D). The use of social media websites were also utilized, including Facebook, Twitter, and LinkedIn (see Appendix E).

Protection of Participant Identity

Qualtrics asked demographic questions (see Appendix A), and explicitly stated that the participants’ anonymity would be ensured. All professionals were deidentified through the Qualtrics software. Once the surveys were collected they were secured in the researcher’s password protected laptop. The surveys are in a hidden folder and password protected. The surveys will be deleted by June 2019.
Data Analysis

Qualitative data was collected through surveys. The researcher looked for specific themes within the answers as well as clusters of meaning. Once the data was analyzed the researcher created graphs of the results with the use of Qualtrics as well as Excel software.

Two different surveys were sent to CCLSs. The first, Data Set 1 (DS1), was a survey designed specifically for CCLSs who have worked full-time in the medical diagnosis camp setting. Data Set 2 (DS2) designed for CCLSs who have volunteered at a medical diagnosis camp. Before engaging in both the surveys participants signed a consent form (see Appendix G).

Both DS1 and DS2 participants completed the same demographic questionnaire before being directed to their specific survey. For the question on ethnicity, participants were encouraged to indicate as many ethnicities that they identify with. Caucasian was the most common ethnicity with 49 participants identifying in that category. Level of education was a second demographic asked of participants with 51% indicating they have a bachelor’s degree and 49% indicated a master’s degree.
Figure 4. Education: What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.

All participants in this study were female. Participants were encouraged to indicate all that applied in reference to their current employment status; of the participants in the study: 38 were employed for wages, 1 was self-employed, 2 were looking for work, 10 were students, and 1 was retired. After the demographic questions, the final study included 48 participants. One individual decided to not continue with the survey. Seventeen took the survey for those who work at a camp and 31 participated in the volunteer survey.
Chapter 4: Results

Data Set 1 Results

Demographics. From the original 17 participants who agreed to complete this survey only 10 completed it in full. These participants gave an array of experiences at camp, with all 10 experiencing a mix of day camps, overnight camps, and family camps.

Figure 5. Is a full-time psychosocial team present at the camp/s you work at?

Figure 6. Are you the first CCLS hired at your specific camp/s?

The amount of psychosocial teams at camp and the CCLSs who work full-time at a camp is exactly even. These participants are from camps all over the country, so at this
time only half of these children who are medically fragile and in intense psychosocial situations are getting the support necessary.

**Need for child life.** This was said by all of the participants when the question “Do you see the need for child life in the medical diagnosis camp setting? Why/Why not?” was asked. One participant backed up the need for a CCLS stating:

Absolutely. Child Life is able to help normalize the camp environment for patients. There were many times during opening day where children would be scared to leave their parents (and parents would also be hesitant to leave their child!). My role was to help facilitate this transition by introducing the children to one another and fostering their engagement. Providing support to parents is also crucial because parents are often scared to leave their sick child in the care of others for an entire week (even if it is trusted nurses and doctors). In addition, oftentimes children would discuss issues about their treatment or other patients that have passed away during camp. This is a prime opportunity for a CCLS to engage the children in therapeutic interventions and help them process different emotions related to diagnosis and treatment.

Another participant stated:

Yes, very much so. The campers I work with are living with serious illnesses every day, in and out of the hospital. The support we provide is both medical and psychosocial/behavioral. Our campers have a variety of needs ranging from homesickness and anxiety to medical and procedural support. Having a CCLS in the role of this support is beneficial in many way including but not limited to the
ability to provide normalization, socialization, program adaptations, developmentally appropriate activities, and of course medical needs support. The skill set that is specific to child life is necessary to cover all of this support. These are just two of the many responses received. From reading the others, it is clear that these professionals see the benefits of having a CCLS in the camp setting. Every single person who answered this question agreed that this was a necessity.

**Child life competency integration.** Beyond just seeing the need for a CCLS at camp, all 10 of these CCLSs were also able to incorporate three very essential aspects of the specialty of child life into their work, the competencies, theory, and interventions. One participation stated the importance of competency integration by stating the following: “We are able to incorporate near every competency into our work. We provide appropriate interactions, interventions, support for potentially stressful situations, etc. We work with our medical and program team to reach outcomes, etc.” Another participant focused on the necessity of using one of a CCLSs main components in her work, assessment,

Assessment of development and emotions in a new environment which should promote normalcy but often promotes fear, bhv issues, etc, assessment and promotion of coping strategies being away from home, interacting with peers with socioemotional stressor and vulnerability, clarification of medical info at ask the counselor, doctor, engaging kids in play especially when assessed to be withdrawn from groups.
**Connection to theory.** Theory is the backbone to every intervention that a CCLS does. Without theory to back it up our work could lack the legitimacy it so deserves. One participant felt that, “Theory drives every intervention and interaction I have with children in a camp setting. You first have to understand child development and be able to verbalize typical stressors these children can face. Theory should drive everything.”

**Interventions.** Purposeful interactions is what makes our profession exist. When asked about how many interventions performed per day at camp a participant shared that, “I would say at least 5 per day. Opening day is typically an entire day of interventions between supporting the parents and transitioning the children into the camp setting.” Another detailed that, “This past summer we charted an average of 4.5 significant interventions based on full days of camp; 138 significant interventions over the summer were charted in total. This does not include adaptations provided, programming provided, mild interventions, and group interventions.” Using methods such as charting the information assist in not only collection of numbers, but also legitimizes the work further.

Beyond being able to use their skills as CCLSs the participants were also to be integrated to the multi-disciplinary team. Whether that be the medical team, program team or if their camp has a psychosocial team. Overall, it was clear the CCLSs felt that there is a need for this profession in the medical diagnosis camp setting.

**Data Set 2 Results**

**Demographics.** Compared to the full-time staff 13 out of the 17 volunteers do not have a psychosocial team present at the camps they volunteer at, most not even having a CCLS hired on.
**Prevalence of a psychosocial team.** Although most said that they did have psychosocial teams present, there were a few that did not have them available at camp. One volunteer said, “No, the director does not allow it. They want the kids to get away from all of this. I disagree. Would be a great place for interventions.” Another saying, “No. Just nursing staff but they could see a benefit of having a full-time child life specialist on site to deal with psychosocial issues.”

**Benefits of child life specialists.** When asked about the benefits of the engagement of a CCLS, there was an in-depth answer:

I actually created this list of job duties and how they apply to camp to present to our management.

1. Provides developmentally appropriate education to patients and families regarding healthcare experiences.
   a. At first glance, camp is often considered more recreational than educational, but camp is a natural setting to reinforce or initiate crucial education related to diagnoses (both formally and informally).

2. Provides developmentally appropriate procedural preparation and support to patients and families.
   a. Campers talk about past medical experiences and anticipate future ones.
   b. CLS serve as an informed professional who can provide education about surgery/hospitalizations, clear up misconceptions and decrease stress related to anticipated medical treatments.
3. Provides appropriate therapeutic interventions to patients and families to assist in coping with illness and hospitalization.
   a. With expertise in development, CLS assists with homesickness and separation anxiety at camp.
   b. So many teachable moments/therapeutic conversations when campers are feeling well enough to participate in group conversations that allow campers to relate regarding illness, body changes, and self-perception. (Unfortunately, when they are hospitalized, patients are often at their worst state of health and are unable to participate in opportunities to receive peer support)
   c. Interacting with children at camp allows CLS to have a more complete perspective or look into the child’s world, which will inform the service CLS provides to patients during hospitalizations.
   d. Fulfills the Family Services mission, values, and vision. Attending camp undeniable allows CLS to complete the mission of “building connections” while recognizing the value in “normalizing the journey,” “balancing the experience” and “making crucial connections” with the goal of improving our patients’ “wellness and quality of life.”

4. Normalizes the environment to reduce the impact of the healthcare experiences on development and coping.
   a. CLS helps normalize having a chronic illness by engaging campers in social interactions with peers who have similar diagnoses. The goal is
promote long-term compliance even after the week of camp is over.

Because campers have a sense of belonging there is new motivation to be compliant with doctor’s visits, medication taking, and with reducing risky behaviors.

b. CLS intentionally helps foster mentor relationships between younger and older campers to promote positive coping and better understanding of what is to expect in the future as they continue to manage their chronic illnesses.

5. Collaborates with the interdisciplinary team in identifying and managing the patients and families emotional and developmental needs

a. Assists with providing vital preparation to volunteers, nursing students, other staff regarding the unique needs of the camper population (to promote supportive, developmentally appropriate environment for campers).

b. CLS teaches volunteers/staff how to manage social situations/group dynamics, how to build therapeutic relationships and assists when volunteers/staff who are struggling with managing behavior issues.

Based on all 17 responses, each of the volunteers felt that CCLSSs are necessary and helpful within the camp setting. Some keywords used throughout their answers were: supporting in coping, answer the questions, psychosocial situations, programming assistance, assessment and child development. All words that support the three big CCLS terms: education, support, and play.
Use of child life specialists’ skills. One interesting point was how many volunteers were encouraged to use their CCLSs skills in their time at camp:

Yes! I have always gotten the "we love child life!" response. I feel as if those I work with recognize my experience with the population and encourage me to incorporate my child development skills as well as my medical terminology knowledge. I have always been met with positivity. Many I work with ask me more about Child Life, if they don't already know, and become interested in it themselves.

Another volunteer stated how she is utilized by staff:

Yes, the camp directors value my expertise and pull me in a lots of different levels of camp. I am involved with planning camp (creating a theme, planning memorial service, planning therapeutic activities and education). I also assist with orienting volunteers who need information about development and what to expect from our patient population and how to handle homesickness and other emotional issues at camp. During the week at camp, I work directly with counselors who are having emotional/behavior issues with their cabins such as homesickness, bullying, conflicts within the group, etc. I also facilitate a child life session with most of the cabins that consists of both education and therapeutic activities with change each year.

The skills and knowledge of the CCLS are used even in the volunteer capacity.
Chapter 5: Discussion

Survey Approach

This survey was sent to a broad range of specialists all around the United States. The respondents all varied in location, and the context in which they practice child life, specialties within the field, education level, age and experience levels. The number and diversity of participants helped to provide statistically valid conclusions.

Since the participants remained anonymous throughout the entire survey this assisted in propelling their answers to be more upfront and honest. The anonymity in the responses resulted in high participation.

The scope of this survey was limited to asking about the CCLSs camp experiences, child life skills they used at camp, and if they felt CCLSs would enrich camp by being present. Knowing what types of camps people were coming from is necessary to know because shorter camps may produce different answers. Being intentional is a necessity with every action of a CCLS, so gaining knowledge on what skills CCLSs find necessary helps to better solidify our CCLSs within the camp setting.

Overall Findings

Based on the research collected and the responses given there is a clear need/want for CCLSs in the medical diagnosis camp setting, with 100% of the participants stating that, yes, there is a need. Starting with the psychosocial needs of the campers, for most campers this could be their first time away from their family for an extended amount of time. Not only are they dealing with the associated stressors to do with their illness, but now they are processing being in an unfamiliar environment with new people. CCLSs
have the ability to assess these psychosocial issues and provide interventions that could be beneficial to the camper.

Most of the CCLSs feel that we can use our tools and training in the camp setting. Most participants described in depth the use of theories as well as child life competencies. CCLSs in camp are able to use their training and the necessary child life foundation to produce positive results with the campers at their camps. Behind every intervention we do at a hospital, we have to have our child life foundation. It is clear that CCLSs are prepared to integrate our necessary training into the camp setting.

In order for the integration to happen it will be necessary for CCLS professionals to advocate the services we can provide for the camps. There are very few CCLSs who work within camps around the country, but if these CCLSs got together and collected data they might be able to educate camp professionals as well as CCLSs on the need and importance of this integration. There is no change that comes without some form of advocating.

**Limitations of the Study**

To have produced better results, it might have been beneficial to rephrase the directions of the survey (see Appendix B). While evaluating the data collected, it seems participants were unsure which survey was applicable to them. Within the survey for the full-time staff members, there were a few participants who had worked as seasonal staff at the camps, not full-time as a CCLS.

Also, there was confusion as to the basic requirements of participation for this survey. We intended that participants should be “in the process of being certified,” yet
there were people filling out the survey who were still in school. Clarifying and making the survey requirements more explicit by saying “someone who has completed an internship and preparing to take the exam,” might have attracted a more concentrated group of participants.

A final limitation was the lack of diversity in the gender of participants taking the survey. There were no men who filled out the survey, and there is a lack of men within the field in general. This does affect the outcome of the survey because men and women think differently and I am only getting one perspective.

**Implications for the Specialty of Child Life**

Within the CCLS community there an ongoing discussion about developing and encouraging integration into alternative settings. As more specialists continue to volunteer/work at camps stronger professional ties may be necessary. The American Camp Association is the governing body for most of the camps and the Child Life Council is the governing body for CCLSs. If these two organizations were to work together and recognize the specialists working/volunteering it would boost the national presence and legitimacy of this “alternative” setting.

In terms of education, future CCLSs may need to be trained with different and more specific skill sets. At camp, there are interventions that could be done done on a larger scale (i.e., ropes course and archery). Typically, CCLSs are trained to make these interventions/activities fit to be compatible with the hospital setting which is typically seen to be a sanitary and tidy environment. Beyond just the interventions education on working with homesick children could be a topic that can be further explored by the
educators. Further education will also be necessary for one of the most prevalent psychosocial issues in camp which is homesickness.

The Child Life Council would also need to enhance efforts to improve training/education of CCLSs. CCLSs are required to do a certain amount of continuing education credits each year. To ensure that all the CCLSs, even those who work in camp, are receiving education relevant to them, the Council will need to supply those courses. Two options for these furthering education could be a webinar hosted by a psychosocial team at a camp, where they speak on the most prevalent issues facing CCLSs at camp. Or there could be a separate conference specifically for CCLSs who work within the camp network. This separate conference could teach more concentrated subject matter relevant to these CCLSs and will help to build a stronger network.

**Implications from Research**

Based on the responses from both the staff and volunteers, there is a strong need for CCLSs to be in the camp settings. In order to validate the research, proper documentation and standards for future jobs must be clear. Appendix H is a sample application; it highlights the responsibilities of the jobs and the qualifications. In the hospital setting there are many high standards of the CCLSs that solidifies their work (i.e., charting). If these same standards were expected by CCLSs at camp this may legitimize the integration into this new setting. Appendix I is an assessment sheet for campers who may have been identified as needing CCLS support, or just for any campers the CCLS sees fit for an assessment. This form looks at the patient as a whole and evaluates how best we can serve them or what interventions may be necessary. Appendix
J is an intervention form where the CCLS will be able to document the interventions and place this within the campers file. With this filing system, the staff will be able to document and keep track of the amount and types of interventions performed. This will then allow the staff to see what psychosocial issues are most prevalent for their campers. By knowing these issues the staff can provide more focused and productive care.

**Implications for More Research**

Currently, within child life curriculum students mostly learn about CCLs within the hospital setting. Integrating CCLs into new settings can only be achieved when more awareness and education is passed to future generations of this profession. As the profession grows within this setting more research and findings will be made to be able to teach others. Studies such as this is a start, but actually studying the interventions, psychosocial issues, therapeutic play activities that are performed at camp will be a necessity to educate. With all of these aspects of the job being studied the ability to evaluate the outcomes and benefits of having CCLs in the camp setting will be possible.

With more research and solidifying of this profession in an out of the hospital setting, more educational training opportunities could be possible. Starting more formalized practicum and internship programs will give the perspective CCLs’ an opportunity to have a different experience in an extraordinary setting. As long as there is a CCL present on camp and the Child Life Council approves this new educational opportunity there is no reason why camp cannot be a new practicum/internship site.
References


http://dx.doi.org/10.1007/s10880-012-9321-4


http://dx.doi.org/10.1080/02739615.2013.753822
Appendix A: Demographic Questions

Q. 1-Ethnicity origin (or Race): Please specify your ethnicity. Check all that apply.
• White
• Hispanic or Latino
• Black or African American
• Native American or American Indian
• Asian / Pacific Islander
• Other

Q. 2-Education: What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.
• Associate degree
• Bachelor’s degree
• Master’s degree
• Professional degree
• Doctorate degree

Q. 3-Employment Status: Are you currently…? Check all that apply.
• Employed for wages
• Self-employed
• Out of work and looking for work
• Out of work but not currently looking for work
• A student
• Military
• Retired
• Unable to work

Q. 4-Gender?
• Male
• Female
• Not Comfortable Answering
Appendix B: Questionnaire for Child Life Full-Time in Camp

Directions: If you practice Child Life in medical diagnosis camp setting whether as a full-time staff member or as a member of a visiting organization’s camp group please fill out this questionnaire. Below are a series of questions some which are multiple choice and some which are short answer/fill-in-the blank.

Q. 1-What type of medical diagnosis camp have you experienced? Check all that apply.
   • Day Camp
   • Overnight Camp
   • Both Day and Overnight
   • Family Camps
   • Other, please explain.

Q. 2-Describe the camp/s you have experience with:

Q. 3- Is a full-time psychosocial team present at the camp you work with?

Q. 4- What types of professionals make up this psychosocial team?

Q. 5-How long have you worked for your camp?
   • 1-2 Years
   • 2-4 Years
   • 4-6 Years
   • 6 Years +

Q. 6-Are you the first CCLS hired at your specific camp?
   • Yes
   • No

Q. 7-How many years has child life been present at your camp?

Q. 8-Do you see the need for child life in the medical diagnosis camp setting? Why?

Q. 9- Have you been able to incorporate the Child Life Competencies into your work?
   • Yes
   • No

Q. 10- If yes, how?

Q. 11-Have you been able to incorporate Child Life theory into your work?
   • Yes
   • No
Q. 12- If yes, how?

Q. 13-On average how many Child Life Interventions do you perform during a given camp session? Please specify.

Q. 14-Has your job been integrated naturally into the multidisciplinary camp team?

Q. 15- Why did you choose to work in camp, which is considered to be an alternative setting?

Q. 16- How has working at a camp changed your perspective of the field of Child Life? If yes how?
Appendix C: Questionnaire for Child Life Specialists Volunteering at Camp

Directions: If you have volunteered at a medical diagnosis camp while being a Certified Child Life Specialist please fill out this questionnaire. Below are a series of questions some which are multiple choice and some which are short answer/fill-in-the blank.

Q. 1-What type of medical diagnosis camp have you experienced? Check all that apply.
- Day Camp
- Overnight Camp
- Both Day and Overnight
- Family Camps
- Other, please explain.

Q. 2-Describe the camp/s you have experience with:

Q. 3- Is a full-time psychosocial team present at the camp you work with?

Q. 4- What types of professionals make up this psychosocial team?

Q. 5-Is there a Child Life Specialist employed by the camp?
- Yes
- No

Q. 6-How long have you volunteered for your camp?
- 1-2 Years
- 2-4 Years
- 4-6 Years
- 6 Years +

Q. 7-Do you see the need for child life in the medical diagnosis camp setting? Why?

Q. 8-When volunteering, does the camp encourage the use of your background in Child Life or do they prefer you act as any other volunteer? Please describe. (If you do use your background in child life go to questions 9 and 10)

Q. 9-Have you been able to incorporate the Child Life Competencies into your volunteering?
- Yes
- No

Q. 10- If yes, how?
Q. 11-Have you been able to incorporate Child Life theory into your volunteering?
• Yes
• No

Q. 12- If yes, how?
Q. 13- Did volunteering at camp change your perspective on the field of child life?
Explain.
Appendix D: Email to Recruit Participants

The following solicitation will be posted on the Child Life Council’s open web-forum. The text that will be posted soliciting participation is as follows:

Email Subject: Survey on Child Life in the Camp Setting

Dear Child Life Council Members,

My name is Becca Wagner and I am currently entering my 2nd year as a graduate student in the Child Life and Family Studies Program with a focus in Child Life at Ohio University. My two passions are Child Life and Camp. I have decided to commit my Master’s thesis to examining the impact, the presence and role of a Certified Child Life Specialist has in a medical diagnosis camp environment. I am interested in collecting experiences from Certified Child Life Specialists who have worked or volunteered in this setting in order to explore what impact Child Life professionals see on having their presence at camp. You are eligible to participate in this study if you are a Certified Child Life Specialist who has worked or volunteered in a medical diagnosis camp setting. Participants will be asked to complete a brief online survey that will take about 20 minutes. Please know that I have taken measures while creating this survey to protect participant anonymity and confidentiality. If you would like to participate in this study, the electronic informed consent and survey may be obtained by clicking on this link: [link]

If you have any questions please do not hesitate to contact me at: bw239209@ohio.edu

Thank you for reading this and for all you do!

Becca Wagner
Appendix E: Participant Recruitment Flyer

Are you a child life professional who has either worked or volunteered at a medical diagnosis camp?

Are you above the age of 22?

If you are interested in sharing your experience working or volunteering at a medical diagnosis camp, please fill out this brief survey [link]. Please email Becca Wagner at bw239209@ohio.edu with questions!
Appendix F: Child Life Competencies

INTRODUCTION

The following child life competencies are the minimal level of acceptable practice as defined by the Child Life Council, and are a guide for individuals or organizations who may wish to further define competencies specific to their situation. The order of competencies does not reflect a sequence or hierarchy of importance.

I. Care of Infants, Children, Youth and Families

A. Competency

The ability to assess and meaningfully interact with infants, children, youth and families.

Knowledge

• Articulate theories of human growth and development, play, and family systems.
• Describe formal and informal assessment techniques to determine developmental and emotional state.
• Describe the cyclical process of assessment, plan, intervention, and evaluation of child life services.
• Cite relevant classic and current research.
• Identify values related to sociocultural diversity.
• Articulate the tenets of patient- and family-centered care.
• Identify general issues in family dynamics.
• Identify diverse child rearing practices.
• Identify child and family’s concept of illness.
• Identify child and family’s concept of death and dying.

Skill

• Implement child life services using evidence-based practice.
• Use developmentally appropriate play as a primary tool in assessing and meeting psychosocial needs.
• Utilize therapeutic/creative modalities such as bibliotherapy to meet individual developmental and emotional needs.
• Match interactions and activities to developmental level, emotional state, and individual needs.
• Pace interactions in response to child’s* and family’s lead.
• Apply formal and informal assessment techniques to determine developmental level and emotional state.
• Apply the cyclical process of assessment, plan, intervention, and evaluation of child life care.
• Support the central role of the family, valuing strengths and needs in implementing child life services.
• Demonstrate respect for sociocultural diversity.

B. Competency

The ability to provide a safe, therapeutic and healing environment for infants, children, youth and families.

Knowledge

• Articulate the central role of play in child life services.
• Identify theories of play that best support child life practice.
• Describe the essential elements of the therapeutic relationship.
• Identify effective communication skills to support a child and family.
• Identify and describe the developmental and psychosocial goals of each activity and interaction.
• Explain the impact of environmental design on human behavior.
• Identify emotional safety hazards and corresponding preventive and protective measures.
• Identify environmental safety hazards and corresponding preventive and protective measures.
• Identify knowledge of privacy and confidentiality policies.

Skill

• Design group process to meet individual needs.
• Establish and maintain therapeutic relationships.
• Create an environment where play is valued.
• Establish and maintain a therapeutic and healing environment.
• Plan and implement varied developmentally supportive activities.
• Utilize effective communication skills in the process of supporting children and families.
• Provide input about facility design to promote orientation, comfort, healing, security and normalization.
• Follow infection control and safety policies and procedures.
• Demonstrate respect for and facilitate privacy and confidentiality.

C. Competency

The ability to assist infants, children, youth and families in coping with potentially stressful events.

Knowledge

• Identify factors that may impact vulnerability to stress.
• Describe coping behaviors specific to various age groups and populations.
• Describe immediate and long term coping styles and techniques, as well as their effect on adjustment and behavior.
• Articulate stress-coping theory.
• Articulate effective pain management techniques including non-pharmacological and psychological.
• Identify effective advocacy.

Skill

• Assess responses to stress; plan, implement and evaluate care accordingly.
• Facilitate opportunities for play to decrease distress and increase effective coping.
• Introduce and facilitate rehearsal of techniques to aid immediate and long term coping, with consideration for the unique needs of the individual and family, such as coping style, previous experience, developmental level, culture, spirituality, family situation and emotional state.
• Facilitate mastery of potentially stressful experiences.
• Utilize appropriate psychological pain management strategies.
• Empower and support patients and families to effectively self-advocate as well as advocate on behalf of those who cannot do so.

D. Competency

The ability to provide teaching, specific to the population served, including psychological preparation for potentially stressful experiences, with infants, children, youth and families.

Knowledge
• Identify basic terminology and processes, and expected course of care associated with the circumstances of the population served.
• Articulate learning styles and needs of individuals of different developmental levels, emotional states, and of diverse backgrounds and experiences.
• Identify literature and teaching techniques for use with individuals of diverse developmental levels and learning needs.
• Describe common fears, misconceptions and concerns of individuals in each developmental stage.
• Describe information processing theory and its implication for psychological preparation.
• Articulate fundamentals of psychological preparation found in child life literature.

Skill

• Assess knowledge level, misconceptions, previous experience, and unique sociocultural and learning needs.
• Determine realistic goals and objectives for learning in collaboration with family members and professionals, and identify an action plan to achieve these goals.
• Use accurate and developmentally appropriate teaching aids and techniques so that knowledge is increased and emotional needs are supported.
• Recognize verbal and non-verbal cues and adapt teaching accordingly.
• Use minimally threatening, developmentally supportive language.
• Describe sensory information, sequence, timing and duration of events.
• Facilitate planning, rehearsal and implementation of coping strategies.

E. Competency

The ability to continuously engage in self-reflective professional child life practice.

Knowledge

• Recognize and describe how personal challenges and learning needs in knowledge and practice skills may impact service delivery.
• Identify resources and opportunities for professional development.
• Articulate reasons for and impact of under-involvement and over-involvement of professionals with children and families
• Articulates the impact of one’s own culture, values, beliefs, and behaviors on interactions with diverse populations.

Skill
• Include evidence-based practice in decisions about assessment, care and evaluation.
• Implement a plan for professional development based on the needs of the population served and the knowledge and skill level of the child life specialist.
• Seek advanced practice mentors and peer supervision.

F. Competency

The ability to function as a member of the services team.

Knowledge

• Describe services and resources of other professionals and identify their roles and functions.
• Identify the unique contribution of the family and professionals in the provision of care.
• Articulate the organizational structure and function of the interdisciplinary team.
• Describe the impact of communication styles on groups and individuals.
• Identify the importance of advocacy in collaboration with the medical team.

Skill

• Communicate concisely with other professionals, integrating theory and evidence-based practice to obtain and share pertinent information.
• Demonstrate respect for the viewpoints of other professionals.
• Coordinate child life services with families and professionals.
• Integrate interdisciplinary goals into child life services.
• Create concise, objective and accurate clinical notes, documenting information pertinent to the plan of care.
• Recommend consults or referrals when circumstances are beyond the scope of child life practice.

II. Education and Supervision

A. Competency

The ability to represent and communicate child life practice and psychosocial issues of infants, children, youth and families to others.

Knowledge
• Describe and integrate the basic concepts of public speaking and teaching methods appropriate to subject matter and audience.
• Identify classic and current literature on issues related to child life services in a manner meaningful to the audience.
• Articulate the process for engaging in evidence-based practice.
• Identify and articulate a definition of advocacy.

**Skill**

• Adapt approaches, media and content according to audience need.
• Apply child life knowledge to contribute to the education of others.
• Maintain professional presentation of self, including careful attention to verbal and written communication, as well as personal appearance.
• Demonstrate effective advocacy for child life practice and psychosocial issues.

**B. Competency**

The ability to supervise child life students and volunteers.

**Knowledge**

• Discuss supervisory styles and their impact on others.
• Identify skills and knowledge necessary for others to complete assignments and tasks.
• Articulate student and volunteer program goals and expectations in the context of providing child life services.
• Identify adult learning needs.

**Skill**

• Provide comprehensive orientation to the setting, and policies and procedures of the work environment.
• Communicate expectations and roles clearly and concisely.
• Structure duties and assignments, matching ability to complexity of task.
• Provide regular feedback in a constructive manner.
• Assess and respond to diverse learning needs of students and volunteers.
• Recommend dismissal, after counseling, when performance does not match expectations.
• Evaluate student and volunteer programs and modify as needed.
• Provide a safe learning environment.

III. Administration
A. Competency

The ability to develop and evaluate child life services.

Knowledge

• Articulate basic research methods and statistics that apply to program review.
• Identify program components that require assessment.
• Identify meaningful data for effective evaluation of child life services.
• Describe resources to assist in evaluation and development of services.

Skill

• Collect and report accurate and pertinent data in a timely manner.
• Recommend program improvements based on data and existing resources.
• Develop and prioritize the range of child life services.

B. Competency

The ability to implement child life services within the structure and culture of the work environment.

Knowledge

• Identify organizational structure and relevant policies and procedures.
• Articulate the mission and goals of the work environment.
• Identify methods for obtaining and managing needed resources.
• Identify information necessary for effectively managing resources.

Skill

• Prioritize and organize workload for accurate and timely outcomes.
• Procure and maintain equipment and supplies in a cost-effective manner.
• Adhere to relevant policies and procedures.
• Advocate for positive change.

*Unless modified, refers to infants, children and youth.

November 1987
Revised and Approved November 2001
Revised and Approved November 2010
Appendix G: Ohio University Adult Consent Form Without Signature

The Impact of Child Life on the Medical Diagnosis Camp Setting

Researcher: Becca Wagner

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to participate in this study. You should receive a copy of this document to take with you.

Explanation of Study
I will be collecting data from professionals ages 22+ within the field of Child Life. These professionals must either be a Certified Child Life Specialist or in the process of being certified. These professionals must have either worked or volunteered at a medical diagnosis camp. The goal of this project is to assess the integration of child Life into the camp setting and to see if it is necessary.

If you agree to participate, you will be asked to fill out a brief 20 minute survey. This survey will be asking about your camp experience as well as your experiences as a CCLS.

Risks and Discomforts
No risks or discomforts are anticipated.

Benefits
This study is important to science/society because we will to be gain insight on the types of skills/strategies used by child life specialists at camp, and how these skills/strategies can improve the overall experience of medical diagnosis camps.

Individually, you may benefit because you will have the opportunity to look back and think about your professional experiences, and also share what makes camp so special to you.

Confidentiality and Records
The surveys will be de-identified. The surveys will be saved in a private folder on the researcher’s laptop, under password security. The surveys will be destroyed three years after the research has been terminated, approximately June 2019.
Additionally, while every effort will be made to keep your study-related information confidential, there may be circumstances where this information must be shared with:

* Federal agencies, for example the Office of Human Research Protections, whose responsibility is to protect human subjects in research;
* Representatives of Ohio University (OU), including the Institutional Review Board, a committee that oversees the research at OU;

**Contact Information**

If you have any questions regarding this study, please contact the investigator **Becca Wagner at bw239209@ohio.edu** or the advisor **Dr. Jenny Chabot at Chabot.ohio.edu**

If you have any questions regarding your rights as a research participant, please contact Dr. Chris Hayhow, Director of Research Compliance, Ohio University, (740)593-0664 or hayhow@ohio.edu.

By agreeing to participate in this study, you are agreeing that:

- you have read this consent form (or it has been read to you) and have been given the opportunity to ask questions and have them answered;
- you have been informed of potential risks and they have been explained to your satisfaction;
- you understand Ohio University has no funds set aside for any injuries you might receive as a result of participating in this study;
- you are 22 years of age or older;
- your participation in this research is completely voluntary;
- you may leave the study at any time; if you decide to stop participating in the study, there will be no penalty to you and you will not lose any benefits to which you are otherwise entitled.
Appendix H: Application Example

Camp CCLS Application

Functions of Position:

- Demonstrates the ability to obtain and interpret information in terms of the needs of campers ages 6 to 16
- Demonstrates an understanding of the range of treatment needed by the campers served.
- Advocates for procedure support and promotes adjustment and coping interventions for the children as appropriate.
- Advocates for campers by addressing clinical and psychosocial issues with the multidisciplinary team, in chart notes, and in conversation with counselors.
- Demonstrates the ability to effectively manage goal oriented individual and group programming.
- Documents all interventions executed with camper daily.
- Demonstrates ongoing assessments of camper adjustment to environment and adapts treatment plans accordingly.
- Assist in adaptive programming with the program team.
- Communicates regularly with campers, families and camp staff.
- Assists in the training and supervision of volunteers.

Demonstrates and promotes excellence in customer service.

Position Requirements:

- Education Requirements:
  - Child Life Certification is required: Employee will have one year from date of hire to sit for and successfully pass the Child Life Certification Exam.
  - Require Bachelor's degree in Child Life or Child Development or closely related field: Master's degree preferred.

- Knowledge, Skills and Abilities
  - Interpersonal skills necessary to communicate effectively and courteously with campers, volunteers, and members of the camp team.
  - Able to effectively communicate with children with special physical and psychosocial needs in a group or individual setting.
  - Ability to act quickly and decisively in emergency situations.
  - Able to communicate clearly, professionally and concisely both in written and verbal context.
Appendix I: Child Life Assessment Form

CHILD LIFE
ASSESSMENT SHEET

Camper: _____________________       Age: ______

ASSESSMENT
Diagnosis:

Medical History:

Family History:

Trauma:

Treatment Process:

Procedures:

Developmental Issues:

Emotional & Behavioral Issues:

Response to previous camp experience (if applicable):

Coping Style:

Comfort Items:

Likes/Dislikes/Fears:

Plan of care:

Goals:

Interventions:

PRIMARY CHILD LIFE CONCERN:

Other information:
Appendix J: Intervention Form

Intervention Documentation

Date:
Camper Age:
Intervention Performed:

Intervention Descriptions/Details:
- Goals
- Outcomes

Length of Intervention:

Staff Present: