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ORIGINAL PAPER

The Scope and Future Direction of Child Life

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Abstract
Child life specialists work in a variety of healthcare settings and help children and families to cope with stress through play, preparation, and education. The purpose of this study was to examine the current scope of child life practice. Child life specialists ($N = 147$), recruited through the listserv of the Association of Child Life Professionals (formerly the Child Life Council), responded to an online survey that examined demographics, work environments and settings, the range of services provided, and perceived levels of competence in providing these services. Results indicate that the typical child life professional is a Caucasian female age 34 years, has a bachelor's degree in child life or human development and family studies, is employed full-time in a children's hospital as a certified child life specialist, and has 9 years of experience in the child life field. Respondents indicated that they perform a wide range of activities and feel competent in performing the majority of these activities. However, gaps in academic preparation such as more knowledge about death and dying and increased skills in working with diverse families were identified. Additionally, respondents felt supported, yet, a lack of awareness of child life persists.

Keywords Child life · Child life profession · Family-centered care · Hospital Play Specialist

Introduction

Illness and hospitalization are potentially very stressful life events for children. This notion becomes even more salient considering that 2.1% of US children, ages 1–17 years, had one overnight hospitalization in 2015 and an additional 0.3% had two or more overnight hospitalizations that same year (National Center for Health Statistics 2017). These percentages represent a striking number of our nation's children experiencing an overnight hospitalization when population estimates of children ages 0–17 years were between 73.6 million (KidsCount.org) and 77.4 million (childstats.gov) in 2015. Children's overall well-being must be considered as they experience hospitalization, regardless of whether it is related to an acute or chronic health concern. Fortunately, over the past 100 years, there has been marked improvement in our understanding of the physical-psychosocial-emotional well-being of children and how children and families experience healthcare settings. From the beginning of the 1900s to the mid-1900s, the hospital setting for children looked much different than it does today. A typical hospital room provided minimal parental contact, limited cognitive stimulation or educational experiences, and little overall comfort for the child. There was a common belief among hospital staff that children who were uninformed about their diagnoses and procedures were saved from the accompanying fear and anxiety (Thompson 1989), yet research documented negative behavioral and emotional reactions in children who had undergone anesthesia and surgery and later concluded these negative reactions were related to separation from family, loss of control, and exposure to an unfamiliar hospital environment (Vernon et al. 1965; Brewer et al. 2006). By educating the child and family members and utilizing play as a vehicle to normalize the medical experience, the potentially detrimental effects of illness and hospitalization can be minimized.

Child life specialists are an integral part of the interdisciplinary healthcare team and can enhance the well-being and healthy coping of all family members during times of stress and uncertainty caused by illness, injury, and pain (ACLP 2017a). Child life specialists provide education and evidence-based and developmentally-appropriate

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interventions before and during hospitalization such as play, psychological preparation, procedural preparation, and family support (ACLP 2017a; Cole et al. 2001; LeBlanc et al. 2014). These interventions result in less emotional distress, better overall coping during hospitalization, clearer understanding of procedures, less time on narcotics for pain, reduced length of hospitalization, reduced fear among pediatric patients, and increased parent satisfaction (Gursky et al. 2010; Madhok et al. 2007; Wolfer et al. 1988). Specifically, therapeutic play has been shown to reduce children's emotional distress (Fereday and Darbyshire 2008), and developmentally appropriate activities such as play, art, reading, drama, and music can help lower children's anxiety levels, make their hospital experience less intimidating and scary, and facilitate children's development (Child Life Council and Committee on Hospital Care 2006; Isenberg and Quisenberry 2002). Procedural preparation, which can include rehearsal with dolls, puppet shows, coping and relaxation skills or orientation tours, aids in reducing fear and anxiety in children undergoing a medical procedure and promotes short-term coping and long-term adjustment to future healthcare experiences (Brewer et al. 2006; Koller 2008). In addition to preparation and play, children need the opportunity to learn and practice coping skills such as breathing techniques or positioning for comfort to reduce the potential stress associated with hospitalization (Dolidze et al. 2013).

While the overarching goal of child life is to support the child, an essential component is to involve and support the family. Patient- and family-centered care is grounded in collaboration among patients, families, and health care specialists, and the American Academy of Pediatrics (AAP) recognized that child life specialists are key in the "establishment of therapeutic relationships with patients, siblings, and parents to support family involvement in each child's care" (American Academy of Pediatrics 2014, p. 1471). The core principles of patient- and family-centered care include: (a) listening and respecting each child and family member, (b) ensuring flexible organizational policies and provider practices tailored to the unique needs of the child and family, (c) honest and unbiased information sharing, (d) providing and/or ensuring formal and informal support, (e) collaboration with patients and families at all levels of health care, and (f) recognizing and building on the strengths of individual children and families (American Academy of Pediatrics 2014).

Child life specialists can minimize family members' anxiety by providing services and advocacy to them during hospitalization (Brewer et al. 2006). In particular, parental anxiety is a significant factor to consider as it positively correlates with children's anxiety (Kain et al. 2002). Encouraging parental presence when appropriate, encouraging care team members to allow children to have their attachment items with them when possible, and promoting comfort positioning, can all have a positive impact on child outcomes (Heard 2007).

In addition to parents, well-siblings of a hospitalized child may be at risk to experience psychological difficulties (Sharpe and Rossiter 2002). Parents have noted that siblings sometimes exhibit feelings of guilt and jealously, academic underachievement, somatic problems and acting out (Sharpe and Rossiter 2002). Child life specialists can play a critical role in helping well-siblings learn to adapt to the effects of having a sibling with a chronic illness (Van Dongen-Melman et al. 1995).

Utilizing a holistic patient- and family-centered approach to children's care, the professional healthcare team empowers the family system to more effectively cope with the child's illness. Enhanced coping skills promote resiliency and overall healthy family functioning during times of stress, and "the provision of child life services is a quality benchmark of an integrated patient- and family-centered health care system, a recommended component of medical education, and an indicator of excellence in pediatric care" (American Academy of Pediatrics 2014, p. 1471).

While the field of child life is rapidly growing in North America, there is still limited awareness about child life services and the responsibilities of child life specialists outside of pediatric healthcare team members in children's hospitals. While healthcare specialists may be aware of child life, they often do not have a comprehensive understanding of educational and training requirements, services provided, and the role of child life specialists within the interdisciplinary healthcare team. Child life professionals encompass both certified child life specialists (CCLS), who currently need a minimum of a bachelor's degree including a course taught by a CCLS, and child life assistants, who need a minimum of an associate's degree. Child life assistants primarily provide play programming, whereas CCLSs provide a broader range of services. For purposes of this study, we focused on CCLSs. Since 1986, the Association of Child Life Professionals (ACLP) has provided certification for child life through an application process, and subsequently incorporated a certification examination in 1998 as a means of ensuring minimum knowledge and skills to meet standards of clinical practice.

The ACLP continues to monitor the evolving needs of child life professionals and revised eligibility requirements for individuals pursuing certification starting in 2019 (ACLP 2018). The revisions include a minimum of a bachelor's degree in any field of study or the international equivalent and the following course requirements: (a) one course taught by a CCLS with prescribed credentials, (b) loss / bereavement or death /dying, (c) research, (d) child development, (e) family systems, (f) play, and (g) three additional courses in child life or child development, with

recommendations such as human anatomy / physiology, medical terminology, and ethics. In addition, candidates for certification must complete a minimum of 600 h in a clinical internship under the direct supervision of CCLS with prescribed credentials. These revisions illustrate the ever-changing and demanding roles and responsibilities of child life specialists.

While many of the roles of child life specialists (e.g., procedural support, health care play) have been highlighted in the literature (LeBlanc et al. 2014; McGee 2003), there is still a need to fully understand the scope and potential of child life services. Therefore, the aims of this study were to identify: (a) a demographic profile of child life specialists; (b) details of the work environments for child life specialists across a variety of settings; (c) the range of child life services provided, (d) child life specialists' perceived levels of competence in providing child life services.

Method

Participants

There were 147 surveys completed by members of the Child Life Council, now known as the Association of Child Life Professionals (ACLP). Overall, 99% of respondents were female and all were past or current child life specialists. The mean age was 34.2, with ages ranging from 23 to 62 years ($n = 122$, SD = 9.4). The majority (96%) were from the United States and represented 34 different states. The remaining 4% lived in Canada. The racial and ethnic background of respondents included 93% Caucasian, 4% Hispanic and 3% other.

Procedure

This was an exploratory study with data collected from child life specialists through an online survey tool. The survey was distributed via the ACLP listserv, which is an email list of professionals within the field of child life. Listserv members received an email inviting them to participate in the study and containing a link allowing access to the survey if they chose to participate. Completion of the survey indicated consent to participate. Participation was voluntary and no incentive for participation was provided. Subscription to the listserv is not limited to those who are members of the organization or those working in the field. Therefore, inclusion criteria for the study included currently or previously employed as a child life professional. Reminders were sent twice after the initial email at two-week intervals. Prior to data collection, the study was approved by the institutional review board at the researchers' home institution.

Measures

The survey, developed by the authors, contained basic demographic questions such as gender, age, ethnicity, level of education, and country of residence. Additional questions addressed child life certification status, professional memberships, years of experience as child life professional, job title, work setting including facility type (i.e., children's hospital, pediatric rehabilitation facility, private practice) and primary unit assigned (i.e., pediatric floor, pediatric intensive care unit, emergency department), and populations served (i.e., newborn, infants, toddlers, preschool, etc.). Perceived level of support from other health care specialists and from upper administration was each measured with a single item using a 5-point scale with response options of "no support" to "extremely supported." Frequency of performing 14 different tasks was measured with the following response options: never/infrequently, daily, weekly, monthly, few times a year, and annually. Perceived competence in doing these tasks were measured with response options from "not at all competent" to "extremely competent." Typical tasks included in child life services were generated from a review of the literature and included items such as preparation of children, engaging in one-on-one play, and charting. An open-ended question assessed additional knowledge, skills, or experiences desired in their child life education and training. A final open-ended question asked for any additional comments.

Data Analyses

Following data collection, the data were exported to SPSS. Quantitative data were analyzed using descriptive statistics, *t*-tests, and analysis of variance. Qualitative data were manually analyzed by the first and second authors using thematic analysis. Each author independently analyzed the data and initially identified two broad themes: content knowledge and skills. Under each broad theme, specific sub-themes emerged. The two authors then discussed their independent themes and negotiated a common ground. The final phase included the authors reviewing the broad themes and sub themes and reaching consensus.

Results

Table 1 provides demographic information on the 147 respondents. All respondents had at least a bachelor's degree, with child life ($n = 29$), and human development/family studies ($n = 46$) the most common programs from which they received their degree. Twenty-two respondents minored in child life and another 20 minored in human development and family studies or early childhood

Table 1 Demographic Results

Category	*n*
Undergraduate education	
Child life major	29
Human development/family studies /family science major	46
Psychology/child psychology major	26
Education major	11
Recreation / art therapy major	6
Other social science majors	10
Other majors	10
Not specified	9
Graduate education	
Human development/family studies	26
Child life	14
Education	9
Psychology	3
Health care administration	4
Other majors	6
Organization affiliation	
Child Life Council	147
American Therapeutic Association	1
National Council on Family Relations	1
Hospice and Palliative Care	1
National Association for the Education of Young Children	6
Lactation Association	2
Other	12
Professional title	
Certified child life specialist	132
Child life administrator/manager/coordinator	12
Other	3
Work environment	
Children's hospital	108
General hospital	25
Other settings	14

education. Nearly half of respondents had master's degrees ($n = 62$, 45%) and none had a doctorate degree. Full time employees ($n = 123$) comprised 85% of the sample, with the remaining 15% working part time ($n = 21$).

In addition to being members of the Child Life Council (now Association for Child Life Professionals), 32% ($n = 47$) indicated they were also a member of at least one other professional organization (See Table 1). The majority of respondents (94%; $n = 139$) were currently employed in child life at the time of the study and 97% ($n = 142$) were certified child life specialists. Respondents had been certified for an average of 7.96 years (SD = 6.77) with a range of 1 to 34 years, and the average length of time working in the child life profession was 8.97 years (SD = 8.48; range = 6 months–40 years). For the 6% ($n = 9$) of respondents who were not currently working in child life, the reasons for leaving the profession were varied. The two most common reasons were their position was eliminated ($n = 3$) and geographic relocation ($n = 2$).

Professional Title

The majority ($n = 131$) listed child life specialist as their official job title. Another 10 respondents had job titles that denoted an administrative role such as child life administrator/manager or child life specialist team lead. Of the 10 respondents with an administrative job title, eight of them had a master's degree. Other job titles were varied and included: play therapy assistant, child & family life supervisor, child life coordinator, and patient experience representative. Respondents reported an average of 9.6 (SD = 8.60) child life specialists employed in their workplace. Outliers (38, 40, 80) were eliminated from analysis because they were more than two SD from the mean. Other specialists that were identified as being part of the team included music therapists, art therapists, teachers, volunteers, bereavement or palliative care coordinators, chaplains, and other health specialists such as recreational or occupational therapists.

Work Environment

The majority (93%) of respondents were employed in children's hospitals ($n = 108$) or in general hospitals ($n = 25$). Fourteen respondents identified their work environment as an alternative setting which included: (a) clinics; (b) pediatrician offices; (c) pediatric rehabilitation facilities; (d) community-based services; (e) educational facilities; (f) private practice; (g) long-term care/hospice/homecare; and (h) child advocacy centers. Many respondents indicated that they had more than one work setting (e.g., children's hospital and clinic).

Using a 5-point Likert-type scale ranging from no support (1) to extremely supported (5), respondents rated their perception of support from their upper administration resulting in a mean of 3.54 (SD = 1.01) and their perception of support from other health care specialists in their work setting (M = 4.02, SD = .837). Perceptions of support did not vary depending on type of work setting (e.g., children's hospital, alternative setting). Size of the child life program was determined by the number of child life specialists employed, with four or less being a small program, 5–12 being a medium program, and a program that employed more than 12 child life specialists considered a large program. There were no significant differences in perceived support or activities performed based on program size.

Respondents reported interacting with an average of 16 different patients in a typical day (SD = 12.07; Range

0–66). In addition to providing services to children of all ages, 90% ($n = 133$) reported providing services for the siblings of their patients, 84% for parents, grandparents and other adult caregivers, and 47% ($n = 67$) for other health specialists. Although child life specialists provide services to the whole family, their patients are the focus of their work. When ranking the *time* spent with different populations, patients ranked first followed by parents or grandparents, other health specialists, and siblings of the patients. Other populations with whom respondents interact included students, volunteers, community, friends of parents or patients, and co-workers. There were no significant differences between child life program size (small, medium, large) and populations served or support services provided.

Scope of Activities & Levels of Competence

The frequency of engaging in a variety of child life activities was rated using a 5-point Likert-type scale with a higher score representing greater frequency. Their perceived competence in performing these activities was then rated using a 5-point Likert-Type scale with a higher score representing greater perceived competence. Preparation of children was the most frequent activity. Overall, respondents felt competent with the tasks in which they engaged (See Table 2).

A competency scale was created from the 20 items included in Table 1 (Cronbach's alpha = .89). Respondents with a master's degree ($n = 50$) perceived themselves as more competent than those without ($n = 59$) ($t = 2.08$; 107; $p = .04$). Using a median split, respondents ($n = 52$) with more experience (>6 years) in the child life profession perceived themselves as more competent than those ($n = 57$) with less experience ($t = 3.02$; 107; $p = .003$).

Academic Preparation: Content Knowledge and Skill Development

When asked what was lacking in their academic preparation, two themes emerged: additional content knowledge, and development of certain skills necessary in their role as a child life specialist. Respondents identified gaps in content knowledge that can be categorized into the following five areas: (a) death, dying and bereavement; (b) medical play and procedural preparation; (c) medical terminology of specific diagnoses; (d) research methods; and (e) family life education activities for parents, siblings, and the community.

Overwhelmingly, respondents noted that the areas of death, dying and bereavement were major gaps in their knowledge base. End of life issues were areas in which respondents felt less prepared to deal as child life specialists and highlighted the need for knowledge about this as well as skills in talking with families about death and dying. One participant elaborated by saying, "Until my internship, I was unaware of the role a CCLS played in bereavement. There should be more education regarding death and cultures, self-care following death, illness and the roles that different cultures / religion play in the hospital."

Table 2 Frequency and perceived competency of child life activities

Activity	Frequency M (SD)	Perceived competence M (SD)
Preparation of children	4.71 (.71)	4.80 (.46)
Charting	4.67 (.78)	4.55 (.60)
Preparation of parents	4.46 (.79)	4.65 (.63)
Engage in 1 on 1 play	4.43 (.80)	4.82 (.39)
Administrative tasks	4.41 (.85)	4.56 (.63)
Sanitizing toys/Equipment	4.17 (1.12)	4.76 (.56)
Meeting with Health Care Team	4.15 (.96)	4.5 (.67)
Preparation of siblings	3.85 (1.02)	4.72 (.53)
Supervising volunteers	3.60 (1.27)	4.48 (.72)
Supervising students	3.57 (1.17)	4.24 (.88)
Education of the health care team	3.52 (.94)	4.26 (.82)
Making referrals	3.40 (1.34)	4.09 (.92)
Playroom play	3.38 (1.35)	4.78 (.45)
Patient programs	2.86 (1.49)	3.97 (.94)
Sibling programs	2.44 (1.24)	4.01 (1.00)
Parent programs	2.30 (1.15)	3.66 (1.10)
Facilitating patient support groups	1.67 (1.11)	3.68 (.99)
Community fairs/Health fairs	1.53 (.71)	3.84 (1.07)
Facilitating sibling support groups	1.48 (.90)	3.61 (1.03)
Facilitating parent support groups	1.44 (.91)	2.99 (1.17)

Child life specialists are expected to demonstrate expertise in the areas of medical play and procedural preparation for children in stressful situations. Respondents highlighted additional needs and offered suggestions such as "…it would be very beneficial for the CLC (Child Life Council) to have a library of videos showing CLS (child life specialists) doing medical play." Another participant shared a similar idea, stating that "development of actual prep kits / books, writing curriculum / activities for the playroom" would be beneficial. Multiple respondents identified the need for "more opportunities for procedural prep, procedural support, and working in child life in alternative settings".

Child life specialists interact with children who have a myriad of medical conditions, so it was not surprising that they stated a need for medical terminology. Respondents stated that "getting more of a medical base knowledge" would be particularly advantageous to educate and prepare children and their families with developmentally appropriate information related to their diagnoses.

Respondents highlighted the need for research skills in their role as child life specialists and believe they would benefit from a better of understanding of "research methods and how to conduct research." Another respondent said she would benefit from education on "evidence-based practices and how to design and carry out research studies."

With a focus on the entire family system, respondents identified the need for knowledge of family life education activities involving parents, siblings, and community. Family life education is a domain of family practice that utilizes a preventive and educational approach to enable individuals and families to function optimally (Myers-Walls et al. 2011). Core areas of family life education include communication skills, knowledge of typical human development, decision-making skills, positive self-esteem, and healthy interpersonal relationships. Respondents identified the need for "more educational experiences working with parents / parenting education" and "more emphasis on the importance of community resources for patients and families to promote ongoing care and coping." One participant stated, "I would like more experience with parent / sibling programs… unfortunately I haven't had the opportunity in my current position. I would attend a conference or other available sessions to learn more about conducting these if they were available."

Another significant gap in academic preparation identified in this survey was related to skill development. Respondents highlighted the need for education related to three specific skill sets in the following areas: (a) self-care and setting appropriate boundaries; (b) working effectively with administrators and other members of the healthcare team; and (c) administrative skills.

Child life specialists providing direct services to children and families may experience stress, and one participant recognized the need to "practice self-care and set appropriate professional boundaries to avoid burnout, compassion fatigue, and vicarious trauma." Often it is the child life specialist that families turn to for education, information, emotional support, and identification of resources. Multiple respondents highlighted the need for professional boundary-setting, as illustrated by the following quote:

> Professional boundaries are really needed… I think we are sadly lacking as a profession where this is concerned; even if you want to help every child, there is no way possible. Setting boundaries for yourself professionally and personally really goes a long way.

The child life profession may not be as well-known as other healthcare disciplines. As such, one participant stated she "would like to learn more about the most effective ways to educate other people about our job and ways to encourage them to consult child life services more often and more appropriately." With such education, respondents stated they "would not constantly be fighting for myself and my job against others who, for the most part, don't care unless it benefits them somehow" and noted that it would assist with "conflict resolution and working with people who may not understand or respect your work / position." In addition, multiple respondents identified the need to know "how to be more assertive with the administration" and develop "interpersonal skills and conflict management within the overall healthcare system."

An additional responsibility of the child life specialist is the supervision of other child life staff, volunteers, and students. Effectively managing the often competing roles as a child life specialist, respondents identified the need for administrative skill development. Specifically, one respondent said:

> More training on the administrative and policy tasks is needed. I came into a small hospital and serve almost exclusively in a leadership / management role. Many CCLS (certified child life specialists) that are hired into small programs face this challenge. I think that we could have more support from the CLC (Child Life Council) in the form of documents and guidance for small programs. For instance, a policy bank with examples of common policies that could serve as templates would be helpful.

In addition to a repository of commonly used documents and written policies, one participant suggested "an administrative class about how to manage budgets and implement different programming in a hospital setting" would alleviate some of the stress related to administrative tasks of the child life professional and the feeling that each has to "reinvent the wheel."

Overall, the content knowledge and skill sets identified by respondents highlighted specific gaps in their academic preparation. Other responses revealed a need for additional multi-faceted learning opportunities to better prepare them to work holistically with the entire family system. Two themes emerged from these qualitative responses that illustrate a cross-over of knowledge and skills related to family-centered practice: (a) family interaction and (b) cultural nuances. Child life specialists are typically considered the child and family experts on the healthcare team. As such, they are expected to have the knowledge and skills necessary to educate and support the child and all family members. Multiple respondents identified the need for "more discussion related to family dynamics" and "styles of family coping." Even though child life academic preparation programs utilize a family systems orientation, challenges arise when considering that every family is unique in such areas as communication, interaction, roles,

responsibilities, and expectations. In many instances, it is the cultural nuances of each family that requires the child life professional to be flexible in meeting these varied family needs. Multiple respondents underscored the need to better understand "cultural diversity and the impact on families" as they work to meet the needs of all families.

Child Life: A Unique Profession

When asked for additional comments related to their role as a child life professional, respondents highlighted three main themes: (a) managing multiple responsibilities; (b) growth and positive changes in the profession; and (c) a passion and commitment to child life. Child life specialists work in a variety of settings and with different populations. Respondents stated the need to be skilled and well-versed in many areas; they "juggle many responsibilities… such as working with different populations, in different settings, that require different skills." For example, one noted, "I have worked in a pediatric burn hospital, pediatric emergency center, sexual abuse center, and am currently in an intermediary care unit.", while another stated, "I work full time in a playroom which seems rare in the profession". Child life specialists must possess the knowledge and skills to effectively interact, educate, and support children and families under stress, regardless of the setting. The following quote embodies the essence of the scope and practice of a child life specialist:

> We wear many, many, many hats. I often feel as though when my nursing staff doesn't know what to do or how to answer a question, their first thought is "let's ask child life!" It is gratifying to be thought of as a resource and to be in a position to help patients and families navigate the hospital experience. However, this can also be draining and frustrating when you become the go-to person for not only play, preparation, and support but also for fixing TVs and video games, providing underwear, coordination of special visitors, finding teddy bears lost in the laundry, etc. Balancing the many aspects of the child life role in order to maximize patient care time is a constant challenge.

Child life as a specialty has also evolved over the past 100 years, and respondents highlighted the growth and positive changes in the profession. One respondent shared:

> I have been so fortunate to see the growth of the profession. When I started out there was an application process to become certified. I feel the examination gives much more credibility to the field. The growth in the programs, with both more professions as well as new programs in hospitals, has been a positive experience.

Another had similar thoughts: "The field has changed a lot since I started. Also, I feel quite competent but there is always room for improvement and we should strive to continue learning". This sentiment was echoed by multiple respondents as they shared their desire to contribute as members of the healthcare team.

The desire to grow as specialists was illustrated in respondents' statements of passion and commitment to the child life profession. There was a resounding theme among respondents that they "love being a CLS" and it is "one of the most rewarding and challenging roles I have ever held!!!". Another echoed this emotion by stating "I thoroughly enjoy my job as a CLS… Once I found child life, my life has been complete and I feel that I make a difference every day in the lives of children and their families."

> Perhaps the diversity of the children and families with whom they work, and the varied settings in which

they work, provides the catalyst for their passion and commitment, as illustrated by one respondent who stated:

> I've been in the profession for a very, very long time. I never find it boring. Daily I am amazed by the strength and resiliency of the kids and their families. Love my job. Love creating a sense of community within the hospital world. Always… always something NEW to learn and to teach to the families!

Discussion

Whereas other studies have highlighted child life services in settings such as the NICU (Smith et al. 2014), the current study included a full scope of child life specialists working in a range of hospital units. Our results indicated that the typical child life professional is a Caucasian female, age 34 years, has a bachelor's degree in child life or human development and family studies, is employed full-time in a children's hospital as a certified child life specialist, and has about 9 years of experience in the child life field. These findings are similar to those reported by S. and T. (1996), who found the majority of child life specialists had a bachelor's degree in child life or child development, and were a certified child life specialist with an average of 3 years in the child life field. Our data revealed little racial and gender diversity among child life specialists. As child life specialists continue to work with diverse families, it is essential to have diversity within the profession.

It appears that a balance between knowledge and skills is necessary to be an effective child life professional. Respondents with a MS degree and those with more experience felt more competent providing the range of services required in their daily activities. This finding underscores the value of both education and experience. As a result of the new eligibility requirements for certification that begin in 2019, one could hypothesize that entry level child life specialists may likely be better prepared to address the needs of the children and families they serve as a result of prescribed coursework and more intensive clinical internship.

As academic preparation programs create or revise master's level curriculum, important future components to be considered include dying, death and the bereavement process, family dynamics and cultural nuances, and medical terminology related to specific diagnoses. Currently, child life specialists are required to complete 50 h of professional development every 5 years for recertification. Starting in 2019, 60 h of professional development will be required to maintain certification. Thus, graduate level coursework and professional development in these areas will allow for in-depth study and additional hands-on practice for continued skill enhancement.

Results of this study are consistent with previous research indicating the need for clearly defined work roles, the importance of practicing self-care and setting professional boundaries, and an emphasis on support systems needed in the child life profession (Holloway and Wallinga 1990; Munn et al. 1996; Shuck et al. 2013). Respondents' sense of support validates the essence of collaboration and the contribution of each team member to strengthen the overall health care experience for all family members.

As child life specialists provide a variety of services to diverse populations in diverse settings, it is imperative for academic preparation programs to embrace the overall mission of child life to support children and families under stress. Current specialists voiced that they are required to "wear many hats" and as such are well positioned to expand the settings and populations they serve. Healthcare is no longer limited to the hospital setting; thus, it is critical for the child life profession to expand the role of child life specialists beyond the hospital walls. In addition to the required practicum and internship components, child life students would benefit from other hands-on experiences that would increase their capacity for working holistically with families in diverse settings such as parent education or family support programs. Other changes can be made to expand the traditional perceptions of child life. For example, course titles such as "hospitalized child" could be changed to "children's health and well-being" or something similar as a way to reframe how we prepare students to think about the diverse settings in which child life services are provided.

As the field of child life continues to evolve in an effort to meet the diverse needs and challenges of children and families, key components of family-centered care must remain in the forefront. The American Academy of Pediatrics (2014) recognized the role of child life specialists in an integrated health care team: "Certified child life specialists (CCLSs) are part of an interdisciplinary, patient- and family-centered model of care, collaborating with the family, physicians, advanced practice providers, nurses, social workers, and other members of the health care team to develop a comprehensive plan of care" (p. 3). Given that the family is generally a constant in a child's life, family members should be actively involved in the care and decision-making process related to the child. Specialists working with children and families may make the assumption that families typically know what is best for their children. However, CCLSs may be in the unique position to best support each family member, based on developmental level, coping style, and other situational factors (LeBlanc et al. 2014). It important for the entire healthcare team to recognize that patients and their families define what is considered family, which may include two or more persons who are related in any way – biologically, legally, or emotionally (Institute for Patient- and Family-Centered Care 2015). Academic training and ongoing professional development in the areas of family interactions and cultural nuances are essential in creating a truly patient- and family-centered model of care.

In many healthcare settings, the healthcare specialists, parents, and other specialists typically focus on the child under care. This limited focus may result in the well sibling (s) receiving less attention (Barlow and Ellard 2006, LeBlanc et al. 2014). Results of the current study supported the idea that well siblings are the sometimes "forgotten population." Although 90% of the respondents reported working with well siblings, it was cited as receiving less time than the hospitalized sibling, highlighting the ongoing need for child life specialists to address sibling needs. Research on the impact of a chronic illness on the well-being of siblings has yielded mixed results. Potential negative effects include emotional distress but also positive outcomes such as being caring, supportive, responsible, and independent were found in siblings of chronically ill children (Houtzager et al. 2004; Sharpe and Rossiter 2002). Psychosocial outcomes of siblings should be viewed along a fluid continuum (Houtzager et al.; 2004) and child life specialists should be aware of the context and the individual when assessing the best way to address the needs of the well sibling.

Respondents highlighted a concern that other members of the healthcare team often do not recognize child life as an

important part of patient- and family-centered care, and indicated the ongoing need to increase awareness among various stakeholders about child life services and the role of child life specialists This finding is consistent with that of LeBlanc et al. (2014) who reported that many people including family members and health professionals are not familiar with the role of child life specialists. Thus, while the child life specialists have a comprehensive educational background to effectively address developmental, psychosocial, and emotional needs of children and their families during times of stress, respondents emphasized a desired to increase their skills in educating others about child life services and the proper utilization of them. Child life specialists' background in child behavior and development enables them to educate referring physicians, nurses, and other medical staff about realistic expectations of a child's abilities to cope with the demands of medical procedures (McGee 2003). Child life specialists need advocacy and leadership skills to inform stakeholders such as hospital administrators, health care providers, or providers of auxiliary services such as music or animal-assisted therapy about the child life profession and the benefits of including a CCLS on the healthcare team. As such, a greater awareness of child life services may foster a collaborative environment which ultimately enhances patient- and family-centered care (Shuck et al. 2013).

The ACLP is clearly a primary organization for child life specialists, but respondents indicated membership in a range of other professional organizations such as the Lactation Association and the American Therapeutic Recreation Association. This range of professional memberships among respondents reflects the broad scope of child life as a profession. Multiple influences from supporting programs can only serve to augment the services provided by child life specialists and serve as a bridge to other health professions such as nursing, physical therapy, or speech therapy.

Respondents identified multiple responsibilities of child life specialists and additional services that could be incorporated into existing programs. Our findings support recommendations by the American Academy of Pediatrics for child life services to expand beyond pediatric inpatient medical-surgical settings such as emergency services, day surgery, imaging, specialty care clinics, and neonatal intensive care and auxiliary programs such as animal-assisted therapy, infant massage, or music therapy (American Academy of Pediatrics 2014). Hicks (2008) edited a book entitled *Child Life Beyond the Hospital* that included many examples of child life in alternative settings (i.e., bereavement programs, camp programs, dental settings, early intervention, funeral homes, legal systems). Emerging empirical literature supports child life services in many of these diverse settings including camps (Dawson et al. 2012; Desai et al. 2013), sibling support programs (Newton et al. 2010), working with children of adult patients in intensive care units (Flick et al. 2014), and in conjunction with auxiliary services such as animal-assisted therapy (Kaminski et al. 2010), music therapy (Colwell et al. 2013), and art therapy (Yount et al. 2013). Now may be the time to challenge the traditional model of a child life specialist only working in hospitals and clinics, and to make child life services standard in any setting serving children and families experiencing life stressors. With the ever-changing healthcare landscape, the current child life specialist can lead the charge to expand the benefits of child life services in any potentially stressful or traumatic setting.

Strengths, Limitations, and Future Directions

It is an exciting time for the child life profession and the current study provided a fresh lens with which to view it. Child life specialists are an essential part of the integrated healthcare team, providing patient- and family-centered care and striving to reduce the negative impact of stressful or traumatic life events and situations that affect the development, health and well-being of infants, children, youth and families. Overall, the current child life specialist engages in and feels competent in a wide range of activities. Child life specialists wear many hats, fulfill many roles within medical settings, and must possess knowledge and skills to address a multitude of responsibilities in their position. In many instances, the child life specialist is the "go to" person when other healthcare specialists need assistance with a child and his/her family. Data indicate that child life specialists are highly committed to their career and possess a passion and energy that drives their interactions with children and their families.

There were some limitations of this study. The sample for this study was limited. There are more than 5000 members of the ACLP and all have access to the listserv that was used to recruit the sample for this study. It is not known how many of the more than 5000 members were eligible for our study (e.g., previously or currently working in the field). However, our sample size of 147 was a very small response rate. We are unaware of how those who did not respond might differ than those who did respond. Therefore, caution should be used in generalizing results of this study. Finally, the data were self-reported, and respondents' perceived competence might not have reflected their actual competence levels. Although this study included a smaller sample size, results have provided a snapshot of the current scope and practice with an eye to future possibilities for child life. Insight gained from this study may provide a launch pad for the profession to move to the next level.

Future research should include program evaluation and effectiveness studies that demonstrate the impact of child life specialists' contributions to the interdisciplinary health care team. Various levels of evaluation that would be helpful in documenting the value of child life include: utilization data (e.g., how many children use the program or how many siblings attend the sibling program), process data (e.g., how well are the services being provided, are families satisfied), and impact data (e.g., what effect do child life services have on child outcomes). These types of evaluation data in conjunction with the support child life specialists feel from their supervisors, will strengthen the position of child life specialists as an integral part of the collaborative health care team.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Ethical Approval The study was approved by the institutional review board at East Carolina University. All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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