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Cultural Competence Among Child Life Professionals

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Cultural Competence Among Child Life Professionals

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Abstract

There is an ever-growing need for individuals to work towards cultural competence, especially when those individuals work in healthcare. As healthcare professionals with backgrounds in child development and who provide emotional and psychological support to diverse pediatric patient populations in a variety of different sectors, child life specialists (CLS) and Certified Child Life Specialists (CCLSs) have an even greater need for understanding cultural competence (Thompson, 2009). The purpose of the current study was to examine the cultural competency levels of CCLSs, the type of cultural competence professional development units (PDUs) they participate in, and their perspectives on cultural competence in child life through survey research. The hypothesis was that the greater number of PDUs related to cultural competence that a CCLS completes, the more culturally competent that individual will be. A total of 97 CCLSs participated in an online survey that asked questions regarding their background, level of cultural competence, as well as the types of Professional Development Units (PDUs) that they have completed that focus on cultural competence or related topics. A significant positive correlation between the number of cultural competence PDUs and interaction engagement subscale of the ISS, indicating that CCLS participants who reported higher cultural competence PDUs also indicated higher reports of engaging with people of different cultures was found. The study also worked to further research on cultural competence within the field of child life as well as explore the connections between certain demographics and levels of cultural competence.

Acknowledgements

Words cannot express my gratitude to everyone who has helped me along the way to this moment. I could not have gotten here without the tremendous help from my committee chair Dr. Jacquelyn Mosley, and my committee members Dr. Betsy Garrison and Dr. Weiyi Ma. I cannot thank them enough for offering me their time, knowledge and expertise, and for guiding me in the right direction. I am also grateful for my undergraduate advisor and honors thesis mentor Ms. Donia Timby, who without her help I never would have reached my dream of becoming a Certified Child Life Specialist. This endeavor would also not have been possible without the endless love and support of my parents, Rick and Kate Burger, my fiancé, Connor Isaacks, and my many other amazing family members and friends. Without their unwavering support and encouragement I never would have had the courage or ability to continue along this journey. Lastly, I would like to thank all of the child life specialists that helped me become the child life specialist that I am today, and thank you to all the child life specialists out there that are doing amazing work to help their patients and families.

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Introduction

There is an ever-growing need for individuals to work towards cultural competence, especially when those individuals work in healthcare. In order to be able to best serve diverse patient populations, healthcare workers need to recognize the importance of cultural competence and culturally responsive care (Rollins, 2005). By placing an emphasis on understanding their own cultural identity as well as understanding how the cultural identity of others can impact their interactions, healthcare workers will be able to provide more culturally competent care. As healthcare professionals with backgrounds in child development and who provide emotional and psychological support to diverse pediatric patient populations in a variety of different sectors, child life specialists (CLSs) and Certified Child Life Specialists (CCLSs) have an even greater need for understanding cultural competence (Thompson, 2009).

The purpose of this research study was to examine the cultural competency levels of CCLSs, the type of cultural competence professional development units (PDUs) they participate in, and their perspectives on cultural competence in child life through survey research. The survey instrument asked about cultural competence levels of current CCLSs, attitudes and perceptions on cultural competence related and PDU related topics, and the types of professional development units (PDUs) that they have completed that focus on cultural competence, as well as some basic demographic characteristics.

In order for the field of child life as a whole to become more inclusive and culturally competent, empirical knowledge must first be gathered on current cultural competency levels of professionals in the field. Steps can then be made towards furthering professionals' cultural competency and better preparing CLSs for working with diverse patient populations so that they are better able to meet their specific and varied needs.

Literature Review

Overview of Child Life

Child life professionals, also referred to as child life specialists (CLSs) or Certified Child Life Specialists (CCLSs) are individuals who work in healthcare settings and use evidence-based interventions to help pediatric patients manage their fear, anxiety, and pain during medical procedures (Bottino et al., 2019). Child life specialists typically have educational backgrounds in child development or in related fields, and they use their knowledge of child development theories to provide psychological support to both children and their families in healthcare environments (Marshall, 2018). Roles of child life specialists include: promoting positive coping in children and their in healthcare settings by engaging in developmentally appropriate play, providing psychological preparation prior to medical procedures, educating patients/families about the hospital environment, medical equipment, and illnesses/diagnosis, providing sibling and family support, creating and implementing coping plans, and providing distraction and support during medical procedures (Thompson, 2009). CCLSs are members of the interdisciplinary team and work alongside other healthcare professionals to promote coping and enhance the overall health care experience for patients and families (Romito et al., 2021).

Overview of Cultural Competence

There is no one singular definition of cultural competence (Shaya & Gbarayor, 2006). Cultural competence has been described as an ongoing, multidimensional construct made up of

knowledge, awareness, and skills that encompass beliefs that people should recognize as well as appreciate other cultural groups and be able to interact effectively with them (Benuto et al., 2018). Another definition of cultural competence is "the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, spiritual traditions, immigration status, and other diversity factors in a manner that recognizes, affirms, values, and preserves their dignity" (Danso, 2018, p. 412). Although both definitions vary in terms of how they define cultural competence, both include awareness and respect of the multidimensional aspects of culture. Cultural competence is not something that can ever be truly achieved. It is a continuous process that is continually being worked towards across the lifespan (Matveev & Merz, 2014).

The need for cultural competence in professional fields such as child and human services is becoming quite evident (Danso, 2018). The population of the United States is becoming increasingly more diverse, which makes it more likely that people will interact with people that are different from them (Shaya & Gbarayor, 2006). There is a great need for people, especially healthcare workers, to be educated on how to best interact with those that are different (Belisario, 2014). Some of the cross-cultural practice concepts that need to be taught to increase one's cultural competence are: cultural awareness – a person's understanding and perceptions of their own culture, cultural sensitivity – the deeper awareness of cultural similarities and differences, cultural appropriateness – what is deemed as appropriate behaviors according to cultural influences, cultural self-confidence – security in one's own culture, cultural competence – the capability to understand, communicate, and interact with people of other cultures, and cultural humility – the suspension of judgment and a true desire to learn from others (Dolan & Kawamura, 2015). It is thought that the three parts of cultural competence include cultural

awareness, which is a person's individual cultural values, beliefs, attitudes, and knowledge regarding diverse people, their needs, and their attitudes that affect relationships, and skills; these abilities are used to combine awareness and knowledge about others (Danso, 2018).

It is important for child life specialists to understand their own culture and cultural identities because they contribute to a person's worldview, personal lens, and implicit biases. A child life specialist who takes time and is intentional about doing the work to learn these things about themselves is on their way to becoming much more culturally competent. The same goes for educating oneself about other cultures, and the similarities and differences between one's own culture and other cultures - as well as between other cultures. Although this knowledge is highly important, it is not enough on its own for intercultural understanding (Perry & Southwell, 2011). Alongside knowledge and education, positive attitudes regarding other cultures is also a necessary component to cultural understanding and thus cultural competence. Intercultural sensitivity is described as "a person's active desire to motivate themselves to understand, appreciate and accept differences among cultures" (Perry & Southwell, 2011, p. 454). By combining these various aspects of cultural competence, a person is able to move into cultural acceptance and eventually cultural adaptation. (Perry & Southwell, 2011).

Measuring Cultural Competence

As the importance of cultural competence is becoming more widely recognized, there is an increased need for methods to measure cultural competence. Cultural competence, also referred to as intercultural competence or cultural humility, can be defined in many different

ways. Due to its complex nature, it can be difficult to conceptualize and thus measure a person's level of cultural competence – especially considering that there is no final level of competence to be reached. There are several existing instruments in which to measure levels of cultural competence. One such instrument is the Intercultural Sensitivity Scale (ISS), which is the chosen measure for the current study (Chen & Starsota, 2000). The five-subscale ISS developed by Chen and Starosta is considered to be valid and has been used in several studies. A sample of 414 college students were asked to rate 44 items that were considered to be important for intercultural sensitivity. A 24-item final version was able to be generated that contained five factors (interaction engagement, respect for cultural differences, interaction confidence, interaction enjoyment, and interaction attentiveness.). This scale was then validated using 162 participants that were students in communication basic courses, who were able to determine the ISS was significantly correlated with other related scales (Chen & Starsota, 2000).

One such study focused on determining the levels of intercultural sensitivity among healthcare professionals, namely doctors and nurses (Aksoy & Akkoç, 2019). This was a descriptive study with a sample group including both physicians (n=70) and nurses (n=87). Mean scores of the Intercultural Sensitivity Scale were reported as 3.46±0.48 for the physicians and 3.48±0.47 for the nurses. The study concluded by recommending that physicians and nurses increase their cultural sensitivity by knowing and forming relationships with more people from cultures different than their own, to develop language competence, and to participate in opportunities that allow them to gain experience abroad and education on cultural sensitivity (Aksoy & Akkoç, 2019).

Importance for Cultural Competence within Child Life

As populations become increasingly more diverse, the likelihood that healthcare professionals will serve and interact with diverse clientele is also increasing (Matthiesen, 2017). According to the US Census Bureau, the population of the United States will increase by 50% from 1995 to 2050, which means the population will go from approximately 236 million people to 394 million people. (Shaya & Gbarayor, 2006). In addition, racial and ethnic minority populations are expected to account for nearly 90% of the increase in the overall US population from 1995 to 2050. This increase in racial, ethnic, cultural and linguistic diversity within the US population prompts the need for change within the healthcare field to become more culturally responsive and to better understand diversity within its workforce (Vermeulen, 2020).

In contrast, those in the field of child life in the US are relatively homogenous in terms of sex and race or ethnicity (Marshall, 2018). In a fairly recent study, 438 of the 476 (92%) child life specialist respondents identified as White and Non-Hispanic. The vast majority of the field is also made up of people who identify as female (Marshall, 2018). This means that most of the people working as CLSs and CCLSs are White women. Another recent study indicated that the "typical" CCLS is a White female, 34 years old, 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 (Lookabaugh & Ballard, 2018). This study also found that while the majority of respondents felt competent performing the wide array of their duties and responsibilities, they acknowledged that there are definite gaps present in their academic preparation (Lookabaugh & Ballard, 2018).

As healthcare professionals in the role of being advocates for pediatric patients and their families, child life specialists have a responsibility to the patients and families they serve to be

culturally competent and to recognize the impact that race, ethnicity, and culture can have on patients/families and their experiences (Suzuki, 2015). If child life specialists understand the cultural backgrounds of the patients and families that they work with, then building rapport with them will be easier, they will be able to better connect with them, and the child life specialists will overall be able to provide better care. Being more culturally competent will lead child life specialists to be better advocates for patients and families, contribute to better healthcare experiences, and assist them in empowering patients and families (Suzuki, 2015).

Presently, there is still a lack of diversity and inclusion training within the field of child life and in healthcare as a whole (Jamar Lee, 2021). Considering the presence of diverse populations within healthcare settings and the fact that the field of child life is made up predominantly of White females, an emphasis on diversity, equity, and inclusion efforts is warranted (Jamar Lee, 2021). Culture and language can have an influence on rapport building, emotional support, and the implementation of appropriate child life interventions that match the individualized needs of the patient and their family (Suzuki, 2015). By child life specialists placing an emphasis on culture and steps towards becoming more culturally competent, it shows the diverse populations that they serve that they are cared about and valued.

Understanding of cultural backgrounds is important in any interaction that child life specialists have with their patients, but it is especially important in end-of-life events. Although difficult, supporting families during end-of-life is one of the many roles of a child life specialist. Education and training on death, dying, and bereavement are not only required but also necessary for CCLSs (Parvin & Dickinson, 2010). In the event of death, child life specialists can offer memory making items such as: hand and feet prints, hand and feet molds, fingerprint charms, locks of hair, heartbeat recordings, and other similar items. Furthermore, due to their extensive

knowledge of child development, child life specialists are able to offer the unique support of helping families explain death to children and help other children cope with death (Parvin & Dickinson, 2010). This includes the patient themselves, siblings of the patient, or any other child affected by the death. Every culture and even every individual family has a different outlook on death and different beliefs surrounding the death process. It is important for child life specialists to be knowledgeable on different cultures' attitudes, beliefs, and perceptions about death so that they can provide more effective support at end-of-life. Even with that knowledge, it is still important for child life specialists to remain open minded towards other cultures, be willing to ask about cultural preferences, be willing to interact, and be confident in those interactions with families from different cultures. Due to this support that child life specialists provide to their patients at families at end-of-life, cultural competence is especially important to the many complex roles of a child life specialist.

Current Study

In order to actually implement change within child life to foster diversity, equity, and inclusion in the makeup of child life, and to have child life specialists become more culturally competent, there needs to be systematic change within the field of child life. This research study will help towards this ultimate goal by gathering data on the levels of cultural competence in current CCLSs and their exposure to cultural competence through PDUs. In order to maintain their certification, CCLSs must either retake the certification exam or complete at least 60 PDUs during each 5-year certification cycle. Most CCLSs opt to recertify through PDUs, which must be electronically turned in and verified by the Association of Child Life Professionals (ACLP). This means that CCLSs should have reliable data on the amount of PDUs they have completed and the category/type of each PDU.

The purpose of this research study is to examine the cultural competency levels of CCLSs, the type of cultural competence PDUs they participate in, and their perspectives on cultural competence in child life. Research must first be gathered on current cultural competency levels of professionals in the field in order for the field of child life as a whole to become more inclusive and culturally competent. This researcher will conduct a descriptive and exploratory research study to gather data regarding current cultural competence levels of CCLSs working in hospitals across the U.S. and abroad. Additional data will be gathered to gain more information about the types of continuing education that CCLSs are choosing to participate in. This information will help assess whether CCLSs are making a conscious effort to become more culturally competent and expand their knowledge on cultural competence related topics, as well as what types of PDUs are available relating to cultural competence.

The study hypothesis is that the greater number of PDUs related to cultural competence that a CCLS completes, the more culturally competent that individual will be. Current CCLSs will complete an anonymous online survey that will be used to assess their levels of cultural competency. The online survey will be disseminated to various CCLSs currently working in the field of child life. The survey includes a series of background questions, seven exploratory research questions to gauge attitudes and perceptions towards PDUs, cultural competence, and accessibility in the field of child life, a 24-item survey (the ISS) to investigate the participants level of cultural competence, and the types of and number of PDUs relating to cultural competence that the participant has completed in the last 10 years. The 24-item survey on cultural competence (the ISS) will be used to measure levels of cultural competence and PDUs will be used to measure the types of cultural competence education and training opportunities

that CCLSs are intentionally participating in. To the knowledge of this investigator, no previous study has examined PDUs in relation to cultural competence in CCLSs.

Methods

Participants

Participants for this study consisted of 97 CCLSs. A non-random, convenience sample of CCLSs was utilized. A total of 115 CCLSs responded to the survey, but 18 had to be excluded from the data analysis due to missing or incomplete data. Of those 97 participants, 96 identified as female, and 1 identified as non-binary, 92 identified as White, 1 as Black or African American, 2 as Asian, and 2 as Native Hawaiian or Pacific Islander. All participants had at least a bachelor's degree, as required by this ACLP for CCLS certification, and 66% (64 participants) had either a Master of Arts or Master of Science, with 1% (1 participant) also having their PhD. Participants' ages ranged from 24 years old to 64 years old, and had been in the field anywhere from less than one year to 34 years with the average being 9.5 years. There were a total of 14 participants from the Midwest region, 33 from the Southeast region, 34 from the Northeast region, 13 from the Western region, and 3 international participants.

Data Collection Process

The survey was posted on the online forum available on the ACLP website called ACLP Connect. This forum is found at connect.aclp.org and is only available to people with ACLP accounts. ACLP Connect is used for people within the child life field to ask and answer questions, make connections, share new ideas, collaborate on projects, share research study surveys, and so much more. The survey link was also posted on CCLS Facebook pages, and directly emailed to CCLSs that this investigator personally knows. Participants were asked to forward the survey on to other CCLSs that had not yet completed the survey. The survey was

originally posted on March 1st, 2023, and re-posted on March 9th, and March 21st. The last responses included in the data analyses were recorded on March 28th of the same year.

Each survey post included a short description about the research study and a link to the survey which included information about IRB approval, a consent form, and the survey questions. This online survey was created and disseminated through Qualtrics. Participation was completely anonymous and voluntary, and participants were not compensated for their participation in the survey.

Participants were asked a series of questions regarding their demographics and background, such as their race/ethnicity, gender, level of education, number of years in the field, name of the hospital they work at or the region they reside in, and name of the unit(s) they work on. The next section of the survey included the following seven exploratory research questions:

1. How familiar are you with the concept of cultural competence?
2. How important do you think cultural competence is to the role of being a child life specialist?
3. How accessible would you consider the field of child life to be?
4. How diverse do you consider the field of child life to be in terms of racial/ethnic representation?
5. How easy/difficult is it for you to access affordable PDUs?
6. How easy/difficult is it for you to access PDUs related to cultural competence topics?
7. How much do you agree with the statement: cultural competence should be included in the required ACLP courses?

Additionally, each participant was asked to list the year range of their current 5-year certification cycle, the total amount of PDUs that they have accrued thus far, and the number of those PDUs

that were related to topics on cultural competence. Lastly, participants were asked to respond to the ISS.

Variables and their Measures

Cultural Competence. In order to find out a participant's level of cultural competence, the Intercultural Sensitivity Scale (ISS) was utilized. Past research has demonstrated that the ISS has "strong reliability and appropriate concurrent validity" as an intercultural competence assessment tool (Chen & Starosta, 2000, p. 12). Participants were asked to use a standard Likert scale (1 = strongly agree, 2 = agree, 3 = uncertain, 4 = disagree, 5 = strongly disagree) to indicate how they feel about a series of 24, 5-subscale statements about how they feel about culture (Table 1).

Table 1

Intercultural Sensitivity Scale

Item	
Subscale 1 – Interaction Engagement	
1.	I enjoy interacting with people from different cultures.
11.	I tend to wait before forming an impression of culturally-distinct counterparts.
13.	I am open-minded to people from different cultures.
21.	I often give positive responses to my culturally different counterpart during our interaction.

22. I avoid those situations where I will have to deal with culturally-distinct persons.

23. I often show my culturally-distinct counterpart my understanding through verbal or nonverbal cues.

24. I have a feeling of enjoyment towards differences between my culturally distinct counterpart and me.

Subscale 2 – Respect for Cultural Differences

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2. I think people from other cultures are narrow-minded.

7. I don't like to be with people from different cultures.

8. I respect the values of people from different cultures.

16. I respect the ways people from different cultures behave.

18. I would not accept the opinions of people from different cultures.

20. I think my culture is better than other cultures.

Subscale 3 – Interaction Confidence

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3. I am pretty sure of myself in interacting with people from different cultures.

4. I find it very hard to talk in front of people from different cultures.

5. I always know what to say when interacting with people from

different cultures.

6. I can be as sociable as I want to be when interacting with people from different cultures.

10. I feel confident when interacting with people from different cultures.

Subscale 4 – Interaction Enjoyment
9. I get upset easily when interacting with people from different cultures.
12. I often get discouraged when I am with people from different cultures.
15. I often feel useless when interacting with people from different cultures

Subscale 5 – Interaction Attentiveness
14. I am very observant when interacting with people from different cultures.
17. I try to obtain as much information as I can when interacting with people from different cultures.
19. I am sensitive to my culturally-distinct counterpart's subtle meanings during our interaction.

Professional Development Units (PDUs). PDUs were used to measure the number of hours of each experience. All PDUs are recorded in increments of at least 30 minutes. For each eligible 30-minute session, CCLSs are awarded 0.5 PDUs. Each hour equals 1 PDU credit. For the purpose of this study, if a participant completed an hour webinar training on cultural competence and received 1 PDU for it, then they were considered to have 1 cultural competence PDU. It was at each participant's discretion to decide exactly which PDUs qualified as cultural competence PDUs. In order to obtain reliable PDU information and make the process of recording their PDU data easier, participants were asked to list how many PDUs they have completed thus far in their 5 year certification cycle, and specify how many of those total PDUs were on topics relating to cultural competence.

Data Analysis

Once data were collected, the necessary survey data were transferred from Qualtrics into SPSS for data analysis. All data analysis was conducted using SPSS. Frequency analyses were conducted for race, gender, age, and degree level in order to describe the sample. Frequency analyses were also conducted for the background questions on how familiar participants were with cultural competence, how important cultural competence is to the role of a CCLS, how accessible the field of child life is, how diverse the field is, how affordable PDUs are, how easy it is to obtain cultural competence PDUs, and if they think cultural competence should be included in the required coursework. Furthermore, descriptive statistics were also conducted for each of the five subscales of the ISS. Items 2, 4, 7, 9, 12, 15, 18, 20, and 22 of the ISS were reverse-coded prior to the 24 items being summed by the mean scores of each items. The higher number indicated a higher level of cultural competence. Correlational analyses were conducted between cultural competence PDUs and the five individual ISS subscales. The correlational

analyses were used to test the hypothesis that the greater number of PDUs related to cultural competence that a CCLS completes, the more culturally competent that individual will be.

Results

Attitudes towards Cultural Competence in Child Life

Following the background demographic questions, participants were asked to use the 5-point Likert scale to indicate how they felt about seven questions relating to cultural competence and the field of child life. When asked how familiar they are with the concept of cultural competence (ranging from not familiar at all to extremely familiar), 52.6% said very familiar, 20.6% said moderately familiar, 18.6% said extremely familiar, 8.2% said slightly familiar, and 0% said not familiar at all (Figure 1 below). When asked how important they think cultural competence is to the role of a child life specialist (ranging from not important at all to extremely important), 57.7% said extremely important, 37.1% said very important, 5.2% said moderately important, 0% said slightly important, and 0% said not important at all (Figure 2 below). As for how accessible they consider the field of child life to be (ranging from not accessible at all to extremely accessible), 38.1% said moderately accessible, 37.1% said slightly accessible, 16.5% said not accessible at all, 4.1% said very accessible, and 4.1% said extremely accessible (Figure 3 below). For how diverse they consider the field of child life to be (ranging from not diverse at all to very diverse), 44.3% of participants said slightly diverse, 40.2% said not diverse at all, 12.4% said moderately diverse, 3.1% said very diverse, and 0% said extremely diverse (Figure 4 below).

Next, when participants were asked how easy/difficult it is for them to obtain affordable PDUs (ranging from very difficult to very easy), 32% said easy, 29.9% said difficult, 22.7% were neutral, 9.3% said very easy, and 6.2% said very difficult (Figure 5 below). When participants

were asked how easy/difficult it is for them to obtain PDUs specifically relating to cultural competence (ranging from very difficult to very easy), 41.2% said neutral, 30.9% said difficult, 15.5% said easy, 7.2% said very difficult, and 5.2% said very easy (Figure 6 below). Lastly, when asked how much they agree or disagree with the statement that a course on cultural competence should be included in the course list required by the ACLP for certification (ranging from strongly disagree to strongly agree), 55.7% of participants said strongly agree, 25.8% said somewhat agree, 13.4% said neither agree nor disagree, 3.1% said strongly disagree, and 2.1% said somewhat disagree (Figure 7 below).

Figure 1.

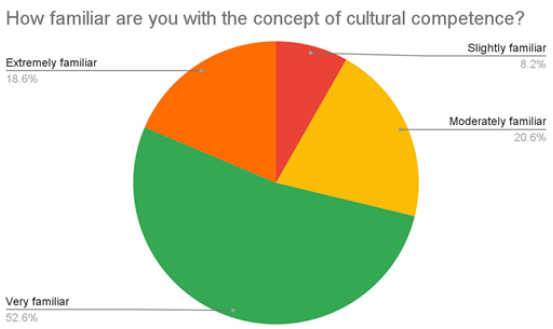
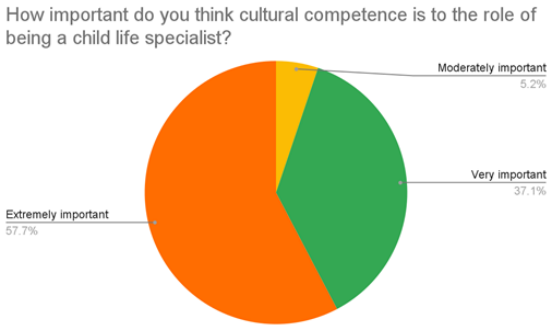


Figure 2.



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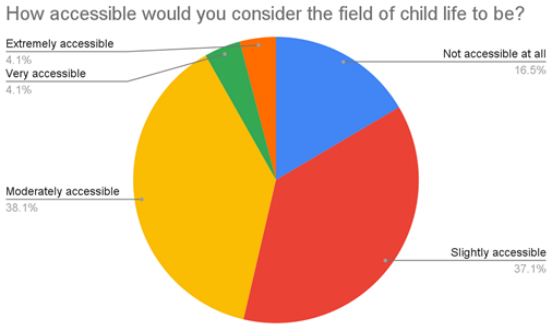

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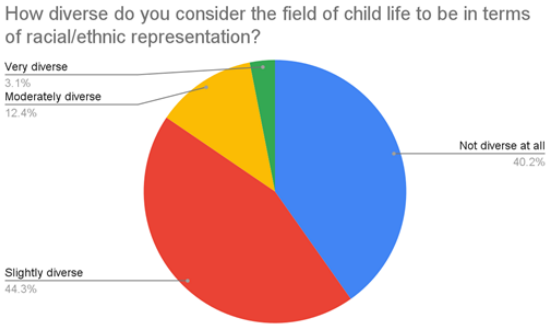

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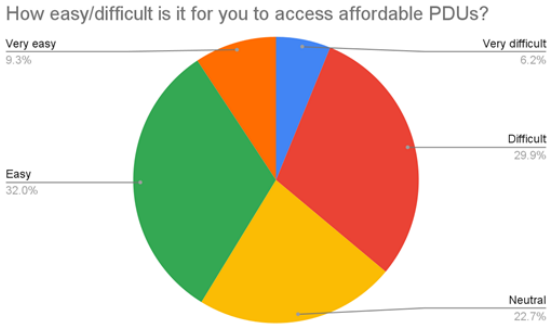

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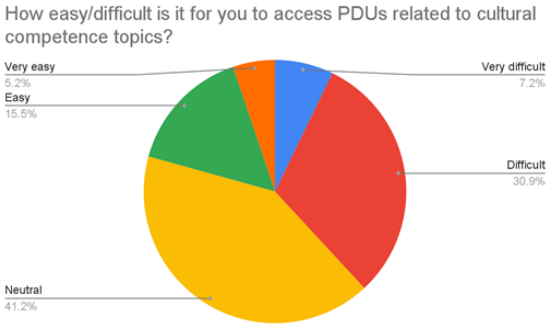

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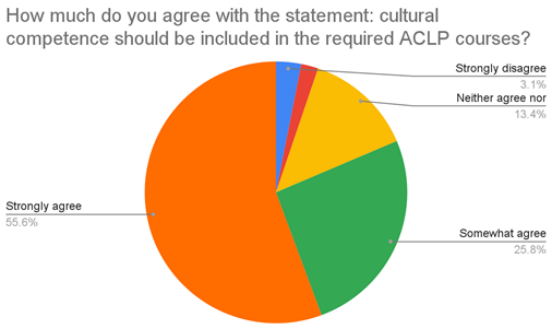

Professional Development Units

The total number of PDUs that each participant had completed thus far in their current certification cycle ranged anywhere from 0 to 125 hours with the average being 37.20 hours. The range of PDUs is so broadly primarily due to the participants being at different points in their certification cycles. Participants with 0 PDUs likely just became certified or just began their certification cycles, and participants with 50+ PDUs are likely in the final year of their 5-year certification cycle. Out of the 97 participants, 8 participants had not yet completed any PDUs and 24 completed 60 PDUs or more – 3 of whom completed over 100 PDUs. Excluding the 8 participants with 0 PDUs, the average PDU score is 38.88. As for the cultural competence PDUs, they ranged from 0 to 45.5 hours with the average being 5.39 hours.

Out of the 97 participants, 26 participants reported completing no cultural competence PDUs. Of those 26, 8 participants had not completed any PDUs yet in their certification cycle. The other 18 participants that reported completing 0 cultural competence PDUs had total PDU hours ranging from 4 to 70, with the average being 23 hours. Excluding the 8 participants that had not completed any PDUs yet in their certification cycle, the average cultural competence PDU score is 5.15 hours. This means that including all 97 participants, the average percentage of cultural competence PDUs to total PDUs is 14.49%, and excluding the 8 participants that had not completed any PDUs yet in their certification cycle, the average percentage of cultural competence PDUs to total PDUs is 13.25%. This indicates that only a small portion of the total PDUs a CCLS completes during the span of their 5-year certification cycle focus on topics relating to cultural competence.

Intercultural Sensitivity Scale Scores

ISS scores were obtained for each participant based on the five categories of the ISS: interaction engagement, respect for cultural differences, interaction confidence, interaction enjoyment, and interaction attentiveness. ISS scores ranged from 3.14 to 4.86 ($M = 3.96$) for interaction engagement, 2.50 to 4.50 ($M = 3.74$) for respect for cultural differences, 1.40 to 3.20 ($M = 2.11$) for interaction confidence, 1.00 to 3.50 ($M = 2.33$) for interaction enjoyment, and 2.33 to 5.00 ($M = 3.66$) for interaction attentiveness.

A correlational analysis indicated a significant correlation ($r = .225$, $p < .05$) between cultural competence PDUs and CCLSs reported interaction engagement, indicating that the more PDUs a CCLS participated in, the more culturally competent (based on the ISS) they were. However, no other significant associations were found between ISS scores and the number of cultural competence PDUs.

Discussion

Interpretation of Results

Due to the fact that there was no significant correlation found between overall ISS scores and the number of cultural competence PDUs a CCLS completed, the hypothesis was not supported. However, there was a significant correlation found between the number of cultural competence PDUs and the interaction engagement subscale of the ISS. This indicates that CCLSs participants who reported higher cultural competence PDUs also indicated higher reports of engaging with people of different cultures. In other words, CCLSs that seek opportunities to educate themselves on cultural competence related topics also engage more with people of different cultures. This could be for a variety of different reasons. For example, CCLSs that actively work to expand their knowledge of cultural competence and expand their skill set of working with different cultures may be more knowledgeable about cultures. It has been found that culture and language can both influence rapport, emotional support, and appropriate implementation of child life interventions (Suzuki, 2015). CCLSs with more knowledge of cultural competence may be better aware of this and use that cultural knowledge in their assessment process and factor it into their interventions. The cultural competence PDUs may have also given them the knowledge and skills to know how to better interact with diverse patient populations, making those CCLSs more likely to engage with people of different cultures because they feel more comfortable engaging with and advocating for culturally diverse patients.

Presently, the field of child life is still relatively homogenous in terms of race, ethnicity, and gender (Marshall, 2018). In other words, the majority of current CCLSs are White women. The sample used in this study was consistent with that since the majority of participants were caucasian females. When compared against the overall race/ethnicity demographics of the U.S.

population, the field of child life is not reflective of this diversity (Jones et al., 2021). Although the White population continues to be the largest race or ethnicity group in the U.S., the Multiracial population has continued to increase and is expected to increase even more in coming years (Jones et al., 2021). Due to the fact that CCLSs work in a variety of healthcare settings across the entirety of the U.S. and internationally, CCLSs work with very diverse patient populations. The main role of a CCLS is to work with patients and families to help them cope with the stress of hospitalization, despite their race, ethnicity, socioeconomic status, or other related factors. Even more so than other medical professionals, it is especially important to the role of child life that CCLSs are able to quickly build rapport with their patients and families. CCLSs are also primarily patient advocates, and work to advocate for the under-recognized needs of their patients and families on a day to day basis. It has been found that both culture and language influence things such as: rapport building, emotional support, and the implementation of appropriate child life interventions that match the individualized needs of the patient and their family (Suzuki, 2015). By being more knowledgeable about different cultures, CCLSs are better able to connect with their patients and adapt their interventions to be more effective and personalized to the patients' individual needs. Due to their unique role in the healthcare environment and the fact that they interact with such diverse patients, it is especially important that CCLSs are knowledgeable on cultural competence, recognize its importance, and intentionally work towards becoming more culturally competent CCLSs.

Furthermore, cultural competence is also greatly important to the role of providing end-of-life support. Each different culture has different views towards death, as well as different customs, rituals, and traditions at end-of-life. By being knowledgeable on how different cultures view death, being familiar with different end-of-life practices and beliefs, by being comfortable

asking families their beliefs on death and their preferences, and by being confident in their ability to interact with and support diverse families, CCLSs can use their cultural competence to provide better support to patients and families at end-of-life.

When looking at the responses to the seven exploratory research questions, it is quite evident in the responses that child life specialists are both familiar with the concept of cultural competence and recognize its importance to the role of being a child life specialist. On the other hand though, it is also evident that they do not consider the field of child life to be racially/ethnically diverse, nor accessible. Participants were fairly split on whether or not they were able to easily access affordable PDUs and specifically access PDUs relating to cultural competence. Considering the limited number of cultural competence PDUs that participants reported, it is unclear whether the lack of cultural competence PDUs is related to the inability to access/afford them, and/or due to lack of motivation or willingness. Lastly, the majority of participants indicated that they strongly agreed or somewhat agreed that a course on cultural competence should be included in the courses required by the ACLP for certification. This indicates that a majority of CCLSs agree that there should be a push from the ACLP to require CCLSs to learn more about cultural competence as part of the academic process. This could better set CCLSs up for success in their careers working with diverse patient populations and help them feel more comfortable and confident in their interactions with people of distinct cultures. CCLSs are saying that cultural competence is important, that it is important to their role, that they want to be more culturally competent, but there is a gap between wanting and achieving.

Currently, there is still a lack of diversity and inclusion training within the field of child life and in healthcare as a whole (Jamar Lee, 2021). This study found similar results with CCLS

participants reporting significantly fewer cultural competence PDUs (average of 5 hours) as compared to overall PDUs (average of 37 hours). This indicates the need for more resources and opportunities for CCLSs, especially relating to cultural competence and diversity, equity, and inclusion. A possible explanation for the low average of reported cultural competence PDUs could be the lack of cultural competence PDU opportunities being offered.

PDUs in general can be difficult to access, and are often very expensive. There are very few free PDU opportunities being offered and they can be difficult to obtain, especially for CCLSs working for smaller hospitals or in non-traditional settings. The lack of easily accessible, affordable PDUs plays into the financial barriers to becoming certified and the longevity of CCLSs. Although more focus is shifting towards cultural competence and its importance, there are still limited opportunities for CCLSs to obtain PDUs relating to topics on cultural competence. PDUs focusing on topics related to cultural competence also often fall into the professional development PDU category, which is the category with the least hours required. There are also more opportunities to obtain PDUs that fall into the professional development category than any other category due to it being so broadly defined. Since there are so few hours required in the professional development category and since they are often easier to obtain, there is not as much motivation to prioritize finding cultural competence PDUs to meet the required number of PDUs. CCLSs would have to intentionally choose PDUs that are related to cultural competence and potentially go out of their way to find these types of PDUs, rather than completing the most affordable and/or most accessible PDUs that they see. It is important to note that the ACLP has recently begun to allow PDUs relating to diversity, equity, and inclusion to fall into any desired category. This does emphasize the growing importance that the ACLP and CCLSs are placing on cultural competence and DEI related topics. However, many CCLSs may

not be aware of this change or may not know exactly which topics can be included under the umbrella of diversity, equity, and inclusion.

Barriers to the Field of Child Life

Although work is being done to increase diversity and make the field more accessible, especially for people of diverse racial/ethnic and socioeconomic backgrounds, there are still many barriers in place limiting entry into the field. Child life is rapidly growing, but it is still a relatively unknown field. Due to the lack of knowledge surrounding the field of child life, it can be difficult for aspiring CCLSs to know how to obtain certification. Despite being a relatively unknown field, child life is extremely competitive. This is mostly due to the limited number of educational programs focusing on child life, the difficultness of gathering relevant experience, and the limited number of internship spots.

The only official requirements for certification as set by the ACLP are: a bachelor's degree, graduation from an ACLP-endorsed child life academic program **or** completion of 10 required ACLP courses, a 600-hour clinical internship under the direction supervision of a CCLS, and a passing score on The Child Life Professional Certification Exam. However, the reality is that there is much more to becoming certified than those four requirements. Aspiring CCLS students must either enroll in ACLP-endorsed child life academic programs, which are both limited in number and highly competitive, or figure out on their own which courses to take and which ones will count as the 10 required courses. Students must then complete an eligibility assessment, which consists of students submitting the course name, course description, and which required course they want it to count for, along with an official transcript so the ACLP can verify that they took and passed the course. However, before they are even able to submit their courses, students must pay a one-time fee of $80 in order to begin the eligibility assessment. This

means that in order to meet the academic requirements for certification, students must pay $80 for the eligibility assessment fee, pay for official transcripts to be sent to the ACLP (possibly multiple times), pay for each of the required courses, and pay for the remaining courses required to earn a bachelor's degree. This is several thousand dollars for academic requirements alone.

Either after students have successfully completed the academic requirements, or oftentimes concurrently as they are trying to complete them, they also must work towards securing an internship. Although the only official requirement is that students must complete a 600-hour internship, it is not that simple. These internships must be completed in traditional clinical settings under the supervision of a CCLS. This means that the majority of internship positions, if not all, are located within children's hospitals. There is a finite number of children's hospitals located in the U.S., meaning that there is a finite number of internship positions. Moreover, not every children's hospital is able to have an intern due to limited size of hospital, lack of inpatient/outpatient departments, inability to meet internship site requirements, lack of staff eligible to supervise interns, or other related reasons. Along with there being a limited number of internship sites, most internship sites are only able to take one to four students per each term (Spring, Summer, Fall). This means there could be upwards of 30-100+ students applying for one spot.

Due to this competition over a limited number of internship spots, students must obtain relevant experience in order to be competitive internship applicants. Although the parameters for what constitutes relevant experience is currently being re-worked by the ACLP, it has traditionally meant volunteer experience with well children, sick children, and children in stressful situations. It is preferred that experience with sick children is in a hospital setting under the supervision of a CCLS. This means that internship sites will often take students with

volunteer experience in children's hospitals with CCLS volunteer supervisors over students with other experience. This type of volunteer experience is often difficult for students to obtain, especially for those who do not live in metropolitan areas that have a children's hospital. Without these experiences, it is unlikely that students will be considered for internship spots.

Although not officially required or endorsed by the ACLP, many internship sites also require or strongly recommend child life practicums. Similar to child life internships, child life practicums are introductory experiences into the field of child life. They are typically held in traditional healthcare settings (i.e. children's hospitals), are under the supervision of a CCLS, and are mainly observational experiences that allow students to gain knowledge and experience on child life interventions and how CCLSs apply developmental knowledge to their interactions with children and families. While internships typically consist of 40 hour weeks for 15 weeks, totaling 600 hours, practicums are typically 100-200 hours and can range from 40 hour weeks for 4 weeks, 16 hour weeks for 10 weeks, or any variation of this depending on the site. It is important to mention that nearly all child life practicums and internships currently being offered are unpaid. While students are sometimes able to work during practicums due to many of them being offered on part-time schedules, students are very strongly recommended not to have, or even prohibited from having, a job during internships. Furthermore, it is commonplace for students to have to relocate for practicums and/or internships. This means that during practicums/internships, students may be responsible for relocation costs, housing costs, food costs, parking costs, and more, all while doing unpaid work. Additionally, it can be very costly to even apply for practicums and internships. Some of these costs include: cost for official transcripts (which range in costs), costs for printing materials, costs for mailing applications, and even application fees (typically range from $20-$30). Although each individual student decides

to apply to a different number of practicums and internships, some students apply to 20+ practicums and 30+ internships. Costs can add up quickly, even for just the application process. Not to mention that many students are not accepted on their first round of applications, so they may have to go through and pay for this process multiple times until they receive an offer. Some students even complete multiple practicums in order to be more competitive applicants for internships.

Then, if a student is able to complete all of the academic requirements set by the ACLP and complete a 600-hour internship, they are eligible to take the certification exam to finally become a CCLS. The certification exam consists of 150 multiple-choice questions and has a 4-hour time limit. Certification exams are typically offered in March, August, and November, and consist of a 15-day testing window. Students are allowed to take the exam once per testing window. However, before being able to sit for the exam, students must first pay the exam fee. For ACLP members (annual student membership fees are $72), the certification exam fee is $300. For non-ACLP members, the certification exam fee is $450. This can be quite a hefty cost, especially for students who just underwent four-month-long unpaid internships. All of the aforementioned factors contribute to the substantial barriers to enter the field of child life and the lack of accessibility and diversity present in the field today.

Not only are there numerous financial barriers preventing people from entering the field of child life, there are also numerous financial barriers contributing to CCLSs leaving the field. Once child life specialists are able to pass the rigorous and costly certification process, it does not stop there. Certification is only good for a period of 5 years. At the end of those 5 years, CCLSs must recertify through the certification exam, once again paying $300 for ACLP members or $450 for non-members, or through PDUs. Although there are some free PDU

opportunities, CCLSs often have to pay for PDUs. PDUs can greatly vary in cost, often depending on if a CCLS works at a larger hospital and/or is an ACLP member. A professional ACLP membership (the corresponding membership type for CCLSs) costs $125 annually, plus a $25 joining fee for first time members or rejoining fee if there is a lapse in membership. One of the most common ways for CCLSs to obtain PDUs is to get them from the ACLP through online webinars, journal publications, or the annual conference. CCLSs are able to earn 1.0 PDUs by reading journal articles. These are typically free for members or $15 per article for non-members. CCLSs are also able to earn 0.5 PDUs for reading focus articles. There are again typically free for members and $15 per article for non-members. Live webinars and on-demand webinars typically offer 1.0-2.0 PDUs depending on their length and cost $35 for members. Attending the annual ACLP conference is another way for CCLSs to obtain PDUs. For the 2023 conference, which was held June 15-18 in Grapevine, TX offered attendees the ability to earn up to 24 PDUs. The exact conference rates can be found in table 2 below.

Table 2

2023 Child Life Conference Pricing by Registration Date and Attendee Type

	Early Bird	Standard	Late
ACLP Member	$400	$550	$650
Non-Member	$550	$650	$750
Student	$49	$49	$49
Retiree	$150	$150	$150
Committee Chair	$325	$475	$575
Presenter - Member	$299	$399	$499
Presenter - Non-Member	$399	$499	$599
Presenter - Student	$49	$49	$49
Presenter - Retiree	$100	$125	$125

"Early Bird" pricing was available from 2/1-3/31, "Standard" pricing was available 4/1-5/31, and "Late" pricing was available after 5/31 and on-site at the conference.

In addition to paying for recertification either through the certification exam or PDUs, CCLSs must also pay yearly certification maintenance fees. Annual maintenance fees are $48 for members, and $68 for non-members. Annual maintenance fee payments are due by January 31st of the year following certification (i.e. if you passed the March, August, or November 2023 certification exam, your first annual maintenance fee payment is due by January 31, 2024). If payment is not made by the January 31st deadline, CCLSs have until March 31st to pay the original fee plus a $35 late fee. After April 1st, CCLSs with unpaid maintenance fees become inactive, and they have until December 31st to reinstate their credentials by paying an additional $60 reinstatement fee. In summary, this means that it not only costs several thousands of dollars to become a Certified Child Life Specialist, but it also costs several hundred if not thousand dollars to maintain certification every year. All of this contributes to the reason that people are not able to afford to enter the field of child life, and not able to afford to stay in the field once they are certified.

Limitations and Futures Studies

Limitations of this study include sample size, time constraints, budget constraints, and possible lack of understanding. Although nearly 100 participants completed the survey for this study, that is still a relatively small sample size. Despite the sample being diverse in terms of region, age, and number of years in the field, the sample was not diverse in terms of race and gender. Due to the limited sample size and its homogeneity, it is possible that the results of this study are not entirely reflective of the field of child life as a whole. The survey was also only posted for a total of three weeks due to time constraints, which factors into the limited sample size. Since the study was not funded, a free cultural competence assessment scale had to be

utilized (the ISS), despite there being more well-established cultural competence instruments, such as the Intercultural Development Inventory (Hammer et al., 2003). Additionally, participants were not offered any type of incentive for survey completion. Lastly, the term cultural competence was not defined anywhere on the survey. As a result of this, there could possibly have been a lack of understanding among participants on what cultural competence is and what topics are included under the term cultural competence. For example, participants could have answered the survey questions solely considering race/ethnicity as part of cultural competence, while others could have taken a broader perspective on cultural competence.

Future studies could address these limitations by garnering a larger sample size, collecting data for a longer period of time, securing funding to use a more established tool to measure levels of cultural competence, and explicitly defining cultural competence. Furthermore, future studies could explore more in depth the types of PDU opportunities that are being offered, how easily accessible PDUs are, how affordable PDUs are, the amount of cultural competence PDU opportunities in relation to other PDUs, which types of cultural competence PDUs are most effective at increasing cultural competence, ways to introduce more cultural competence and diversity, equity, and inclusion topics into child life coursework and training, and ways to increase diversity and limit bias in the field of child life.

Conclusion

The purpose of this study was to examine the cultural competency levels of CCLSs, the type of cultural competence professional development units (PDUs) they participate in, and their perspectives on cultural competence in child life. The study's hypothesis was that the greater number of PDUs related to cultural competence that a CCLS completes, the higher that individual will score on the Intercultural Sensitivity Scale (ISS). A total of 97 participants

completed an online survey. Results were analyzed in SPSS and correlational analyses were conducted to test the study's hypothesis. A significant positive correlation between the number of cultural competence PDUs and interaction engagement subscale of the ISS, indicating that CCLS participants who reported higher cultural competence PDUs also indicated higher reports of engaging with people of different cultures was found. This study also found a lack of racial and gender diversity among CCLSs that is consistent with previous similar studies. Overall, there is still much more work that needs to be done in the field of child life in order to diversify CCLSs and create more culturally competent CCLSs so that they are better able to meet the unique needs of their diverse patient population.

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