Bank Street College of Education

Educate

Spring 8-30-2018

A Study of Diversity and Social Capital in the Field of Child Life

Madalyn L. Marshall
Bank Street College of Education, mmarshall@bankstreet.edu

A Study of Diversity and Social Capital in the Field of Child Life

By

Madalyn L. Marshall

Child Life Online

Mentor:
Genevieve Lowry, M.Ed, CEIM, CCLS

Submitted in partial fulfillment of the requirements of the degree of Master of Science in Child Life
Bank Street College of Education 2018

A Study of Diversity and Social Capital in the Field of Child Life

Madalyn L. Marshall

Abstract

Certified Child Life Specialists are professionals with a background in child development who traditionally provide psychosocial support to children and families in a pediatric healthcare environment (Pearson, 2005). According to the last job analysis done in 2013, 92% of child life specialists identify as White and Non-Hispanic (438 out of 476 respondents). Compared to an ever-diversifying patient population, the field of child life can be considered homogenous in terms of racial representation. Considering the racial homogeneity of the field and the potential impact of implicit biases, increasing the diversity of child life specialists would be beneficial to the development of the field. However, due to the reported effects of social capital and a lack of social networking for future child life specialists of color, there are many barriers to enter the field (Bourdieu, 1986). The purpose of this non-experimental, quantitative research study conducted using a survey is to determine relationships between race and how certified child life specialists learned about and chose to pursue a career in child life. The results of the survey sent out to members of the Association of Child Life Professionals forum was that 89.9% of participants identified as White with the remainder of the participants identifying as non-White or biracial (10.1%). The means by which child life specialists both of color and White learned about the field were varied, although 13% of specialists were exposed to the field through relationships with friends. Considering the Social Capital Theory, diversifying the field will require an increase of recruiting efforts as well as structuring opportunities for mentorship (Bourdieu, 1986).

Table of Contents

Introduction

Systemic racism refers to institutions, policies, and economic and political structures that have placed racial and ethnic minority groups at a disadvantage over the course of America's history. Systems that have been proven to disadvantage people of color are employment, the wealth gap, housing, government surveillance, and incarceration (The Center for Racial Justice Innovation, 2017). For example, over the last 60 years in America, the unemployment rate of Americans has been twice as high as that for White Americans. This also holds true for unemployment rates of Black Americans and White Americans who have undergraduate degrees - unemployment rates for Black college-educated people are twice as high as that for White people (The Center for Racial Justice Innovation, 2017). I have been interested in understanding systemic racism for years, but it is a complex system to grasp especially for a White person in America whose privilege is difficult to see. The first time I truly began to understand the basics of systemic racism was while reading Debbie Irving's book *Waking up White and Finding Myself in the Story of Race* which is a story of the author's journey to understand her own privilege. The book was incredibly powerful to me in that it helped me to understand some of my own ingrained beliefs and where I am lacking in my understanding of systemic racism. One of the chapters of this book is titled "Headwinds and Tailwinds" and begins with a simple formula for understanding systemic racism - "skin color symbolism + favoritism + power = systemic racism" (Irving, 2014). She goes on to tell a story about her journey to find her career which ultimately informed this research question.

Irving gave background information about the type of homogenous, White neighborhood she grew up in and the predominantly White college she attended. Through working for a professional summer theater over a summer break, she discovered that she had an interest in

going into the field of arts administration. After graduation, Irving's father suggested someone

for her to call to pursue this interest. She shares, "I think no matter what profession I had chosen,

my father would have had someone for me to call" (Irving, 2014). This connection led to a

volunteer experience, which pointed out is a privilege reserved for those who are able to afford

to take the time to volunteer. On her first day of volunteering, Irving met a man who became her

mentor. He asked for her resume so that he could send it to people he knew in the hopes of

making more connections for Irving, and through this process, he eventually found her a job to

apply to. She ended up being selected for this managerial position at a local dance company for

which this man served as a board member. However, Irving soon learned that this job only paid

$12,000 due to it being a new position - the company needed someone with relatively little

experience to take a small salary and to be trained. One of Irving's family friends happened to

own a rent-controlled apartment close by to her new position which Irving was able to afford

even with this less than desirable starting salary. Irving's quotes to close her story changed the

way I looked at my struggle to become a Certified Child Life Specialist and the way I look at the

lack of racial and ethnic diversity in this field:

> *I also lived with the constant comfort that my parents would always be there for me*
> *financially if I needed help. Among other things, socioeconomic privilege affords the*
> *freedom to explore, take risks, and find work you truly love - the kind that brings out your*
> *best...Somehow I must have justified my entitlement to access all the privilege I had*
> *without really questioning who wasn't living in the apartment I'd just moved into, or who*
> *wasn't getting the job I'd just gotten. Dismissing the plight of others comes easiest when*
> *you don't actually know them* (Irving, 2014).

There have been many moments throughout my journey to become a child life specialist

that I once attributed to my ability to work hard and persevere that now I remain proud of but

recognize as being made possible by my privilege. I had a handful of White child life specialists

who recommended me to other White child life specialists, and I also had parents who shared my

values of pursuing a fulfilling and meaningful career which also happen to be characteristics deeply embedded in White culture (Irving, 2014). At times during my own awakening, I have wondered about what the journeys of the few child life specialists of color have been like. I wonder if people of color are equally able to learn about the field if we know that the majority of child life specialists are White. Through understanding more about how child life specialists of color have learned about the field of child life, perhaps the field can improve the way we reach a diverse population and increase the equity of entering the field. Although socioeconomic barriers are a large contributor to the inequity, for the purposes of this paper, I will be examining the role of social capital and networking as barriers or advantages to enter the field.

Literature Review

Child Life Demographics

Certified Child Life Specialists (CCLS) are professionals with a background in child development who traditionally provide psychosocial support to children and families in a pediatric healthcare environment. Child life specialists provide interventions such as procedural support, preparation, diagnostic teaching, as well as play-based interventions such as child-centered play and medical play in order to support children as they go through medical experiences that are often unfamiliar and stressful (Pearson, 2005). The Association of Child Life Professionals (ACLP) is the governing body of Certified Child Life Specialists and is the organization who maintains certification credentials and requirements. The association operates with a set of guiding principles, and one in particular will be the basis of this research study and that is, "we will attract highly skilled, diverse, and committed individuals who are able to demonstrate competence in communication and human services skills" (Association of Child Life Professionals, 2018).

The last job analysis of CCLS was completed by the ACLP in 2013 which included a survey of the demographic data of the field at the time. Out of the 476 CCLS who responded to the survey, 438 identified themselves as White and Non-Hispanic, meaning that 92% of the child life workforce is made up of White child life specialists. According to United States census data from 2016, people who describe themselves as White alone make up 76.9% of the population, meaning that the racial and ethnic makeup of the child life field is fairly homogeneous compared to the general population (United States Census Bureau, 2016). The homogeneity of the field relates directly to the services child life specialists aim to provide in that family-centered and

culturally competent care are two tenets of quality child life interventions which will be explored further in subsequent sections.

Social Capital and Networking

Social capital is defined as a resource that lies within family connections and the ties between individuals in organizations - a resource "springing from social relationships" (Strömgren, Eriksson, Bergman, & Dellve, 2015). Throughout history, there have been many definitions and descriptions of the ways in which social capital is formed and used in political science, economics, and occupational attainment. The definition that is the focus of this paper was introduced by Glenn Loury in 1977 as "a set of resources that inhere in family relations and in community social organization and that are useful for the cognitive or social development of a child or young person. These resources differ for different persons and can constitute an important advantage for children and adolescents in the development of their human capital" (Coleman, 1990). In his book *Foundations of Social Theory*, Coleman continues to explain the failure of society to understand interpersonal relationships' effects on the advancement of individuals. Neoclassical economic theory and many intellectual advancements that have occured after the 17th century have created a fiction focusing on the achievements of individuals as opposed to understanding individuals in the context of their environments (Coleman, 1990).

This narrative of attributing success to individual efforts can be seen clearly in Herbert Hoover's "Principles and Ideals of the United States Government" campaign speech given on October 22, 1928. In this speech, Hoover famously attributed the success of the American system to "rugged individualism" and "self-reliance", and argued that the American government had taken too much economic power during World War I. He explained that if the government were to maintain this uneven balance of economic power, power would be striped from the

individual leading to stagnation. A self-made millionaire, Hoover believed that success should be wholly attributed to each individual and federal relief programs would undermine individual effort and motivation (Digital History, 2016). Irving touches on this idea of the "Rugged Individualism" and explains that this idea often goes unidentified as a part of the White-dominant culture of America and is not shared by other racial and ethnic groups. "My glorification of independence and individualism made me an easy target for the myth of meritocracy, and overshadowed what in my heart I knew to be true: the deep interconnectedness I longed for with family, friends, colleagues, and even strangers is core to human survival" (Irving, 2014). Large government systems that advantage White families at the expense of families of color also happen to be invisible which allows White families to attribute their success wholly to their efforts as individuals. These systems include the "right to citizenship, land ownership, subsidized housing, preferential education, medical care, and retirement benefits" (Irving, 2014). As a result of these undetected advantages, more lucrative and powerful careers remain White-dominated such as the healthcare workforce (Johnson, 2005). Understanding the ways in which social ties and connections are working within groups to determine career success is important to diversifying workforces that have been predominantly White.

Social Capital Theory has been applied to the ways in which individuals' social networks affect career advancement. This has been done through three different but interrelated theories: weak-tie theory (Granovetter, 1973), structural hole theory (Burt, 1992), and social resource theory (Lin, 1990). These theories work to explain how social capital affects career mobility through access to more information, resources, and sponsorship (Seibert, Kraimer, & Liden 2001). First, weak-tie theory posits that weak ties between people are what lead to career

mobility and success. Strong ties are the ones formed between family members and close friends. The information possessed by any individual of these cliques has a high likelihood of being similar due to the homogeneity of the individuals. When individuals reach outside these networks of strong ties to form weaker ties, they are more likely to gain social capital that results in career advancement due to the variation of the ties (Granovetter, 1973; Seibert, Kraimer, & Liden, 2001). Burt's structural holes theory focuses on the bridges between groups and how individuals that serve as gatekeepers connecting two homogeneous groups expands both groups social capital (Burt, 1992; Seibert, Kraimer, & Liden, 2001). Lastly, social resources theory examined the nature of ties between an individual and others. The weak ties formed between the individual and other individuals higher up in career attainment were more likely to result in the individual attaining career success (Lin, 1990; Seibert, Kraimer, & Liden, 2001). Seibert, Kraimer, and Liden sought to examine all three theories in relation to career attainment. They found that weak ties and structural holes both led to increases in social resources, and social resources were positively related to current salary, number of promotions, and career satisfaction. Their study also demonstrated an added benefit of having multiple mentors as opposed to a single mentor and suggest the implementation of "mentoring networks" throughout the levels of an organization to support individuals throughout their careers (2001).

Bourdieu (1986) explains that the relationship between two individuals allows them to access each other's resources therefore increasing each individual's total social capital. Vaughan, Sanders, Crossley, O'Neill, and Wass (2015) define social capital as the connections that "help individuals to 'get by' through the provision of support and the reinforcement of identity; they are links between like-minded people and serve to reinforce homogeneity and homophily". These homogeneous groups are often similar in aspects of race and ethnicity, which determines

the resources in-group people gain from their social capital. Reflecting back on Irving's story shared earlier, the homogeneity and homophily of these social groups creates networks of people who are able to recommend each other for professional advancement. For example, if the unemployment rate of Black people is twice as high as the unemployment rate of White people, the groups recommending each other for employment opportunities will be made up of significantly more White professionals than Black professionals (The Center for Racial Justice Innovation, 2017). In a study by Caldas and Cornigans (2015), it was found that even middle- and upper-class minority families have less access to social capital than do White families. Considering that 92% of the child life workforce in 2013 were White, and as demonstrated by studies on social capital, White people often have majority White friend groups, the people who are being referred to and exposed to the field of child life will continue to have a white majority (Association of Child Life Professionals, 2013).

Though the literature is limited in terms of understanding social capital's influence on the diversity or lack of diversity in healthcare fields, social capital theory has been applied to the field of Earth System Sciences (ESS) (Callahan, Libarkin, McCallum, & Atchison, 2015). ESS fields have been experiencing a workforce shortage. Due to this shortage, efforts have been made to recruit underrepresented groups including women and minorities. This commentary viewed the recruitment efforts through the lens of Social Capital Theory in order to understand why including individuals with diverse backgrounds has proven difficult. The authors point to a sense of "professional isolation" felt by women and minorities, lack of role models, and lack of trusting relationships. Once underrepresented groups are recruited, this sense of isolation undermines the sense of belonging necessary to continue in the field; belonging that is created by

seeing oneself represented in the rest of the field. In describing the absence of role models, the authors explain:

> *One example of this is the oft-noted lack of visible role models for women, minorities, and individuals with disabilities in STEM organizations or academic departments. This absence has the potential to raise doubts among young scientists and engineers in those underrepresented groups about their ability to succeed: Why would they succeed if others like them have not? Negative racial stereotypes encountered by underrepresented minority students majoring in STEM disciplines can be a significant deterrent to their persistence* (Callahan et al., 2015).

The intertwined ideas of social capital and a lack of role models continue to perpetuate the homogeneity of fields that have historically been dominated by majority groups. When considering the field of child life, which is relatively new and small compared to many fields, social capital, role models, and mentors become even more crucial in being able to navigate the steps leading to employment. One main way young people from diverse backgrounds can be exposed to the field is by interacting with child life specialists during a medical experience. However, interacting with majority White child life specialists not only prevents the diversification of social capital, but it also limits minority patients' abilities to envision themselves succeeding as a child life specialist of color.

Developmental Perspective

In the 1940s, two psychologists, Kenneth and Mamie Clark designed and carried out a series of experiments referred to as "The Doll Tests" (NAACP Legal Defense and Educational Fund, Inc., n.d.). In these now famous experiments, Black children between the ages of three and seven were shown four dolls that were identical in every aspect besides their race. The children were asked to identify the races of each doll and then select the doll that they would most want to play with. The results of the study were shocking, and were later used in the body of evidence opposing the segregation of schools in *Brown v. Board of Education* (1954). The majority of the

children preferred the White doll and described this doll with positive characteristics. Drs. Clark cited this as evidence that segregation leads to feelings of inferiority and damaged self-esteem (NAACP Legal Defense and Educational Fund, Inc., n.d.). Though these experiments took place during a time in the United States when explicit bias was expressed in every aspect of society, the results of the experiment have been shown to hold true in more recent history as well.

In 2010, Margaret Beale Spencer, a leading researcher in the field of child development conducted a modern version of the doll test as a pilot study for CNN (Billante & Hadad, 2010). Spencer's team recruited 133 children in two age groups - four to five and nine to ten. The sample of children met specific economic and demographic requirements, and though the sample was small, the results yielded conclusive results. In Spencer's study, the younger children were asked to respond to a series of questions by pointing to one of five cartoon pictures of children that varied in race. The older children answered the same questions using the same pictures. In addition, the older children were asked questions to which they responded using bar charts with a variety of racial skin tones. The results were similar to the original Doll Tests in that Black children demonstrated a preference for White. However, White children demonstrated a much stronger preference for White, and these stereotypes for both groups of children persisted in the older age groups (Billante & Hadad, 2010).

These tests can be understood through the lens of ethnic and racial identity development. According to Erik Erikson as quoted by Way, Hernández, Rogers, and Hughes, identity development is located "in the core of the individual and yet also in the core of his communal culture (2013). Identity scholars following the work of Erikson emphasized the role of the social context, "including the role that stereotypes and discrimination play in the construction of identities" (Way et al., 2013). Ethnic and racial identity development has been defined in a

variety of ways. One of the most common perspectives centers on one's view of the self compared to his or her racial and ethnic group. Ethnic and racial identity has been shown to increase with age and has also been linked to psychological, academic, and social satisfaction. Way et al. explored the ways in which stereotypes affect the racial and ethnic identity development of minority adolescents. The authors found that race, ethnicity, gender, and socioeconomic status stereotypes created intersections that helped participants define their roles and identities. For example, one male, Black participant's identity was greatly associated with being a rapper or a professional athlete. These aspirations are seen as the domains of a Black male, specifically, and in this way, stereotypes can influence one's image of self compared to one's racial and ethnic group (Way et al., 2013). The results also demonstrated a greater resistance to stereotypes in the eighth grade as opposed to the sixth grade, revealing an increased sensitivity to stereotypes in earlier developmental stages (Way et al., 2013).

Bronfenbrenner's Ecological Systems Theory has also been used to describe how one's environment and social context influences development (Ecological Systems Theory, 2016).

In order to truly influence the racial and ethnic makeup of the child life field, it is imperative to evaluate the presence of minority mentors and role models for potential child life specialists of color entering the field.

Study Purpose and Research Questions

There is currently no research that aims to assess the lack of diversity in the field of child life as well as the barriers to entry experienced by minority groups. Understanding these barriers will help the field of child life determine potential solutions to make the field more equitable for people of color. Once the field is more equitable for all groups to reach certification, the diversity of the field and quality of child life services provided to all families will increase. Additionally,

once child life teams in hospitals are more representative of the general population, the ideas that members of the teams bring to the table will diversify and increase the creativity of the teams' approach. Lastly, patients with child life specialists who look like them may be inspired to pursue the career as well due to seeing themselves in their child life specialists. Therefore the purpose of this study was to determine relationships between race and how Certified Child Life Specialists learned about and were encouraged to pursue a career in child life. Further, the following research study was guided by the question - is the method by which child life specialists were exposed to the field related to the concordance of race/ethnicity between the future child life specialists and the person sharing the information?

Outline of Plan

In order to examine the method by which child life specialists were exposed to the field and the concordance of race/ethnicity between the future child life specialists and the person sharing the information, a non-experimental quantitative research study was designed and approved by the Institutional Research and Review Board at Bank Street College of Education. The approval letter can be found in Appendix B. A survey design was selected in order to gain a representative sample of child life specialists to provide rich descriptive statistics. Survey questions were written to both capture the current racial/ethnic makeup of child life specialists and other demographic information as well as identify the variety of methods child life specialists were exposed to the field. Questions were also included that allowed participants to select the race/ethnicity of mentors, family members, and friends who exposed them to the field in order to investigate the social networks of child life specialists. The survey description and survey questions were written in Google Forms, and the survey can be found in Appendix A.

The survey was distributed to child life specialists through the profesional email forum on the Association of Child Life Professionals website, and specialists had eight days to complete the survey. Out of the 3940 forum users who received the survey, 111 completed the survey. Three participants were not yet certified and therefore did not qualify for the study. The remaining 108 surveys were analyzed using descriptive statistics (N= 108). The sample was representative of the current field of child life specialists.

Results

Demographics of Child Life

Of the 108 child life specialists considered in the analysis, 97 identified as White. This percentage of White child life specialists (89.8%) is consistent with the results of the 2013 job analysis which found 92% of child life specialists were White (ACLP Job Analysis, 2013). Five participants identified themselves as Black or African American (4.6%), four specialists were of Hispanic, Latino, or Spanish origin (3.7%), four specialists identified as Asian (3.7%), one as Middle Eastern (0.9%), and one as American Indian or Alaska Native (0.9%). Participants were able to select multiple racial and ethnic identities which accounts for the overlap. A visual representation of the racial and ethnic makeup of participants can be found in Figure 1 in the Tables and Figures section.

Surprisingly, of the child life specialists participating in the survey, 50.9% were between the ages of 25 and 35, meaning that a significant portion of the child life workforce is fairly young (Figure 2). However, the number of years of experience child life specialists had was varied as can be seen in Figure 3. Although the current minimum requirement for a child life specialist to become certified is a bachelor's degree (29.9%), 57% of participants reported having a master's degree, with 11.2% currently in a master's degree program (Figure 4).

Exposure to Child Life and Support

In order to begin understanding how to recruit and increase the diversity and inclusivity of the child life profession, it is imperative to first understand how child life specialists are learning about the field. The results of this survey seem to point to the multitude of ways specialists have been exposed to the knowledge of child life considering 38.9% of specialists entered their response under "other" in order to provide additional information. The response

most often chosen by child life specialists (13%) was learning about the field from a friend. This was followed by 12% who were exposed to the field by a family member, 12% by a college counselor or advisor, and 8.3% by the internet or media. Figures 6-8 depict the race and ethnicity of the person participants identified as someone who exposed them to the field or provided support throughout certification. Participants shared that either there was no specific person who exposed them to the field or provided support, or the majority of these support persons were identified as White. Lastly, the degree of support participants felt throughout the certification process were mixed which can be seen in Figure 9.

Process

In order to understand how the race and ethnicity of a child life specialist could be determining exposure to the field, results were separated according to race and ethnicity in spreadsheets. Due to the small sample size of child life specialists of color, for analysis purposes, participants who did not identify as White were placed on the same spreadsheet. Out of 108 participants, 94 identified as White and 14 did not identify as White. Additionally, to isolate the analysis of social capital specifically, it is important to separate the effects of other sources of capital. Though there are many theories as to the number and types of capital people possess, because this study asked questions that address two types of capital, the focus will be primarily on the "Five Capitals Model". These five sources are natural capital which consists of the resources and processes that maintain life itself, human capital which consists of individuals' health, knowledge, skills, motivation, education, and training, social capital which has been the primary focus of this research, manufactured capital which consists of fixed assets that contribute to the production process such as tools, machines, and buildings, and lastly financial capital

which is a symbolic representation of all of the other sources of capital such as shares and bonds (Forum for the Future, n.d.).

The survey questions aimed to understand how participants were exposed to the field of child life and how supported they were throughout the process of certification were considered questions evaluating participants' social capital. Participants' current level of education is considered an aspect of their human capital. In order to determine the barriers for child life specialists of color entering the field, it is important to also evaluate if human capital, or level of education is also a factor. Out of the 14 participants who did not identify as White, 10, or 71%, had obtained a Master's degree. The remaining four participants who identified as child life specialists of color shared that they had obtained a Bachelor's degree. The distribution of education level for White participants was as follows: 28 obtained Bachelor's degrees, 12 were students in a Master's degree program, 51 obtained Master's degrees, and two obtained a Doctorate degree, and one participant did not answer this question. Though the sample of child life specialists of color was considerably smaller than the sample of White child life specialists, interestingly a much smaller percentage of White child life specialists obtained a Master's degree or higher (56%). In this sample, child life specialists of color were more likely to have obtained a Master's degree which leads to the conclusion that human capital is less of a barrier to enter the field than social capital.

To examine aspects of social capital, the same two spreadsheets were compared as to the ways in which participants were exposed to the field of child life - one made up of child life specialists who identified as White, and one made up of child life specialists of color. Out of the 14 child life specialists of color, one learned about the field from a family friend and one from a personal medical experience. The other 12 participants learned about the field in a variety of

ways, many of which include individual efforts made by the participant in high school or college as opposed to interpersonal relationships made with people who were privy to child life information and resources. For example, participants shared that they heard about the field from a college healthcare professionals course, a college board search online of healthcare professions, reading a manual at school, volunteering under a child life department in high school, and a fellow student sharing about the field in a child development class. Out of these same 14 participants, none had racial or ethnic concordance with the person who exposed them to the field or the person they identified as a mentor or advisor, which is to be expected considering the racial and ethnic homogeneity of the field.

Comparing the ways in which child life specialists of color were exposed to child life information, 14 child life specialists who identified as White learned about the field through a friend, 13 through a family member, 3 through a family friend, 4 through a family member or friend's medical experience, 6 through a personal medical experience, and 14 through a college or high school advisor. Therefore, 54 out of the 94 child life specialists who identified as White identified one of these personal relationships as the way they were exposed to the field of child life. Compared to child life specialists of color who were only exposed to the field 14% of the time through a personal relationship, White child life specialists were exposed to the field 57% of the time through a personal relationship which is a much larger discrepancy than what was seen in the level of education between the two groups. This comparison seems to point toward barriers in social capital as opposed to human capital. This was expected due to the theory of social capital discussed previously and the homogeneity of the field (Bourdieu, 1986).

Lastly, the question of the survey that sought to understand how supported child life specialists felt throughout the certification process also spoke to the differences between child

life specialists who identify as White and those who identify as people of color. For child life specialists of color, one felt no support (7%), five felt moderately supported (35%), three felt supported (21%), four felt very supported (28%), and one did not select a numerical representation of the support he or she felt. For child life specialists who identified as White, five felt no support (5%), 27 felt moderately supported (28%), 19 felt supported (20%), and 37 felt very supported (39%). The remaining child life specialists who identified as White did not select a numerical representation of the support they felt. In comparison, the largest percentage of child life specialists of color felt moderately supported which was defined in the survey as "2 - Moderately supported. Friends and family members supported my decisions but were mostly unable to provide career advice." The largest percentage of child life specialists who identified as White felt very supported which was defined in the survey as "4 - Very Supported. I was part of a child life academic program (undergraduate or graduate), or a program with a concentration or minor in child life. A certified child life specialist(s) mentored me throughout my journey and made many connections on my behalf."

Though it is difficult to draw definitive conclusions about the comparison between the two groups due to the small sample size of child life specialists of color, these descriptive statistics do point to a difference between the social capital of child life specialists of color and that of White child life specialists. As anticipated, child life specialists of color were less likely to be exposed to the field through their personal relationships with friends and family members. They were also less likely to feel very supported throughout their certification processes. However, in this sample, child life specialists of color were more likely to have obtained a higher level of education than child life specialists who identified as White which reduces the likelihood

of a barrier of human capital as opposed to social capital. This may be a possible explanation for

why diversity scholarships do not necessarily increase the field's diversity.

Discussion and Rationale

Family-Centered Care and Cultural Competency

Family-centered and culturally competent care are two tenets of quality child life interventions (Association of Child Life Professionals, 2018). In order to provide family-centered care, child life specialists aim to incorporate families in decision making as important members of the child's healthcare team. Bell, Johnson, Desal, and McLeod describe family-centered care as "an approach to healthcare that is based on mutually beneficial partnerships between patients, families, and healthcare professionals" (2009). Family-centered care developed out of the recognition that caregivers are the experts on their children and providing care to the child in isolation was not meeting the needs of the family as a whole. Improvements in family-centered care led to benefits such as providers' increased responsiveness to patient and family needs, greater patient and family satisfaction with care, reductions in healthcare costs, and families advocating for their children's needs (Bell et al., 2009). One of the elements of best practice family-centered care is "honor[ing] the racial, ethnic, cultural, and socioeconomic diversity of families" (Bell et al., 2009). This includes being aware of one's personal biases, values, and beliefs throughout interactions with children and families. Therefore, the homogeneity of the field relates directly to the services child life specialists aim to provide

According to Johnson (2005), "by 2020 approximately 40% of school-age children in the United States will be from non-White ethnic groups. However, the diversity of healthcare providers serving this population has not increased at the same rate. In fact, among registered nurses in 2000, 86.6% identified as White. Understanding culture within the context of healthcare requires practitioners to understand their own cultures and backgrounds including communication styles, the ways in which we use and interact in physical space, concepts of time,

and assumptions that we make about healing and health. Our own understanding of these concepts among others affects our interactions with children and families from similar backgrounds as well as those who have different backgrounds (Johnson, 2005). Cross (1988) developed a continuum for cross-cultural competence including six points ranging from "cultural destructiveness" to "advanced cultural competence". Advanced cultural competence is achieved when practitioners begin to seek ways to add to what is understood about culturally competent practice. This can be seen in engaging in research, developing new therapeutic approaches based on culture, and publishing the results of such projects (Cross, 1988). In examination of the Child Life Code of Professional Practice, principle three states, "Child Life professionals shall have an obligation to serve children and families, regardless of race, gender, religion, sexual orientation, economic status, values, national origin, or disability" (Association of Child Life Professionals, 2000). This obligation to serve does not simply end at striving to practice cultural competence individually, but it can also be seen as an obligation to attain cultural competence that expands what we know about culture's impact on the healthcare experience for children and families of color as well as evaluating the lack of diversity in the healthcare workforce as a whole.

Implicit Bias and Connections to Systemic Racism

Providing culturally competent care as described in the tenets of family-centered care is an ideal way to interact with children and families in that each individual brings his or her own background and experiences to the healthcare experience. However, many studies using the Implicit Association Test have shown that implicit biases can decrease patient satisfaction and influence the quality of care practitioners are providing (Blair, et al., 2013; Cooper, et al., 2012; Maina, Belton, Ginzberg, Singh, & Johnson, 2018). Implicit Association Tests were developed to study mental associations, or the speed with which two things can be associated in one's mind

using previous experiences. For example, the IAT examining racial bias tests how quickly the participant can make a mental association between male faces that are Black with negative descriptors and male faces that are White with positive descriptors. This speed is compared to how quickly the participant can associate male faces that are Black with positive descriptors and male faces that are White with negative descriptors. Using this method, the IAT can demonstrate racial "blindspots" and biases that are formed throughout development. These blindspots are difficult to detect, because for many, they are deeply ingrained and do not usually appear as explicit biases (Banaji & Greenwald, 2013). According to Banaji and Greenwald (2013), 75% of those who take the race IAT on the internet and in laboratory settings show an automatic White preference.

Maina et al. (2018) conducted a systematic review of the literature examining the implicit racial/ethnic biases of healthcare providers specifically through the use of the racial/ethnic IAT. Out of the 37 studies included in the review, 31 demonstrated that healthcare providers across many disciplines held implicit pro-White or pro-light skinned biases. Additionally, these implicit biases are not reported in tests of explicit bias, or bias that healthcare providers are conscious of having (Blair et al., 2013). Though results are mixed for precisely how pro-White implicit racial bias affects provider-patient interactions, increased provider bias does consistently correlate with poorer patient-provider interactions (Miana et al., 2018). Limited research has been conducted using IATs in healthcare settings, and the vast majority of studies were conducted with physicians. Examining the lack of racial and ethnic diversity in the field of child life through the lens of implicit bias, child life specialists' ability to practice truly culturally competent care is questionable.

However, implicit bias is merely a symptom of the deeply embedded systemic racism in healthcare that has led to significant health disparities for people of color in America (Feagin & Bennefield, 2014). In order to understand the importance of not only diversifying the field of child life but also healthcare professions as a whole, the connection between systemic racism and healthcare disparities for underrepresented populations must be examined. Feagin and Bennefield (2014) point to systemic racism theory to portray the larger framework of healthcare disparities including five major dimensions of U.S. racism: "(1) Dominant racial hierarchy, (2) comprehensive White framing, (3) individual and collective discrimination, (4) social reproduction of racial-material inequalities, and (5) racial institutions integral to White domination of Americans of color". Over 20 generations of American history, White Americans have benefitted unfairly from the oppression of Americans of color leading to significant socioeconomic resources beyond just social capital. Due to the enrichment this oppression brought to White Americans, the impoverishment and health disparities seen for Americans of color persist. "Americans of color have been economically impoverished and unhealthy because White Americans have long used extensive discrimination and resistance to change to insure they as a group are economically much better off and generally healthier" (Feagin & Bennefield, 2014).

Many healthcare disparities that have been shown in the literature stem from issues of access. For example, members of socioeconomically disadvantaged communities are significantly more likely to be people of color. People of color who have less socioeconomic resources also have lower levels of education, work jobs with increased occupational hazards, and live in areas that have higher environmental hazards compared to White Americans (Betancourt, Green, Carrillo, & Ananeh-Firempong II, 2003). Health disparities have also been

demonstrated for Americans of color with access to the healthcare system. These disparities

include "the utilization of cardiac diagnostic and therapeutic procedures, prescription of

analgesia for pain control, surgical treatment of lung cancer, referral to renal transplantation,

treatment of pneumonia and congestive heart failure, and the utilization of specific services

covered by Medicare" (Betancourt et al., 2003). Even in studies that have been controlled for

confounding factors such as socioeconomic status, age, comorbidity, and insurance status, over

175 studies have shown decreased health outcomes for people of color in America (Betancourt et

al., 2003). In a technical report generated by the American Academy of Pediatrics, it was found

that in a systematic review of literature published between 1950 and 2007, significant health

disparities were found for children of color that were pervasive and persistent. For example,

childhood mortality rate disparities were found for all four U.S. racial/ethnic minority groups

that were studied - African Americans, Asians/Pacific Islanders, Latinos, and American Indians

and Alaskan Natives. These disparities included increased likelihood of death from drowning,

acute lymphocytic leukemia, congenital heart defects, and after congenital heart defect surgery.

Children of color with Down syndrome also had an earlier median age at death. Additionally,

decreased health outcomes for children of color with chronic illnesses were found throughout the

literature including children experiencing asthma, cancer, eye disorders, HIV.AIDS, kidney

disease, mental health, special health care needs, and stroke (Flores, 2010). Though literature has

been explored that examines physicians' implicit racial bias, this is an individual view of a

broader systemic issue that can be seen through examining the entirety of the healthcare

workforce as well as the racial and ethnic identity of those engaged in the research that is telling

the story of healthcare disparities.

From 1978 to 2008, 75% of graduates from American medical schools were White (Association of American Medical Colleges, 2010). Not only are physicians majority White, but public health researchers and policymakers, executives of insurance and pharmaceutical companies, hospital administrators, and medical educators are dominated by a majority White workforce as well (Feagin & Bennefield, 2014). Looking at the National Institute of Health specifically, out of the 896 senior investigators, only 1.1% identify as African American and out of 238 lab/branch chiefs, 0.8% identify as African American (Gottesman, 2011). A figure detailing NIH Intramural Research Program Demographics can be found in Figure 10. These numbers highlight the fact that research on physician implicit bias does not tell the whole story of the racial disparities in America, and in fact, the voices of Americans of color are missing from this research and subsequent dialogue leaving conclusions void of overarching solutions (Feagin & Bennefield, 2014).

Though child life specialists are a relatively small group within the larger healthcare system, our philosophy grounded in cultural competence and interest in expanding the racial and ethnic diversity of the field positions us to implement change through engaging in dialogue and recruiting diverse members of our leadership teams. With an ever-diversifying patient population and a homogenous child life field, implicit biases are most likely affecting specialist-patient and family relationships. Additionally, with an 8% minority population represented in the child life field, many diverse backgrounds and ideas are not being incorporated into the child life services provided as originally intended by the Association of Child Life Professionals (Association of Child Life Professionals, 2013). Though there have been attempts to address this issue such as providing diversity scholarships, there may be larger barriers to entry for people of color that may be hidden as the field of child life is still relatively new. One of these barriers may lie in the

networking required to gain entry to this field that begins with being privy to the knowledge that the field exists and what the necessary steps are to become certified.

Though it is difficult to draw definitive conclusions about the way child life specialists of color are exposed to the field, perhaps one of the most interesting outcomes of this survey was the additional comments and information participants felt led to contribute. A few of these quotes are included to demonstrate the interest in this topic as well as to speak to some of the experiences of child life specialists of color and the importance of this topic to the field of child life as a whole:

> *I'm not sure about nation wide, but there are very few child life specialists of color here in New England! Most hospitals have NO diversity on their child life team, and it can definitely be intimidating and challenging when issues of race/prejudices/racial comments come into play. My school did pair me for the final internship (3rd) with a supervisor who was also a minority. It was interesting to hear her perspectives as a longer certified CLS.*

> *I am very intrigued by this study and am interested in learning more about it. A few colleagues and I- of diverse backgrounds- have often discussed the lack of diversity in the field and how it effects our role & interactions with patients, families and the medical team; especially since we work in an inner city environment where the majority of our patients are minorities.*

> *I have only met one non-White CCLS in my experiences (out of about 20 and she was Hispanic). Getting into this field would have been almost impossible for me if I did not receive a diversity scholarship through ACLP, so I am very thankful for that. I appreciate that they are attempting to diversify the field. Even in videos online about Child Life services across the country, I have not seen any minorities represented. I hope that can change in the coming years.*

> *I was taught to be self-driven and researched independently about this career field through the then called child life council's website. I did seek advice from a few child life specialists in my area who were Caucasian and they were not helpful or friendly about helping me. In fact, one of the women specifically declined my request to help with child life programming knowing of my interest in child life, but offered the opportunity to help to another person not interested in child life (and who didn't ask to help). However, once I was an intern, the child life specialists at the hospital where my internship was were*

extremely supportive. My internship site was not in the Midwest, but in a large diverse metropolitan city.

I believe that socioeconomic status plays a role into this career choice, as it is expensive to pursue, and socioeconomic status is intertwined with race, which is sad. Thank you for looking into this subject. I hope someday this field will have specialists who are ethnically more representative of our patients.

These comments were shared by child life specialists who identified as people of color, but comments were also shared by child life specialists who identified as White in support of exposing this topic and increasing the diversity of the field. Some of the themes and similarities that emerge from the additional information participants share is a lack of support throughout not only the certification process but also as a professional. Besides what was mentioned by child life specialists of color in the comments, there was a large amount of comments exuding interest in the topic and a desire to remedy this deeply felt issue in the field.

Study Limitations

Though valuable information was learned about the ways in which child life specialists of color are exposed to knowledge of the field, there are limitations to the study and directions future studies can take to expand on the information gained. Firstly, in order to learn more about how specifically child life specialists of color learn about the field, the sample could have been limited to only child life specialists of color. Additionally, the amount of time the survey was available could be lengthened in order to encourage a greater number of respondents and a more representative sample. Due to the interest in the subject that was shared in the additional comments section, a future direction may include conducting an in-depth qualitative study about the individual experiences of a few child life specialists of color. Conducting research along with child life specialists of color will allow their voices to be amplified as well as provide the field a picture of what child life specialists of color are experiencing in their practice currently.

Conclusion

The purpose of this research study was to examine the ways in which child life specialists are exposed to the field of child life and how this may or may not be affected by racial and ethnic identity. Though the sample of child life specialists of color was small though representative of the demographics of the field, it was found that there was not racial concordance between the child life specialists of color and their advisors or means of exposure to the field. It was also found that there is an enormous variety of ways child life specialists were exposed to the field which speaks to the relative newness of this profession. In addition, this provided an opportunity to consider ways to reach people of color who may be interested in pursuing the field. Further, the fact that half of the participants of the survey were between the ages of 25 and 35, perhaps the field is experiencing a period of growth that may lead to a critical time to focus on increasing the diversity of child life specialists.

Future Ideas and Next Steps

This survey served as a first step of a long process of identifying embedded barriers experienced by potential child life specialists of color. The lack of social capital with friends and family members who have knowledge of child life may be one of the first barriers preventing potential specialists from pursuing the field; however, there are other barriers experienced by child life students who have learned about the field. Fortunately, the Association of Child Life Professionals have developed diversity scholarships for students to apply to the internship process. Though this is a step towards making internships more equitable for students of color, there are few diversity scholarships alloted and the financial burden of relocating for an unpaid internship is high. Despite the steps being taken to address the financial strain of internships, we continue to face the issue of how to expose potential child life specialists of color to the

knowledge of the field as well as provide support throughout the certification process that involves much more than the internship.

     Considering that half of the child life specialists of color who participated in this research learned about the field through a high school or college experience, one of the recommendations that can be made based off of these results, is to reach out to high schools and colleges in a variety of locations in order to expose a diverse group of students to the field. For example, another field that has experienced a historical lack of diversity is the field of Occupational Therapy. To address the issue of diversity, a group of occupational therapists began the Coalition of Occupational Therapy Advocates for Diversity. The approach this coalition takes to diversify occupational therapy is multifaceted and is represented visually in Figure 11. On the bottom, there are attempts to reach out to the general population which includes strategies that support financial resources, celebrating differences, and providing service opportunities in the U.S. and internationally. Secondly, there are attempts to diversify on the group and organization level. Lastly, the efforts made at the individual level are the ones that can apply the most to future efforts the Association of Child Life Professionals can begin to make. These include, "Promote OT to individuals in underrepresented communities, initiate mentoring relationships, seek community leaders to serve as intermediaries, and explore literature which depicts diverse experiences" (COTAD, 2017). One of these programs in action includes a mentorship opportunity for occupational therapists of color who are interested in pursuing the field (COTAD, 2017). Following a similar model, it is recommended that the Association of Child Life Professionals form an "Equity and Inclusion" task force to continue to evaluate the ways in which the field can recruit diverse individuals as well as hear directly from child life specialists of color as to the ways in which they may have felt more supported and encouraged. This effort

should also include mentorship opportunities for high school students of color who are interested in the field of child life.

Jenni Luke, the CEO of a program called "Step Up" gave an example of how adults can leverage their social capital to improve the career outcomes for youth of color in a TedX Talk (2016). Step Up is a non-profit organization that seeks to provide mentorship to young girls in under-resourced communities as an afterschool program (Step Up, 2014). In her TedX Talk, Luke shares the story of a girl named Stephanie who participated in the Step Up program. She grew up in a Spanish-speaking home in South-Central Los Angeles in the 1990s, which was a time of increased gang violence and drug activity. Her parents immigrated to the United States and always pushed their children towards educational achievement despite their limited understanding of the process of pursuing higher education. Stephanie's goal was to complete her high school education and move on to college, and she would be the first in her family and one of the first in her extended family and neighborhood to achieve this goal. After graduating college with honors, Stephanie began working at one of the top entertainment industries in the world where her perspective as female of color is extremely needed. Luke's central question in her talk was how Stephanie was able to be successful and reach these milestones. Luke explained that Stephanie had a great deal of social capital in her supportive family and neighborhood, but she needed additional social capital to help her pursue her individual aspirations that she did not see represented in her community. Stephanie needed a support system that shared information about going to college, inspiration that encouraged her to examine careers she had not considered, and relationships with people who treated her like a professional peer. "She worked with mentors who really recognized her strengths and opened their social capital to her to give her resources that she really needed to achieve her goals" (Luke, 2016). The mentors Stephanie

worked with in the Step Up program introduced her to professionals who were not working in minimum wage labor jobs. When Stephanie was promoted two years into her first position, she was asked who she thought would be a good fit to fill her old position. She recommended one of the girls she had grown up with her shared her work ethic and career aspirations. To conclude Stephanie's story, Luke emphasizes all of our abilities to share our social capital with others:

> *Everyone has a part to play. So if you saw yourself as the mentors in Stephanie's story, the part that you can play is by opening doors and advocating on behalf of young people of color from under-resourced communities whose value is often overlooked. If you see yourself as the school in Stephanie's story, you have a part to play by collaborating with mentoring organizations that can connect your students with the social capital they say they need but may not have access to. If you see yourself as the employer in Stephanie's story, the part that you can play is by looking at your employment pipelines - who are you hiring and where are you going to get those people - broadening that reach and considering points of view and life experiences that can really add value to your company and to your industry* (Luke, 2016).

Diversity versus Inclusion - "Diversity is the Mix; Inclusion is Making the Mix Work"

-Andrés Tapia (Chu, 2017)

Though the word diversity has been used throughout to mean increasing the variety of racial and ethnic backgrounds represented in the population of Certified Child Life Specialists. It is understood that there is a difference between diversity and inclusion. Diversity is a crucial first step towards inclusion; however, child life teams and hospitals in general must be prepared for inclusion before diversity can successfully increase. In Chu's (2017) article entitled, "Diversity, Inclusion, Cultural, and Linguistic Competence: Do We Have a Strategy?" he states:

> *A workforce, a student body, a profession may be diverse, but if minority groups (all forms) are not included in decision-making or leadership roles then segregation is the result and the benefits of diversity are not achieved. Before the value of diversity can be appreciated, organizational and individual commitment to having all groups heard and understood must be present. This inclusion must also entail opportunities for participation in leadership roles so that all may learn from the experiences of a diverse group of individuals.*

Considering both the ideas of diversity and inclusion, it is recommended that child life programs participate in activities that encourage growth in self-reflection and understanding the influence of one's own culture and background on one's career path and child life practice. It will also be crucial to not only hire diverse individuals to be a part of child life teams, but also to be aware of their experiences in a homogeneous workplace and provide a safe place to be able to discuss these differences. At the same time as providing a space for open dialogue and support, it will be important to ensure that child life specialists of color are not put in a position where they are responsible for answering for the collective experiences of all child life specialists of color or of persons of color. In order for every member of a child life team to be able to learn and grow from one another, each individual must be committed to be vulnerable to one's own experiences and perspectives.

References

Association of American Medical Colleges. (2010). Diversity in the physician workforce: Facts & figures 2010. Washington, D.C.: Association of American Medical Colleges

Association of Child Life Professionals. (2000). *Making ethical decisions in child life practice.* Arlington, VA: Association of Child Life Professionals.

Association of Child Life Professionals. (2013). Job analysis. [Email Correspondence].

Association of Child Life Professionals. (2018). *Vision, mission, values.* Retrieved from http://www.childlife.org/about-aclp/purpose-mission-values

Banaji, M. R., & Greenwald, A. G. (2013). *Blindspot: Hidden biases of good people.* New York, NY: Bantam Books.

Bell, J., Johnson, B., Desai, P., & McLeod, S. (2009). Family-centered care and the implications for child life practice. In R. Thompson (Ed.), *The handbook of child life* [1st ed.], (95-115). Springfield, Illinois: Charles C Thomas, LTD.

Betancourt, J. R., Green, A. R., Carrillo, E., Ananeh-Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293-302.

Billante, J. & Hadad. (2010). *Study: White and Black children biased toward lighter skin.* Retrieved from http://www.cnn.com/2010/US/05/13/doll.study/index.html

Blair, I. V., Steiner, J. F., Fairclough, D. L., Hanratty, R., Price, D. W., Hirsh, H. K.,...Havranek, E. P. (2013). Clinicians' implicit ethnic/racial bias and perceptions of care among Black and latino patients. *Annals Of Family Medicine, 11*(1), 43. doi:10/1370/afm.1442

Bourdieu, P. (19 86). The forms of capital. In J. Richardson (Ed.), Handbook of theory and research for the sociology of education (pp. 241–258). New York, NY: Greenwood. Retrieved from

http://www.marxists.org/reference/subject/philosophy/works/fr/bourdieu-forms-

capital.ht1m

Brown v. Board of Education, 347 U.S. 483 (1954).

Burt, R. S. (1997). The contingent value of social capital. *Administrative Science Quarterly, 42*,

339-365.

Caldas, S. J., & Cornigans, L. (2015). Race/ethnicity and social capital among middle- and

upper-middle-class elementary school families: A structural equation model. *School*

Community Journal, 25(1), 137-156.

Callahan, C. N., Libarkin, J. C., McCallum, C. M., & Atchison, C. L. (2015). Using the lens of

social capital to understand diversity in the earth system sciences workforce. *Journal of*

Geoscience Education, 63(2), 98-104. doi:10.5408/15-083.1

Chu, G. Y. (2017). Diversity, inclusion, cultural and linguistic competence: Do we have a

strategy?. *Optometric Education, 43*(1), 44-45.

Coalition of Occupational Therapy Advocates for Diversity (COTAD). (2017). *About us.*

Retrieved from https://www.cotad.org/about

Coleman, J. S. (1990). *Foundations of social theory.* Cambridge, MA: Harvard University Press.

Cooper, L. A., Roter, D. L., Carson, K. A., Beach, M. C., Sabin, J. A., Greenwald, A. G., & Inui,

T. S. (2012). The associations of clinicians' implicit attitudes about race with medical

visit communication and patient ratings of interpersonal care. *American Journal Of*

Public Health, 102(5), 979-987. doi:10.2105/AJPH.2011.300558

Cross, T. (1988). Services to minority populations: Cultural competence continuum. *Focal Point,*

3(2), 1-5.

Digital History. (2016). Herbert Hoover, "rugged individualism" campaign speech. Retrieved

    from http://www.digitalhistory.uh.edu/disp_textbook.cfm?smtID=3&psid=1334

Ecological systems theory. (2016). *Salem Press Encyclopedia of Science*

Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Science &*

    Medicine, 103, 7-14. doi:10.1016/j.socscimed.2013.09.006

Flores, G. (2010). Technical report - Racial and ethnic disparities in the health and health care of

    children. *American Academy of Pediatrics, 125*(4). doi: 10.1542/peds.2010-0188

Forum for the Future. (n.d.). The five capitals. Retrieved from

    https://www.forumforthefuture.org/project/five-capitals/overview

Gottesman, M. (2011). Valuing diversity at NIH. NIH Catalyst, 19, 2.

Granovetter, M. S. (1973). The strength of weak ties. *American Journal of Sociology, 6*,

    1360-1380.

Irving, D. (2014). *Waking up White and Finding Myself in the Story of Race.* Cambridge, MA:

    Elephant Room Press.

Johnson, L. (2005). Cultural influences in children's health care. In Rollins, J., Bolig, R., &

    Mahan, C. (Ed.), *Meeting children's psychosocial needs: Across the health-care*

    continuum. (pp. 421-454). Austin, TX: Pro-ed.

Lin, N. (1990). Social resources and social mobility: A structural theory of status attainment. In

    R. L Breiger. (Ed.), *Social mobility and social structure*. (pp. 247-271). New York, NY:

    Cambridge University Press.

Luke, S. (2016). *TedX Youth@Hewitt: Social capital* [Video File]. Retrieved from

    https://www.youtube.com/watch?v=z4dE4WJH160

Maina, I. W., Belton, T. D., Ginzberg, S., Singh, A., & Johnson, T. J. (2018). A decade of

    studying implicit racial/ethnic bias in healthcare providers using the implicit association

    test. *Social Science & Medicine, 199*, 219-229. doi:10.1016/j.socscimed.2017.05.009

NAACP Legal Defense and Educational Fund, Inc. (n.d.). *Brown at 60: The doll test.* Retrieved

    from http://www.naacpldf.org/brown-at-60-the-doll-test

Pearson, L. J. (2005). Children's hospitalization and other health-care encounters. In Rollins,

    J., Bolig, R., & Mahan, C. (Ed.), *Meeting children's psychosocial needs: Across the*

    health- care continuum. (pp. 1-42). Austin, TX: Pro-ed.

Seibert, S. E., Kraimer, M. L., & Liden, R. C. (2001). A social capital theory of career success.

    Academy of Management Journal, 44(2), 219-237.

Step Up. (2014). *What we do.* Retrieved from https://www.suwn.org/what-we-do

Strömgren, M., Eriksson, A., Bergman, D., & Dellve, L. (2016). Social capital among healthcare

    professionals: A prospective study of its importance for job satisfaction, work

    engagement and engagement in clinical improvements. *International Journal of Nursing*

    Studies, 53, 116-125. doi:10.1016/j.ijnurstu.2015.07.012

The Center for Racial Justice Innovation. (2017). *What is systemic racism? [videos].* Retrieved

    from https://www.raceforward.org/videos/systemic-racism

United States Census Bureau. (2016). *QuickFacts: Population estimates, July 1, 2016.* Retrieved

    from https://www.census.gov/quickfacts/fact/table/US/PST045216

Vaughan, S., Sanders, T., Crossley, N., O'Neill, P., & Wass, V. (2015). Bridging the gap: the roles of social capital and ethnicity in medical student achievement. *Medical Education, 49*(1), 114-123. doi:10.1111/medu.12597

Way, N., Hernández, M. G., Rogers, L. O., & Hughes, D. L. (2013). "I'm not going to become no rapper": Stereotypes as a context of ethnic and racial identity development. *Journal of Adolescent Research, 28*(4), 407-430. doi: 10.1177/0743558413480836

Tables and Figures

Figure 1 - Racial and Ethnic Makeup of Child Life Specialists

How would you describe yourself? (Multiple boxes can be selected)
108 responses
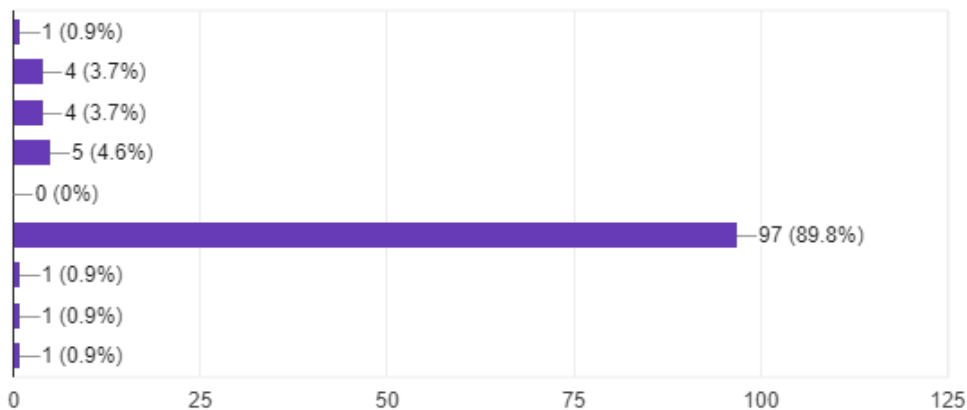
Figure 2 - Age of Child Life Specialists

What is your age?
108 responses
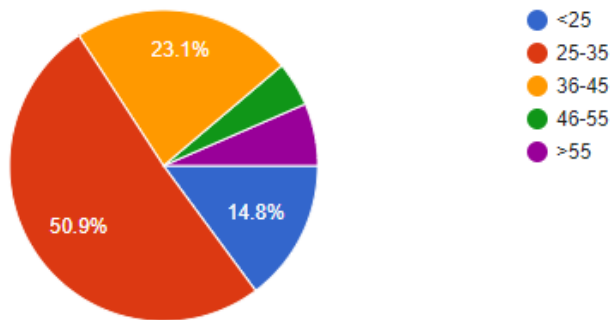
Figure 3 - Years of Experience of Child Life Specialists

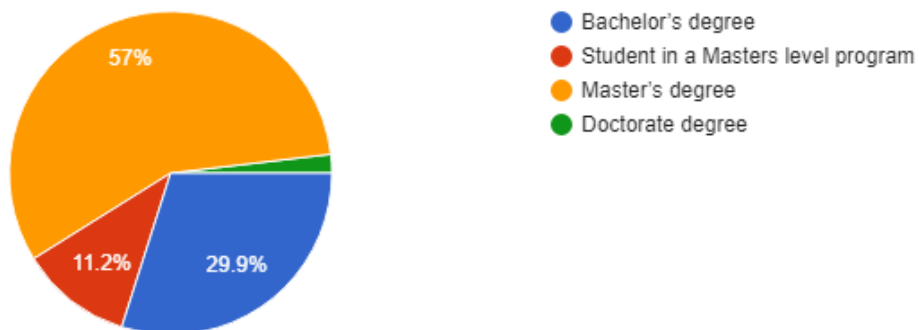How many years have you been practicing as a Certified Child Life Specialist (CCLS)?

107 responses

- <1
- 1-2
- 3-5
- 6-10
- 11-15
- 16-20
- >20

26.2% 10.3% 8.4% 11.2% 20.6% 18.7%
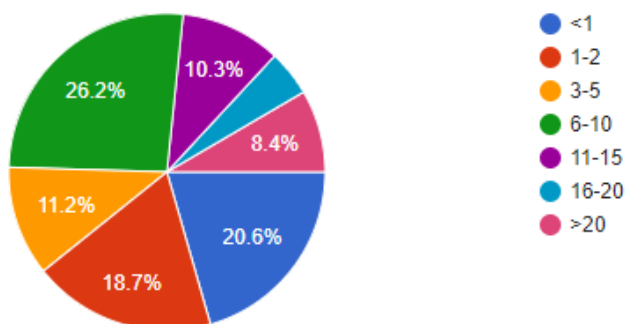
Figure 4 - Education Level of Child Life Specialists

What is your current education level?

107 responses

- Bachelor's degree
- Student in a Masters level program
- Master's degree
- Doctorate degree

57% 11.2% 29.9%

Figure 5 - How Child Life Specialists Were Exposed to the Field

How did you learn about the field of child life?

108 responses

- High School counselor/advisor
- College counselor/advisor
- Personal medical experience
- Family member
- Family friend
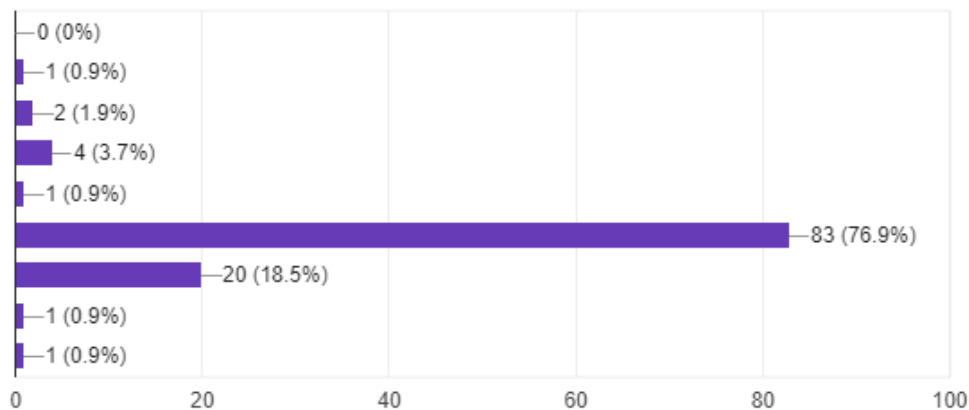- Friend
- Family member or friend's medical…
- Internet/Media

1/7
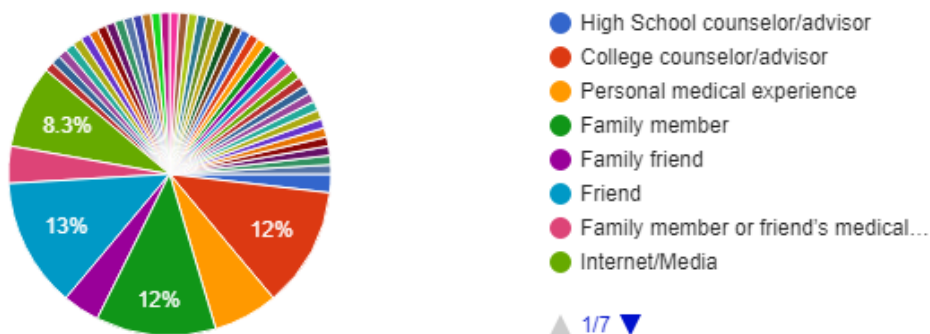
Figure 6 - Race/Ethnicity of Person who Exposed Participant to the Field

How would you describe the race/ethnicity of the person/family/group who introduced you to the field of child life? (Multiple boxes can be selected)

108 responses

Figure 7 - Race/Ethnicity of Child Life Specialist Participants Interacted With

If you learned about the field of child life from a medical experience, how would you describe the race/ethnicity ...with? (Multiple boxes can be selected)
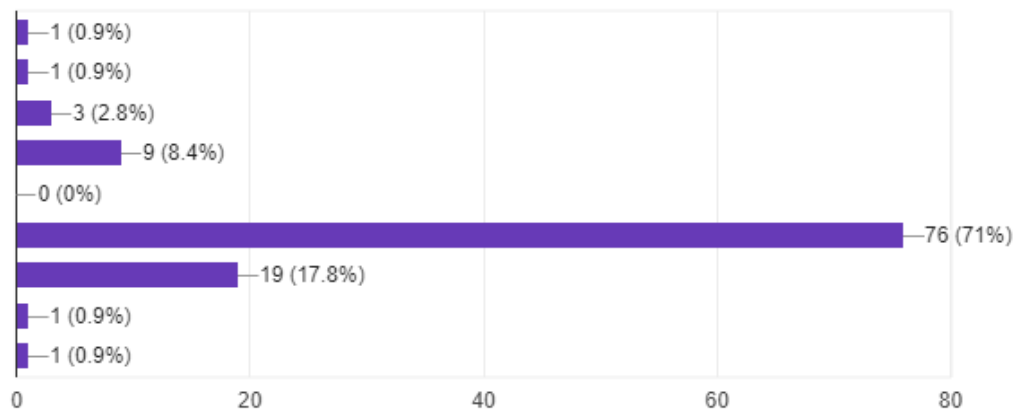98 responses
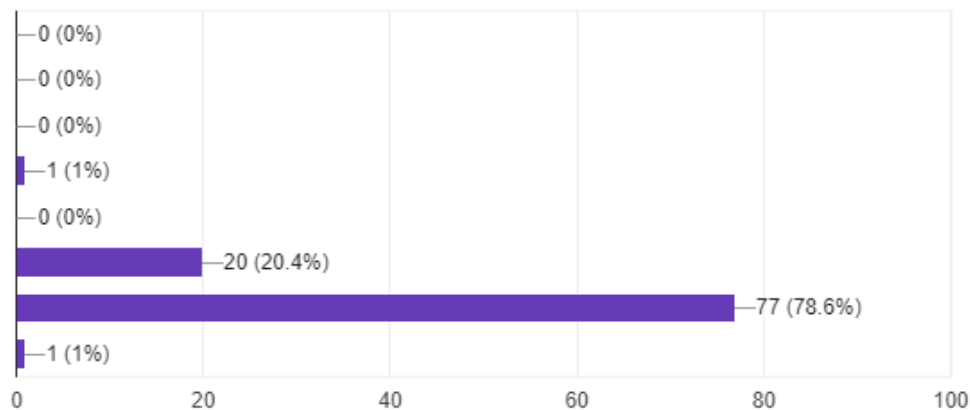
Figure 8 - Race/Ethnicity of Mentor/Advisor

If you had a mentor/advisor throughout your certification process, how would you describe that person's race/...city? (Multiple boxes can be selected)
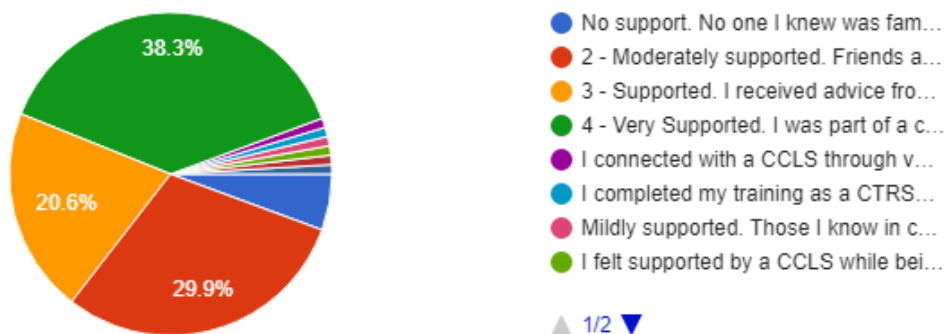107 responses

Figure 9 - Degree of Support

How supported did you feel throughout the certification process?
107 responses

Figure 10 - NIH Intramural Research Program Demographics (Gottman, 2011)

NIH Intramural Research Program Demographics			
	Tenure Track	Senior Investigator	Lab/Branch Chief
Total	253	896	238
Females	33%	19%	16%
Males	67%	81%	84%
African–American	1.2%	1.1%	0.8%
Hispanic	3.2%	3.0%	2.9%
Native American	0%	0.1%	0%
Asian–Pacific Islander	26%	13%	5.9%
White	62%	83%	90%

Note: Only U.S. citizens and permanent residents are classified by race/ethnicity; therefore the percentages do not necessarily add up to 100%.

Figure 11 - Framework for Promoting a Diverse Workforce in Occupational Therapy

(COTAD, 2017)
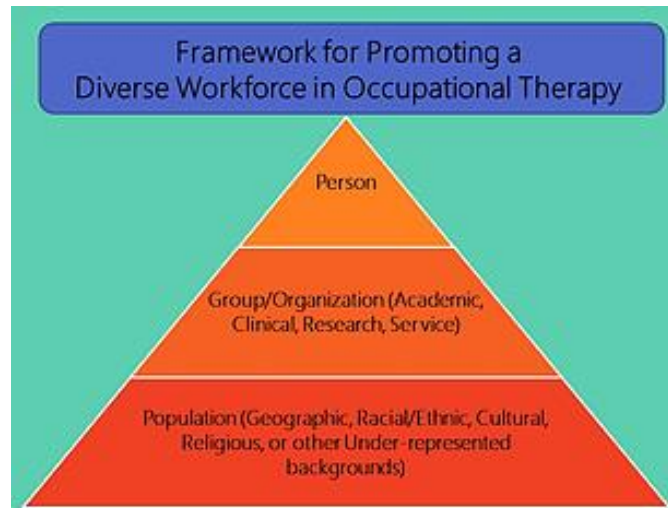
Appendix A
Survey
Diversity in Child Life

The purpose of this study is to understand the current racial and ethnic demographics of the child life field. The study also aims to evaluate how child life specialists are learning about the field and if the method used to learn about the field is related to the race/ethnicity of both the person sharing information about the field and the aspiring child life specialist. Understanding how aspiring child life specialists learn about the field may help identify barriers that can be addressed in order to make the field of child life more diverse.

Your participation is entirely voluntary. If you agree to participate, you will be completing an online survey that will take approximately 5 to 10 minutes to complete. There will be questions for which you can select an answer as well as provide additional information if you feel your answer requires elaboration. Please feel free to skip any questions you do not wish to answer.

Only the researchers will be reading the responses to this survey. Due to the online nature of this survey, there is a possibility that responses could be read by a third party, though every effort will be made to ensure the confidentiality of your answers.

If you want to know more about this research project, please contact my advisor Genevieve Lowry at glowry@bankstreet.edu or 212 875 4722
Board at Bank Street College of Education.

Information on Bank Street College policy and procedure for research involving human participants can be found on the college website at:
https://www.bankstreet.edu/graduateschool/academics/institutional-research-review-board/.
Additional questions or concerns you have about the way the research is being conducted should be addressed to the Chair of the Institutional Research Review Board, Dr. Wendi Williams at ResearchReview@bankstreet.edu.

Thank you for your time and participation.

Google Forms Survey:

1. What is your age?
○<25
○25 – 35
○36 – 45
○46 – 55
○>55

2. How many years have you been practicing as a Certified Child Life Specialist (CCLS)?
○< 1

○1 – 2

○3 – 5

○6 – 10

○11 – 15

○16 – 20

○>20

3. How would you describe yourself? (Multiple boxes can be selected)

❏American Indian or Alaska Native

❏ Hispanic, Latino, or Spanish origin

❏Asian

❏Black or African American

❏Native Hawaiian or Other Pacific Islander

❏White

❏Other:_____

4. In which geographical region are you currently practicing as a CCLS?

○Northeast

○Midwest

○South

○West

○Canada

○Other (please specify)_____

5. What is your current education level?

○Bachelor's degree

○Student in a Masters level program

○Master's degree

○Doctorate degree

6. How did you learn about the field of child life?

○High School counselor/advisor

○College counselor/advisor

○Personal medical experience

○Family member

○Family friend

○Friend

○Family member or friend's medical experience

○Internet/Media

○Other (please specify)_____

7. How would you describe the race/ethnicity of the person/family/group who introduced you to the field of child life? (Multiple boxes can be selected)

❑American Indian or Alaska Native

❑ Hispanic, Latino, or Spanish origin

❑Asian

❑Black or African American

❑Native Hawaiian or Other Pacific Islander

❑White

❑ N/A

❑Other:_____

8. If you learned about the field of child life from a medical experience, how would you describe the race/ethnicity of the CCLS you interacted with? (Multiple boxes can be selected)

❑American Indian or Alaska Native

❑ Hispanic, Latino, or Spanish origin

❑Asian

❑Black or African American

❑Native Hawaiian or Other Pacific Islander

❑White

❑ N/A

❑Other:_____

9. How supported did you feel throughout the certification process?

○1 - No support. No one I knew was familiar with child life.

○2 - Moderately supported. Friends and family members supported my decisions but were mostly unable to provide career advice.

○3 - Supported. I received advice from a certified child life specialist as to the steps I should take for certification. A certified child life specialist helped make connections on my behalf.

○4 - Very Supported. I was part of a child life academic program (undergraduate or graduate), or a program with a concentration or minor in child life. A certified child life specialist(s) mentored me throughout my journey and made many connections on my behalf.

○ Other:_____

10. If you had a mentor/advisor throughout your certification process, how would you describe that person's race/ethnicity? (Multiple boxes can be selected)

❒American Indian or Alaska Native

❒ Hispanic, Latino, or Spanish origin

❒Asian

❒Black or African American

❒Native Hawaiian or Other Pacific Islander

❒White

❒N/A

❒Other:_____

11. Additional comments or information relevant to the study:

Appendix B
Bank Street College of Education
Institutional Research and Review Board Application Acceptance

Bank Street College of Education
Institutional Research and Review Board

Dear Madalyn,

We have reviewed the IRRB application for your study, *Diversity in Child Life.* With the exception of minimal revision of the recruitment email, the procedures of the study were described well. As the study does not require the provision of personal information and the survey will be completed anonymously by members of a nation and state wide organization whose identities cannot be determined by the data collection or analysis procedures you have described, the study qualifies for expedited review.

IRRB approval for engagement with study participants is permitted through August 30, 2018 when it is expected you will have fully completed data collection activities. Should more time be required, you will need to submit a request for extension to the IRRB committee.

The committee wished you very well on your project. Should you have any questions or concerns, please feel free to be in contact with us any questions or concerns regarding this correspondence. We can be reached at researchreview@bankstreet.edu.

Sincerely,

Wendi S. Williams, Ph.D.
Associate Dean of Academic Affairs
Chair, Institutional Research and Review Board

cc: Brian Hogarth, Leadership Department
Nancy Nager, Teaching & Learning Department
Sean O'Shea, Teaching & Learning Department
Robin Hummel, Leadership Department
Robin Hancock, Graduate School
Dirck Roosevelt, Teachers College, Columbia University
Genevieve Lowry, Advisor

Bank Street
College of Education
Graduate School of Education
610 West 112th Street
New York, NY 10025
212 875 4457
www.bankstreet.edu

For office use only:
Reviewed by: Wendi Williams
Date   April 2, 2018

Approved   Wendi Williams
Revisions required April 2, 2018