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Jami Baretta
Bank Street College of Education

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Empowering Adolescents through Mentorship

By

Jami Barretta

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Abstract

From Greek mythology to peer tutoring programs in schools, mentorship has been around for thousands of years and has continued to evolve through time. The literature reviewed highlights not only the way mentorship looks across settings, but more importantly the factors that make it a powerful experience. The goal of this thesis is to explore how mentorship can be utilized in a hospital setting as a short-term inpatient intervention. The program is designed to be implemented by child life specialists who are working with school-age and adolescent patients to address their developmental needs. Specifically in the hospital setting, mentorship can serve as a coping outlet for patients who are going through similar experiences to work together and make a meaningful connection. The adolescent is given a role as a mentor for a younger patient, which empowers the teen through leadership opportunities. The mentorship experience allows children to help each other in a way that promotes empathy, responsibility, and overall adaptive coping. The hospital manual includes step-by-step instructions for how to create a program including goals, guidelines, training, needs assessment tool, and activity ideas.

Key Words: mentorship, adolescence, school-age, empowering, development

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Rationale

Entering into my child life internship, the population that scared me the most was adolescents. I did not have a lot of experience working with this age group and I feared my own youthfulness would inhibit the formation of powerful relationships. Within the first few days of the rotation on the adolescent unit, however, my perspective began to shift. I found myself truly enjoying the interactions and felt compelled by the stories and experiences teens had to share. I reflected on the judgments associated with teens and how they can be viewed as difficult, moody, and highly challenging.

The idea of mentorship program was inspired by the desire to provide a meaningful intervention for teens in the hospital setting and to provide a healthy coping outlet, while giving them an opportunity to build life skills that will exceed beyond the hospital walls. In speaking with my preceptor, I learned that in her own practice, she would provide mentorship experiences spontaneously when she saw that there were two patients who could really benefit from it. These conversations sparked an interest to move forward with the idea, research the literature about why mentorship is so powerful, and create an intervention for child life programs around the world to utilize in providing mentorship experiences within the hospital environment. The hope is that other child life specialists can use this manual as a resource to implement a mentor program in their department. The program is cost effective, as there are no outside finances needed to get the program running.

Through the years, literature has proven the validity of mentorship relationships and although the dynamics may change through time, the results are still significant. This study will focus on how mentoring imparts knowledge to the less experienced person, and more specifically, how mentoring empowers the mentor through leadership opportunities. When

mentoring opportunities are provided to place adolescents in the leadership role, teens not only can help the younger mentee, but can also build and develop their own self-esteem, character, and leadership skills.

The spiritual principle of "a kind man benefits himself" supports the idea of empowering adolescents to be mentors as well (Proverbs 11:17-27). When they help others by being mentors, they can develop their own sense of self as change agents in the world. Developmentally, teens are experiencing the journey of discovering their own identity. It is critical to provide the tools for them to nourish skills of leadership, responsibility, and kindness even during times of difficulty, stress, and personal crisis.

The literature displayed in this thesis shows the importance of mentoring, and my hypothesis is that mentoring will provide a rewarding experience for hospitalized adolescents to carry with them beyond hospitalization and into their future lives. While the benefits for adolescents may be highlighted, the effects on the school-age child cannot be underestimated as their developmental needs of industry and concrete operational thinking are met through the process. The hope of this thesis is that perhaps a seed will be planted in the mentorship process and those patients involved will soar with confidence and grow into competent and caring adults.

Introduction

Building relationships and imparting wisdom through the act of mentoring is not a recent development. Mentoring can be traced back to Greek mythology when Odysseus entrusted "a wise and faithful advisor" named Mentor to protect his son, Telemachus, while he was fighting against Troy (Ragins & Kram, 2007, p. 3). Mentor acted as a tutor for Telemachus, but on several occasions, Athena assumed Mentor's form to give advice to her son and husband. The term mentor has transcended time, gender, and culture to embody one who passes on wisdom to and shares knowledge with another less experienced one. These relationships where information is transferred intergenerationally "has been an integral part of social life and the world of work for thousands of years" (Ragins & Kram, 2007, p. 4). The principles of mentorship have powerful effects for both the mentor and mentee. Mentoring is a natural phenomenon where people create relationships out of the desire to impart or receive knowledge without a formal process necessarily in place.

Furthermore, the hospital is one particular setting where mentoring occurs naturally on so many levels. There is such a great learning opportunity among doctors, administrators, and professionals for someone with more knowledge to share it with others who are eager to learn. Mentoring within the patient population may occur naturally as well based on the shared experiences hospitalization creates. Hospitalized children in particular face a unique set of challenges. As medial professionals strive to reduce the stress and anxiety of hospitalization, psychosocial interventions address non-pharmacological ways to promote adaptive development and coping. Mentorship has the power to provide these experiences for children. While some peer-to-peer mentoring occurs naturally in a playroom setting, for example, a more formal program can provide a safe environment for these relationships to nourish both patients involved.

This paper will aim to outline the literature surrounding mentoring and move into the logistics of what a program in a pediatric hospital setting could look like. The research begins on a more general level of the mentoring relationships between an adult and a child. It will then move to mentoring in a school setting and how these relationships benefit a child's educational outcomes. Using these studies to support why mentorship does in fact work, the paper shifts to the idea of how we can use mentorship to empower adolescents, particularly in a hospital setting. Finally, a mentorship program is outlined as a way to take teens out of their current medical situation by bestowing on them the role of being a mentor to a younger patient. Through this mentoring relationship, the developmental goals are to empower teens through leadership, offer socialization opportunities, and provide a coping outlet for them. As teens navigate the identity versus role confusion stage of development and seek opportunities to increase self-esteem, mentorship within the hospital addresses such needs. Unlike other programs that are currently being utilized in outpatient settings or between current and discharged patients, this program will focus on providing a short-term, inpatient intervention. In an inpatient environment, the length of stay is unknown so the program takes into account the fact that the mentoring experience may be a one-time session. Both the mentor and mentee would be current patients at the facility and the pairing of patients is not diagnosis based but psychosocially matched through assessment criteria.

By looking at mentorship through a developmental lens, one can see how the skills and responsibilities required for being a mentor can benefit the mentor's character development. Furthermore, looking at adolescence through a developmental lens provides great insight into the needs of this population of children. As adolescents navigate finding their own identity and experimenting with increased opportunities for independence, they are at a critical point in their

lives developmentally where the experiences around them greatly impact their behavior and way of thinking. Hospitalization, unfortunately, can potentially interfere with many of these adolescent experiences, so teens often have difficulty coping during hospitalization. A mentorship experience provides positive benefits and therapeutic value to offset those difficulties. By highlighting the strengths that are already innate in the adolescent, the mentoring role supports the adolescent's ability to become a responsible adult, leader, and empathic responder.

Literature Review

The power of mentoring can be appreciated in the relationships it fosters and the mutual growth, learning, and development that occur within this relationship. Traditionally, mentoring relationships exist "between an older, more experienced mentor and a younger, less experienced protégé for the purpose of helping and developing the protégé's career" (Kram, 1985, as in Ragins & Kram, 2007, p. 5). Through time, however, the definition of mentoring has expanded to include diverse relationships across a variety of settings. Research over the years has been dedicated to understanding mentorship dynamics. The findings highlight the benefits for the protégé but often neglect the unique experience a mentor gains from these relationships. Allen (as in Ragins & Kram, 2007) speaks to the "inherently dyadic and complex process" of a mentoring relationship, "with the mentor and the protégé each enacting different roles and responsibilities" (p. 123). The success of a mentoring program depends on the behaviors of all members involved, from the mentor and the protégé, to the supervisors and caregivers. For the purpose of this paper, the mentoring relationships that will be focused on are those that support children.

The California Research Bureau evaluated the literature on mentoring from 1995-2000 and found that mentoring programs were moderately successful in improving academic performance and contributing to the well-being of children and youth (Foster, 2001). Although the review focused on mentoring relationships between adults and youth, alternative mentoring designs were explored and evaluated. Additionally, mentoring programs were examined through a developmental lens, rather than being designed to focus on specific problems children may be at risk for. According to Foster (2001), mentoring can be viewed as a *comprehensive youth development strategy*, or an essential way for "youth [to] gain the competencies they need to

meet the challenges of adolescence and become successful adults" (p. 2). More importantly, mentoring supports development in a way that does not try to change an individual, rather build upon their existing qualities. This idea is in line with the strength-based approach practiced in fields of education, mental health, psychology, social work, and child welfare (The University of California, 2009). By emphasizing a strength-based assessment of children and families, practitioners are able to build off existing strengths and competencies as they move forward in development. In highlighting a child's existing strengths, mentorship gives children the opportunities to foster those strengths through development of mentorship relationships. While mentoring programs are often designed to target "at-risk" youth, it may be beneficial to look at these children in a different way to highlight their strengths rather than risk factors.

Furthermore, The California Research Bureau reviewed the impact of infrastructure on the effectiveness of a mentoring program. Through this assessment, different variables were found to be either helpful or detrimental to the success of a program. Those factors that contributed to a quality mentoring program included mentor screening, careful matching, orientation and training, and ongoing support and supervision (Foster, 2001). As programs are developed and the traditional model of mentorship is altered, these variables should be kept in mind. Additionally, the role of evaluation is often overlooked and the idea of standards tends not to exist. While there should be some way to evaluate the validity and effectiveness of programs, there is often lack of resources to do so. Guetzloe (1997) cites having these standards as the future for research because as the number of programs continues to grow, the issue of quality becomes an important concern. A meta-analysis by DuBois et al. (2002) found the best practices from the reviewed programs included "ongoing training for mentors, structured activities for mentors and youth as well as expectations for frequency of contact, mechanisms for support and involvement of

parents, and monitoring of overall program implementation" (p. 187). In order to prove why mentorship is necessary and effective, there needs to be a standard of practice.

According to Guetzloe (1997), "every child needs a dependable, consistent, and positive relationship with at least one adult" (para. 1). This relationship has the potential to foster the child's ability to achieve his or her fullest potential in areas such as emotional health, academic achievement, interpersonal relationships, and career skills. Guetzloe (1997) defines mentoring as "a relationship established between a young person and one who is older that lasts over time and is focused primarily on the developmental needs of the younger individual" (para. 2). Similar to other literature that references "at-risk" youth, Guetzloe refers to these children in mentoring relationships as *disadvantaged youngsters*. Although each program may target a different risk factor, most aim to blend academics, moral development, citizenship, child rearing, social/personal skills, and career/vocational exploration and training. Furthermore, every program may look different but there are fundamental ingredients that have been outlined for a successful program. According to Saito and Blyth (1992, as in Guetzloe, 1997), the following have to be incorporated: appropriate screening, matching, and training, adequate structure for communication and support for mentors, opportunities for program-supported social activities for mentors and youth, and a good match between program goals and mentor expectations.

And so, much of the research that is currently published focuses on mentoring benefits within an educational framework. The value of education is extremely high in our society so helping children is a heavily interested area. Especially for those children who are at-risk because of the geographic location they live in or the socioeconomic status of their family, mentors can serve as a key to their development. A peer mentoring program in a junior/senior high school in Vermont, for example, showed that mentored students demonstrated positive

changes such as increased attendance and attention (Foster, 2001). The program trained older students to be peer leaders by providing activities, such as field trips and community service projects, to younger students. The most widely known mentor program and subsequent study is that of Big Brothers and Big Sisters. Children were randomly assigned to either a treatment group who received mentoring or a control group who did not, and the groups were followed for 1.5 school years. The results of the study found that at the end of the first school year, mentored youth performed better academically, had more positive perceptions of their own academic abilities, and were more likely to report having a "special adult" in their lives (Herrera, Baldwin Grossman, Kauh, & McMaken, 2011). Although there were limitations to this study about the improvements regarding global self-worth and rates of problem behavior, the critical piece was the fact that the presence of mentors in schools does help students get more out of their educational experience. Guetzloe (1997) uses this program as an example of what works in mentoring, pointing specifically to the hard screening procedures for determining volunteer eligibility, a consistent system of supervision, and a matching procedure that takes into account the preferences of both the child and the child's family.

After reviewing the literature about mentoring relationships generally, I wanted to look at how it benefits the mentor in particular, specifically in a peer-to-peer setting when older youth act as mentors to younger children. Before understanding the logistics of formal programs, it is important to note the research that follows how mentoring occurs naturally in society. Natural mentoring relationships can occur outside of a formal program without any prompting (DuBois & Silverthorn, 2004). Results from a National Longitudinal Study of Adolescent Health found that those who reported a mentoring relationship were more likely to experience positive outcomes relating to education/work, reduced problem behavior, psychological well-being, and

health and "facilitate positive gains in the health and well-being of developing youth" (p. 522). As other reviews noted that formal programs target *at-risk* youth, natural relationships tend to be created between those not at risk. These natural relationships foster positive development through social support, role modeling, opportunities to develop new skills, and advocacy. One thing to note about this study was the important factor of longevity. When relationships can be continued for a prolonged period of time, there are opportunities for more powerful bonds to develop between mentors and youth. When these relationships occur naturally, the chance for longevity is more feasible because they are being built outside of the constraints of a formal program. This is an important consideration in creating mentoring programs to have protocols surrounding the termination of a program and the possibility of continuing a relationship outside of a formal program. While the possibility to continue relationships is something that is often out of a supervisor's control because of the technologically advanced world in which we live, programs do not have to be the ones to facilitate the continuity of communication.

Because some mentoring relationships are being created unnaturally in a more formal setting, it is important to consider the mentor's willingness to in fact take on the role of mentor. Allen (2007) explores research that shows the biggest intention to become a mentor relates to previous mentoring experience. Willingness to mentor is also related to the locus of control. Individuals with an internal locus of control were more willing than those with an external locus of control to be a mentor. This could be related to the fact that people with an internal locus of control are more intrinsically driven and self-motivated to help others. Motivation is another factor, with those who are "positively associated with greater upward striving" being more inclined to take on the role (p. 127). Furthermore, it is important to create guidelines about how a mentor and protégé should be paired. Two theories are explored in Allen's (2007) text. The

*similarity-attraction paradig*m states that "mentors will be attracted to those they perceive to be similar to themselves" (Byrne, 1971, as in Allen, 2007, p. 128). *The social exchange theory*, on the other hand, states "individuals enter relationships in which they believe the rewards will be greater than the costs" (Blau, 1964; Homans, 1958; Thibaut & Kelley, 1959, as in Allen, 2007, p. 128).

Since some children have a lack of role models in their lives, organized mentoring programs are created to fill that gap (Goldner & Mayseless, 2008). Particularly, some programs are formalized on the philosophy that teens are able to effectively impact the lives of younger children by acting as mentors. For example, a program to promote a healthy diet and physical activity was piloted with the idea of pairing teens with younger children in an after-school setting. Smith (2010) found that mentored children demonstrated greater improvement in knowledge, attitudes, efficacy, perceived support, and BMI. Furthermore, the inclusion of mentoring in educational curricula has led to improvements for children in skill development and a sense of self-worth. One theory behind the success of an adolescent/child relationship can be attributed to French's (1984) theory of children's knowledge of the social functions of younger, older, and same age peers. These findings concluded that "older children were preferred sources of instruction, leadership, help, and sympathy, whereas younger children were preferred targets of instruction and sympathy" (p. 1429). When adults appreciate and understand the nature and importance of cross-age interaction to the development of the individual child, interventions can be better planned to help children. French (1984) referred to these relationships as "asymmetrical behavior[s] in mixed-age interactions" with the behaviors associated with "nurturance, leadership, and instructional functions" (p. 1429). It was noted that children demonstrate increased leadership behaviors when they are placed in a group with younger children.

Additionally, Kalkowski (n.d.) had similar results from the study of peer and cross-age tutoring. The benefits of such tutoring include the learning of academic skills, the development of social behaviors and classroom discipline, and the enhancement of peer relations (p. 2). In both the tutor and tutee, there were improvements in self-esteem and internal locus of control. Damon and Phelps (1989, as in Kalkowski) state that peer tutoring works in a unique way because "unlike adult-child instruction, [in] peer tutoring the expert party is not very far removed from the novice party in authority or knowledge…the tutee in a peer relation feels freer to express opinions, ask questions, and risk untested solutions" (p. 5). Overall, the idea of creating a balanced relationship between peers is what contributes to success in these mentorship opportunities.

Moving on from mentoring in an educational setting, there is a large amount of research dedicated to how mentoring affects the leadership and character of today's youth. Rhodes and Spencer (2010) introduce the idea of "character capabilities" that "influence life chances, including labor force opportunities, income, emotional well-being, health, and social connections" (p. 150). These capabilities are fostered in the development of high-quality mentoring relationships. Structuring mentoring relationships based on building the character of youth moves mentoring in a new, powerful direction because it gives less fortunate youth the opportunity to attain such skills. As Rhodes and Spencer state, "We should think of mentoring relationships as an opportunity to hone critical skills and foster a sense of purpose among less advantaged youth" (p. 150).

Moreover, Fertman and Van Linden (1999) build on the idea of building character education and how that develops youth leadership. They state that, "[e]very adolescent has latent leadership abilities that will become evident once recognized and nurtured" (p. 11). In

empowering teens to be inspired by this leadership, the goals of the program should make leadership concrete, or a "physical sensation: a need to share ideas, energy, and creativity" (p. 12). By giving teens the tools to lead and be confident in doing so, insecurities that tend to plague adolescents in this stage of development do not have to be an obstacle to being successful mentors to younger children. Mentorship programs can provide that safe environment which fosters leadership. One area of caution, however, is how there can be unfulfilled expectations for the continuation and deepening of the mentorship relationship (Goldner & Mayseless, 2009). When you are instilling so much excitement and responsibility for adolescents to take on this mentoring role, reflection and debriefing become critical for when the session is over and the relationship may in fact be terminated.

It is crucial to look deeper at how mentorship empowers teens through providing leadership roles. The model of servant leadership applies to this idea, as it believes that "all youth are gifted and are capable of making a positive difference in their communities" (Grothaus, 2004, p. 228). Using the strength-based model again, servant leadership aims to improve an adolescent's self-esteem and resilience through the encouragement of community outreach. Because teens lack the innate confidence to be leaders, opportunities need to be created to foster that confidence. This study did so by encouraging the participation in community projects. Furthermore, Wolff (2002) highlighted the need for such programs to empower teens because of the changing society in which we live; "Young people need a sense of security to help them deal with societal pressures and global events, a security that comes from leaders who display strong character, integrity, morality, competence, courage and vision" (p. 7). Leadership programs can help teens understand the critical role they play in teaching values such as respect

and appreciation of diversity and planting a seed for the future generation to become leaders themselves.

With this in mind, a mentorship program within the hospital setting can build upon the research and theory of existing programs. For example, it is important to recognize that a patient may not have previous mentorship experience to draw upon in deciding whether or not they want to participate. A hospital mentor program may be their first introduction to mentorship and what this sort of relationship entails. When creating ways to assess which patients would be fitting mentors, some research sites "positive affectivity, altruism, and organization-based self-esteem" as good qualifications (Aryee, Chay, and Chew, 1996, as in Allen, 2007, p. 126). As child life specialists, our role is to build relationships with patients where we recognize such features of their personality and behavior. This assessment piece is also beneficial in how to pair patients. As the research discusses the similarity and social exchange approach, the similarity theory would be most applicable in the hospital setting. Some similarities may include similar diagnosis or similar physical characteristics such as being in a wheelchair or having no hair. Pairing based on shared interest such as preference for arts and crafts or love of a certain sport may also be a way to build relationships based on similarities. The social exchange theory may be less appropriate in the pediatric hospital setting, but certainly something to take into account that teens may not want to be mentors if there is a great amount of physical or emotional costs involved. Adolescents are developmentally able to weigh out the cost/benefit ratio of taking on the responsibility. Finally, it is important to keep the idea of longevity of mentoring relationships in mind in a hospital setting because there are terminating factors such as discharge or death of a patient that are specific to such an environment.

The responsibility of being a mentor to a younger child certainly grants that opportunity for adolescents to be role models for their peers and impart important life lessons. Beyond benefiting the younger child, teens are gaining life lessons and character building. Mentoring is a way to hone critical skills and foster a sense of purpose, which are often much needed areas of focus in the hospital. Research has highlighted the benefits of mentoring in a vast array of settings and dynamics and outlined important considerations and guidelines to follow when creating a program. As we strive to empower today's youth as the future leaders of the world, mentorship has the power to be that special force that creates positive change.

Development

The foundation for how mentorship can be used as a clinical strategy to empower adolescents is rooted in the developmental needs of this population. As Evans and Zeltzer (2006) state, "Emotional, cognitive, and social/developmental changes in adolescence and young adulthood impact views of self, emotional state, thinking and problem-solving, and interaction with family, peers, and others during this phase of life" (p. 1663). By looking at teens through this developmental lens, one can see how mentorship can nourish their identity formation, teach them the importance of morality, provide peer interactions, and offer opportunities to practice life skills for their future. There are many aspects of an adolescent's life that make this time critical in their developmental progression as they move into adulthood as competent, future oriented people. Unfortunately, hospitalization takes away many of the important experiences of adolescence and makes this population of patients vulnerable to the stress and anxieties of being in the hospital. According to Pearson (2005), the period of mid-adolescence, ages 14 to 18, is described as the most difficult time for an adolescent to be hospitalized" (p. 14). As professionals try to reduce this stress and provide interventions that promote positive coping, mentorship is a way to meet a teen's developmental needs and give them experiences to foster a strong sense of identity.

According to Erikson (1963), adolescence marks the psychosocial stage of identity versus role confusion. These years are critical for a teen's ability to form an identity as they try to figure out how they relate to the world around them. Erikson (1963) states, "Their specific developmental task involves identifying, evaluating, and selecting values and roles for their adult life" (as in Hamman, 2005, p. 72). As teens actively formulate this identity, their previously held beliefs may be called into question, which is why adolescence appears to be a time of rebellion.

Erikson believed that identity formation was successful when there was both "a sense of uniqueness" and "a sense of unity or sameness" (p. 72). In order to achieve that uniqueness, teens must define themselves as distinct from parents and peers. At the same time, however, the teen wants to feel some sense of sameness by maintaining "continuity of the past, present, and future." Erikson describes the adolescent mind as being in "moratorium, a psychological stage between childhood and adulthood" (Erikson, 1963, p. 262). Adolescents are grappling with the morality learned in childhood and the ethics that are expected to be developed as an adult. Having this knowledge of where teens are developmentally, adults can encourage identity formation by providing a safe environment for adolescents to explore their identities. Furthermore, adults can highlight areas in which the teen demonstrates competence to promote confidence in their skills.

Cognitively, adolescents are in Piaget's formal operational stage of thinking. Teens are able to analyze situations logically in terms of cause and effect and make predictions for hypothetical future outcomes (Piaget, 1950, as in American Psychological Association, 2002). They are able to think abstractly, evaluate alternatives, and set personal goals. Adolescents, however, still need guidance from adults to develop their potential for rational decision-making. Because of this level of cognition, teens can conceptualize hospitalization and illness in a future oriented way so some of their fears and anxieties are more complex than younger patients. With increased cognition, comes the development of higher language skills, specifically the use of pragmatics and semantics (Silverberg, 2013). Semantics refers to the meaning of words, while pragmatics go a step further with meaning to look at how *context* contributes to meaning. Adolescents have the ability to develop complex syntactic structures to explain the new concepts

they are cognitively learning. Finally, they have the ability to alter their use of language based on how certain groups communicate and the situation they are in at the moment.

The psychosocial and cognitive development of adolescents are compounded by the physical, biological changes their bodies are experiencing. Just before adolescence, the prefrontal cortex, or "the part of the brain that governs our ability to reason, grasp abstractions, control impulses, and self-reflect," undergoes a huge change (Senior, 2013, p. 21). This brain activity is what gives adolescents the ability to develop the notion of self. Physically, adolescents go through a growth spurt, hit puberty, and experience sexual maturation all in the early years of adolescence. These new bodily experiences can place great concern on physical appearance, which is why so many teens are challenged by body image. The newfound sexual developments affect not only the teen physically, but biological changes create new drives and desires that teens must be able to appropriately manage.

Moreover, the above changes can impact the adolescent's social development as well, which relies heavily on peers, family, school, work, and the community. While family ties are still important, teens tend to have decreased contact with family so that they can establish greater independence from their parents. The American Psychological Association (2002) reports that healthy family relationships were found with parents who are warm, involved, provide firm guidelines and limits, have appropriate developmental expectations, and encourage the teen to develop their own beliefs. Socially, however, teens begin to date and engage in relationships with sexual behavior. Social experiences can impact the teen's moral judgment and values, as well as being sources of popularity, status, prestige, and acceptance. According to the American Psychological Association (2002), peers "provide[ing] a temporary reference point for a developing sense of identity" (p. 21). Finally, school is an integral part of an adolescent's life,

particularly for the education they receive and the safe and stable environment that often contributes to a teen's sense of belonging.

Furthermore, the emotional development of adolescents is critical because of the complex emotions that can be experienced. Teens are able to recognize and manage emotions and identify the source of those feelings, which can lead to discovering ways to resolve the problem (American Psychological Association, 2002). Emotionally, they are developing a self-concept and self-esteem, which must be fostered by positive experiences. Teens have the emotional capability to develop empathy by taking into account the feelings of others, learn to resolve conflict constructively, and develop a cooperative spirit. This emotional growth is supported by moral development in adolescence. The emergence of values and ethical behavior is in line with the adolescent's cognitive development. Adults can help facilitate this morality by modeling positive behaviors.

Volunteering in the community is one prosocial behavior that is noted as a way to promote moral development by fostering a sense of purpose and meaning. Adolescents are often placed in Kholberg's *conventional level* of moral reasoning: good interpersonal relationships and maintaining the social order. According to McLeod (2011), teens in this stage are concerned with behaving well in order to seek the approval of others and obeying rules to uphold the law and avoid guilt. Teens also have a connection to spirituality because in the search for identity formation, they are constantly searching for meaning. The American Psychological Association (2002) states the benefits of religion for teens as being a social support in the community that provides positive roles models, structure and teaching of prosocial values, and explicit discussions of moral values in a spiritual way.

Additionally, mentorship can be looked at through the developmental lens of Vygotsky's zone of proximal development, or "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers" (Berk & Winsler, 1995, p. 26). The adolescent is the one with greater knowledge who can help younger children problem solve and work to their fullest potential. This idea is based on the notion of *scaffolding* to focus on what children can do with the help of another person and has the potential to learn with that aid. While we already looked at the development of the older adolescent as mentor, we must also shift our focus to examine the school-age child's needs in the mentoring relationship, as mentee. Mentorship is a powerful intervention for school-age children as well because of the growth and progress they have the potential to make.

Children in this developmental domain may be less vulnerable to hospitalization, but there are certain needs that can be addressed through mentorship. According to Pearson (2005), school-age children "are more social, able to be separated from parents for longer periods of time, and capable of cognitive reasoning" (p. 12). Cognitively, they are in Piaget's concrete operational stage of thought so they are able to process information in a more organized, logical fasion and understand relationships between events and experiences. The cognitive level of school-age children impacts where they are spiritually. There is often a strong interest in religion during these years as they navigate what being a moral and ethical person means, as well as the concepts of confession and forgiveness (Gesell, 1946). Understanding good and bad behavior through religious reasoning is common. Morally, school-age children are in Kholberg's pre-conventional stage, which focus on obedience and punishment orientation and individualism and

exchange. According to Silverberg (2011), the child is good in order to avoid being punished and recognizes that there is not just one right view.

Psychosocially, school-age children are in Erikson's industry versus inferiority stage where finding success in schoolwork and peer interactions are integral. The school-age child needs to feel productive and capable of doing work on his or her own. This includes the experiences of interacting with peers, accomplishing new skills and receiving knowledge. Emotionally, the child's self-esteem should be nourished as they are navigating increased independence, friendship, and challenges to parental authority, self-definition, and competence. Biologically, school-age children vary in their coordination, endurance, balance, and physical abilities. Fine motor skills are practiced daily with tasks such as writing neatly, dressing appropriately, and performing chores. A school-age child's language development lies in simple but complete sentences that average 5-7 words. Grammar and pronunciation become routine, as they can carry on a conversation at a relatively adult level and can follow series of commands with complex directions (Child Development Institute, 2012).

One area of development that is addressed in both school-age years and adolescence is racial identity formation. Beverly D. Tatum (1992) describes the journey that individuals of color and those who are white go through in this development. For children of color, they begin in the pre-encounter phase where they are internalizing society's messages about race. If the child does not have parents or teachers to evaluate these messages, the child will adhere to them. As people of color grapple with what it means to be a member of that group, they surround themselves by symbols of that racial identity and internalize and feel a sense of security in this identity. White people, on the other hand, find themselves in a pre-encounter phase where they learn that being white is normal and superior. They eventually become aware of the reality of

racism and face pressure to conform to the norms of society. Although they may understand the effects of institutional and cultural racism, they may not be sure of what to do about it. Eventually they may surround themselves with positive white anti-racist people and become autonomous by separating from values of white supremacy. This lens of development is important to be aware of as children are forming their identities in the larger context of society and cultural norms.

As the development of both adolescents and school-age children has been reviewed, it is important to reflect on how hospitalization affects each population differently. Identity formation and peer interactions are key elements of adolescent development, which is why hospitalization can be so stressful for this age group. According to Pearson (2005), "the hospital experience becomes threatening as it separates the teen from normal group activities, disrupts future plans, and increases insecurities about appearance and self-worth" (p. 14). The common issues that are related to this age group specifically are limitations related to privacy, loss of control, peer relationships, independent activity and decision making, concern with perspective of others, and body image (Turner, 2009). As Evan and Zeltzer (2006) state, the adolescent "must move through this developmental process while coping with the emotional impact of the diagnosis, the therapy [for cancer], and the emotional, social, and psychical late effects of the disease and its treatment" (p. 1663). Interventions and strategies within a hospital milieu should focus on peer group support and providing an environment specifically designed for adolescents. By allowing opportunities for choice, control, self-expression and relationship building, a teen's developmental needs are better addressed. Professionals should respect the teen's privacy and confidentiality as well, so that trust can be maintained and a more adult-like relationship can grow.

And so, offering teens the opportunity to act as mentors within the hospital supports many of the aforementioned areas of development. Mentorship gives adolescent patients a role within a health care environment to develop a sense of purpose and identity. By selecting them to fulfill this role, it highlights their strengths as a leader to work with younger children. These are also social opportunities to work with peers both their own age and younger. Mentorship is a positive act that promotes moral development as well. As the program trains teens how to be mentors, life skills such as respect, role modeling, using appropriate language, and empathic responses will be taught. Because this is a specifically vulnerable group, adaptive coping strategies need to be promoted, and mentorship supervision can serve that purpose so that teen patients do not become overwhelmed with limitations they face in a hospital setting.

On the other hand, school-age children are challenged by the limitations surrounding control and independence, which includes separation from normal activities associated with home, school, and peers (Tuner, 2009). As concrete thinkers, school-age children are at increased risk for misunderstandings and misconceptions. A mentorship program can be beneficial for this age group because they are given the chance to feel a sense of industry in completing activities. It also provides a peer interaction with an older child who can allow them to feel a sense of control and independence. By observing the mentor, the school-age child can learn the values of being a positive role model and leader.

Because of the shared experience of hospitalization, supportive relationships can grow out of these experiences to promote better overall coping for all patients involved. When patients are able to recognize that they are not alone and believe they have the have the support and resources to make hospitalization less stressful, there are actually opportunities to make it a positive experience. Every child chooses to cope differently, and while mentorship may not be

appropriate for everyone, there are patients who can use this outlet to cope in a healthy, productive way. Mentorship is a unique intervention because of the variety of developmental needs it addresses. Although the mentorship relationship that is created from this program can range from a one-time meeting to a weekly occurrence, a dynamic relationship between the adolescent and the school-age patient is formed, and it has the potential to develop depending on how much each participant is willing to put in and take out of the experience.

Conclusion

The unpredictable nature of the hospital environment impacts a child's ability to cope with the often-stressful experiences. Aside from the medical interventions that are nonnegotiable, there is another side to medicine that deals with the psychosocial implications of hospitalization. Children and families often benefit from any additional support they can receive and are willing to engage in therapeutic outlets for coping. The way in which the interventions are offered take into account a developmental approach to understanding children and families. Although each patient may be different, there is something inherent in the developmental needs of children as a collective group. As patients and family members of sick children, it is easy to get caught up in the stress of hospitalization. It is not uncommon for people to be unsure of how to handle these situations, but when they are given a role or a job, it often eliminates that discouraging feeling of helplessness. The goal of this thesis was to explore how mentorship gives adolescents a role and removes them from their own situation for a moment. The vision for the idea came from the simple yet powerful theory that when people help others, they are inevitably helping themselves.

Mentorship has long been regarded as a way to pass on knowledge and wisdom and for people to build relationships based on this sharing of information. While mentoring takes on many different forms, it has the power to fulfill the needs of those it is aiming to affect. Peer to peer mentoring is a relatively recent development, but the effects have repeatedly been shown to make a difference in the lives of children. Using the literature about mentorship as a foundation for creating a short-term intervention in a hospital setting, it is evident that mentorship between patients can serve as a powerful way to address the developmental needs of not only typical children, but also more specifically, those affected by hospitalization.

During the critical time in an adolescent's identity formation, hospitalization can take away many of the opportunities that are needed to properly allow for such formation. Mentorship can be a way for adolescents to feel empowered through the role, have a sense of responsibility, practice the skills needed to work with younger children, and develop empathy, community building, and overall respect for others. School-age children, on the other hand, can benefit from the social interaction with an older peer who is going through similar experiences. The experience of working together can create a dynamic relationship that is advantageous for both patients involved.

The mentorship manual to implement a short-term, inpatient intervention can be utilized by child life specialists to address the developmental needs of the patients they serve. Child life specialists have the unique perspective of looking at children in a different way than other health care professionals because of the developmental approach that is taken. Mentorship is a powerful intervention to address those needs in a way that employs a strength-based approach and highlights characteristics of a child may otherwise be overlooked in a hospital setting. While hospitalized children go through different experiences than most others, the desire to be normal is standard among the majority of patients. Mentorship is a normalizing experience with latent therapeutic benefits. As child life specialists, we hope the tools and skills imparted on patients within the hospital walls are transferable to coping with daily stresses once they leave. The mentorship experience is a win-win situation for all involved, both in the moment and also in the future of those patients' lives.

The Win-Win Situation of Mentoring:

How to Implement a Hospital Mentorship Program

In a Child Life Department

Mission Statement

A hospital mentorship program provides a short-term intervention for hospitalized children in an inpatient setting. Mentoring can meet the developmental needs of school-age and adolescent patients by addressing aspects of identity formation, cognitive processing, and emotional and social advancement. Using a strength-based approach to highlight the similar experiences and challenges that patients face with hospitalization, adaptive coping, developmental growth, and empowerment can be achieved through mentorship.

Program Objectives

The goal of creating a mentorship program is to address the developmental needs of school-age and adolescent patients. The first step is to pair an adolescent patient with a younger patient using the needs assessment guidelines. A certified child life specialist will introduce the idea of mentorship and supervise the session. The aim is for the mentorship program to bring patients together to build community among children sharing similar experiences, learn about oneself and others, and increase empathy and life skills.

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Defining Responsibilities

A mentorship program will be successful only if it is well organized and coordinated. This section outlines the expectations for a mentoring relationship and the role of a supervisor. The program requires that patients and the supervisor share responsibility for ensuring the program meets the program objectives. By outlining the responsibilities in this section, each participant is aware of how the program works.

Mentor/Mentee Relationship

-Each patient will be given a verbal explanation before the session begins so both parties understand the purpose and expectations. Guidance will be provided through out the session as well as after it is over.

Sample Introductions:

For the Mentor: "I would like to ask you if you would be interested in being a mentor for one of our younger patients. I think you have really strong skills that would make you great at working with younger children and leading this sort of interaction."

For the Mentee: "I am putting together an activity with an older patient who I want you to meet. I think it would be really great for you two to get to know each other. Would you be interested in working with him/her?"

-The mentor should be committed to fulfilling the role and being present during the designated session. There are inevitable hospital factors that may affect this commitment, so flexibility will be key.

-Both patients should be willing participants.

Supervisor

-The supervisor must be a Certified Child Life Specialist (CCLS). The specialist will conduct the initial assessment regarding which patients would benefit from the program and match the patients accordingly (See Needs Assessment).

-Depending on the role of Social Work in the hospital, there is an option for this program to be co-facilitated by a social worker. A social worker can make the needs assessment as well, but the CCLS would be considered the lead facilitator, as this is a program run through the Child Life department.

-The CCLS will facilitate the session by presenting the activity, providing direction and conversation when needed, and being present.

-The supervisor observes the sessions to guarantee quality control, monitors which patients attend, keeps records of attendance (Appendix A) and distributes evaluation sheets (Appendix B) to track the effectiveness of the program.

Layout of Program

Each Child Life Department can determine the logistics of the program based on their other scheduling commitments and previously existing activities, but general guidelines include the following:

- Choose a public, Child Life space such as a playroom to conduct the sessions so they can be supervised by a CCLS.

- Generally a session will last between 45 minutes-1 hour, depending on the activity, how the session is going, and the overall well-being of the adolescent and school-age patients.

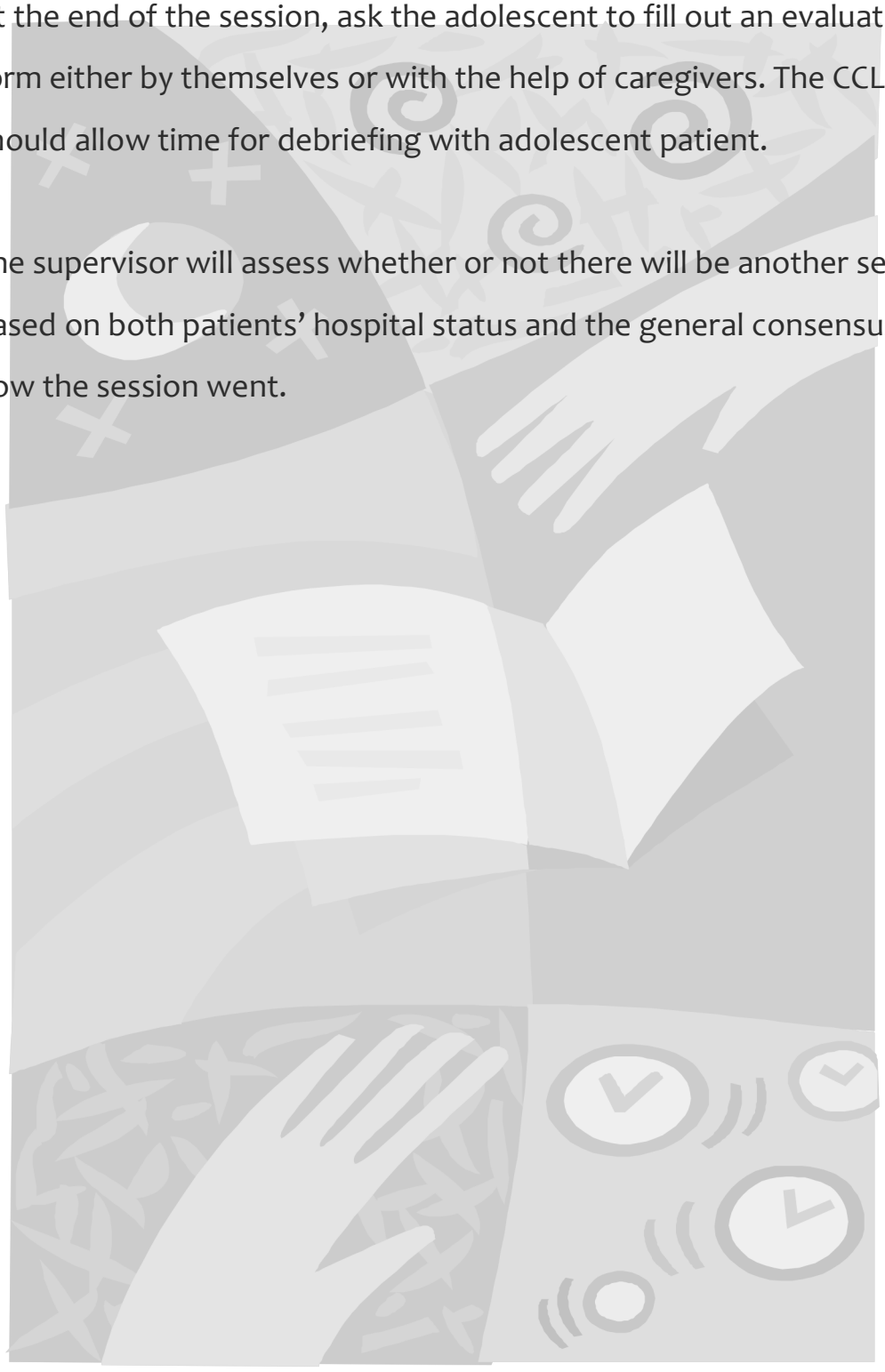
- On any given day the census may change, so the decision to conduct a session may be done on a daily, weekly, or monthly basis. There must be one adolescent as mentor, between one and three school-age mentees, and one supervisor for the session to occur.

- The supervisor will use the needs assessment criteria when choosing the participants. He or she will then introduce the school-age and adolescent patients to each other and offer the choice for an activity.

- The CCLS will allow the patients to guide the direction in which the session goes, but must be available to address possible conflicts or emotional topics that may arise during the session.

- At the end of the session, ask the adolescent to fill out an evaluation form either by themselves or with the help of caregivers. The CCLS should allow time for debriefing with adolescent patient.

- The supervisor will assess whether or not there will be another session based on both patients' hospital status and the general consensus of how the session went.



Program Guidelines

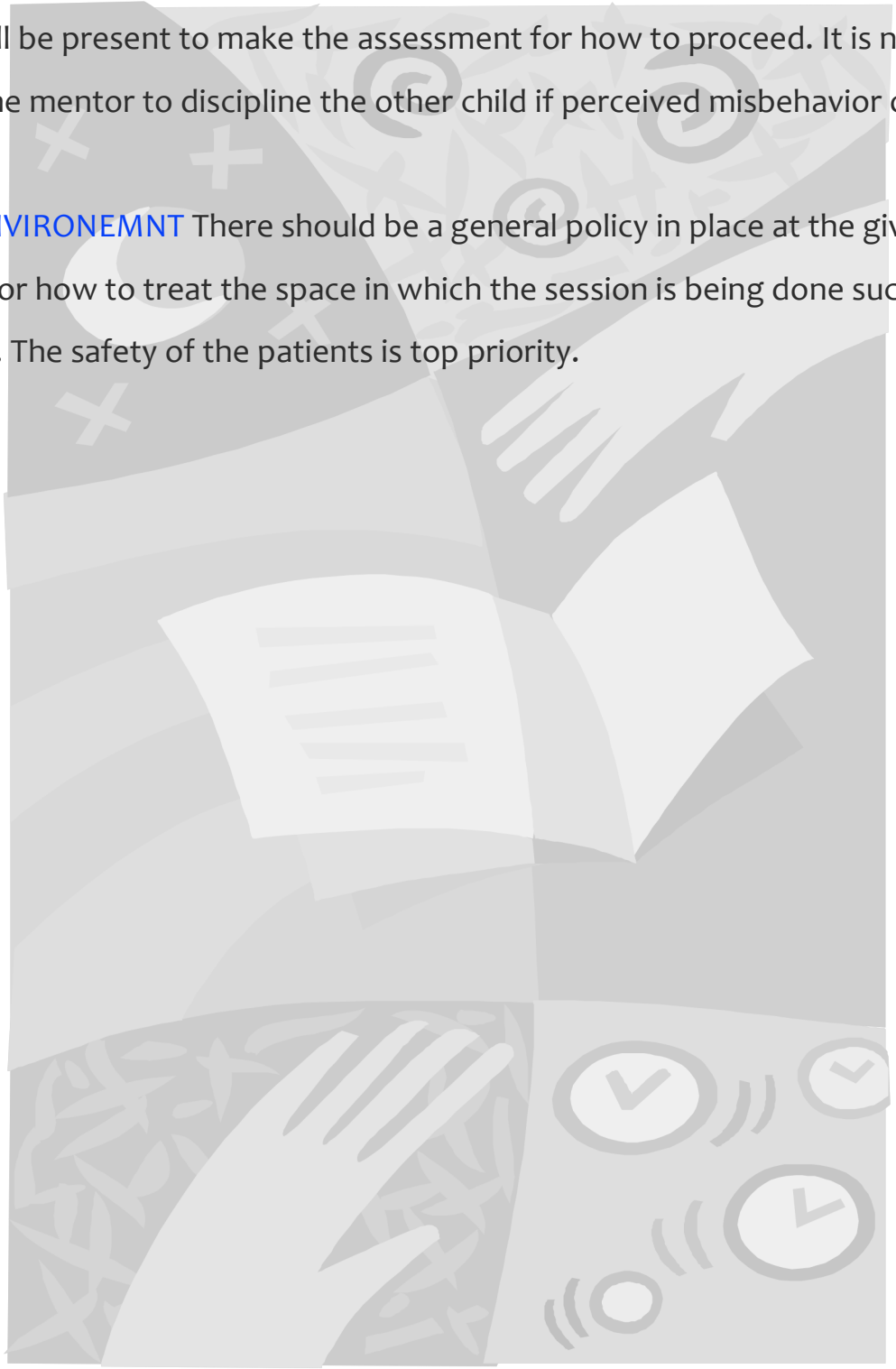
Because this is an intervention offered through the child life department, there should be a set of guidelines of which the children agree to follow when entering the mentorship experience. Each department may already have playroom policies that patients and families are expected to adhere to, but the following points are guidelines in which the department can modify according to their own program and standards of practice:

RESPECT Each participant must be respectful of one another, the supervisor, the physical space, and the mentorship process. It is important to be aware and politely accepting of the feelings and beliefs of others. We can show respect by actively listening, being considerate, having manners, and being fair. Cultural variation should not be overlooked, as the way respect is shown and received among cultures may be different. For example, some cultures show respect with physical contact, while others expect physical distance.

APPROPRIATE BEHAVIOR Particularly from the adolescent mentor, it is expected that their behavior reflect their position as a role model. This includes refraining from cursing, providing positive language and compliments when necessary, and acting in an overall polite and caring way towards others. The mentor will have their own training guidelines to educate them about prosocial behaviors.

CONFLICT RESOLUTION If at any time either patient feels uncomfortable, the CCLS will be present to make the assessment for how to proceed. It is not the job of the mentor to discipline the other child if perceived misbehavior occurs.

SAFE ENVIRONEMNT There should be a general policy in place at the given facility for how to treat the space in which the session is being done such as no running. The safety of the patients is top priority.



Needs Assessment Guidelines

The child life supervisor is charged with the responsibility to match patients. As child life specialists, the relationships we build with children and families will help guide our knowledge of which patients could work well together and get the most out of a mentorship experience. Keeping the goals of the mentorship program in mind, criteria for mentor and mentee selection can be established.

The following developmental chart is a guide for supervisors to use in making assessments about potential patients' participation in a mentorship experience. The chart can be used to understand the school-aged and adolescent patients' behaviors, thinking patterns, and possible issues related to being in the hospital. When we understand where the child is developmentally and compare it to typically developing children, we can better assess their needs and subsequent interventions.

DEVELOPMENTAL ASSESMENT	Psychosocial	Cognitive	Issues with Hospitalization
Adolescence	Identity versus Role Confusion: adolescents need to develop sense of self and personal identity-→ success leads to an ability to stay true to yourself, failure leads to role confusion/weak sense of oneself	Formal Operational: deductive and abstract reasoning, can imagine the condition of a problem (past, present, and future) and develop hypothesis about what might logically occur	-Limitations related to privacy, peer relationships, independent activity and decision making -Concern with perspective of others -Fear of bodily injury and pain, fear of loss of identity, body image and sexuality, concern about peer group status after hospitalization
School-Age	Industry versus Inferiority: child copes with new social and academic demands-→ success leads to sense of competence, failure results in inferiority	Concrete Operational: increasing ability to think logically in the physically concrete realm, understanding the meaning of series of action, order, and sequencing	-Separations from normal activities associated with home, school, and peers -Fear of loss of control, loss of mastery, bodily mutilation, bodily injury and pain -Fear of illness itself, disability and death

Criteria for Choosing Mentors

The adolescent patient is chosen as the mentor. This patient should be 13 years of age or older. The teen must be medically cleared to leave their room. Additionally, an assessment of developmental maturity, ability to adapt and be flexible, and leadership skills will be made by the CCLS based upon the behavior that has been observed and the interpersonal relationship between the adolescent and the CCLS. The adolescent must be a willing participant and demonstrate a sense of motivation to fulfill the role.

There are possible psychosocial risk factors that may affect an adolescent's coping and thus increase their need for a mentorship intervention. These factors include lack of family support, poor prognosis, maladaptive coping, and developmental need for an empowering opportunity.

Criteria for Choosing Mentees

The school-age patient is chosen as the mentee. This patient should be 7 years of age or older. The child must be medically cleared to leave their room. The child should have a desire to have a mentor and be willing to work with an adolescent.

There are possible psychosocial risk factors that affect a school-age child's coping and thus increase their need for a mentorship intervention. These factors include lack of family support, poor prognosis, maladaptive coping, and developmental need for a socialization opportunity.

These criteria are flexible and should be assessed on a case-by-case basis by the child life supervisor. Pairings can be, but do not have to be, based on similarity of shared interests between both patients.

Training the Mentors

Although the nature of a short-term intervention may not allow for a lengthy training process, adolescents can be guided toward positive interactions with younger children. The child life supervisor will make the assessment based on his/her criteria that the adolescent patient can fulfill such a role. Once the decision to ask the adolescent to be a mentor is made, the child life specialist can verbally prepare the adolescent for the mentorship experience. The following points give a brief overview on how to train the mentor in a short time frame, while still addressing the important factors they need to be aware of as they enter the session. See also Appendix D.

STRENGTH-BASED APPROACH Inform the mentors that they were selected because the supervisor assessed that they would be responsible people and demonstrate positive behaviors with a sense of maturity that will make them strong leaders.

COMPLIMENTS/PRAISE Compliments should be used as a way to intrinsically motivate people. Show the adolescent ways to avoid giving compliments out of habit. Save praise for a child's positive behavior and effort, and be sure they mean what they say. Praise does not always have to be verbal; the same message can come across through 'thumbs up' or 'high five' gestures.

EMPATHIC RESPONSE Guide the mentor to respond to a child in a way that reflects what the child is feeling. You want to indicate to the child that you have heard their concerns and understand them on an emotional level. For example, if the school-age child expresses how much he or she misses school and peers, the adolescent can say, "You seem really sad about not being able to go to school and hang out with your friends. Being in the hospital can be really hard because we miss the things that we were used to at home."

VALIDATING FEELINGS/EXPERIENCES Promote empathy by highlighting how a mentor can validate possible emotions the child is feeling. The child needs to know that they are not alone in their hospital experiences. If the adolescent notices that the child has an IV like they do, the teen can point it out and mention something about how they coped with getting an IV. For example, the adolescent can say, "I was really nervous before getting my IV, but I listened to music to distract myself."

PRIVACY & CONFIDENTIALITY It should be explained to the mentor that it is not their role to inquire about a child's reason for being in the hospital or other private details. The school-age child and adolescent can disclose information to one another at each patient's own discretion. If medical information comes up in natural conversation, we request that the mentor does not disclose it to anybody else.

Activity Ideas

The following activities are a few possibilities to complete during a mentorship session. They each have diverse therapeutic goals and each patient will receive some benefit from them. It is important to remember, however, that flexibility is critical in the hospital environment. The patients may not want to do the designated activity, so it is acceptable to have the patients pick the activity. The important piece is that they are interacting and building rapport, regardless of the activity. Hospitalized children face so many instances where they have no control in the hospital, and the mentorship program should be an intervention where they regain a sense of control. If you do want to focus on one specific activity, however, make sure there are supplemental choices within that activity, e.g. arts and crafts options.

1. Hospital Mad Libs (Appendix C) and Stress Reduction Gloves (Millard, 1998)

   Therapeutic Goals: Give the patients an opportunity to make procedures a more positive experience by reflecting on ways to cope and distract through them. Highlight the importance of patients advocating for their needs.

   Materials Needed: Mad libs, writing utensil, medical gloves, 4-6 containers of play-doh

   Process: First have the patients complete the Mad Libs and facilitate conversation surrounding coping with procedures and ways to reduce

anxiety. Explain how a stress glove can be used when the child may feel anxious as a stress reducer and relaxation technique. Distribute gloves and play-doh. Put the play-doh inside the gloves and tie a knot in the opening. Instruct the patients to squish the dough into the fingers of the glove.

2. All About Me (Hart & Rollins, 2011)

Therapeutic Goals: Foster a sense of connectedness with staff and other children in the hospital. Allow other people to learn about each child's unique personality, which can then grant the child more individualized care.

Materials Needed: About me posters, markers/crayons, variety of decoration materials, scissors, glue

Process: Have the child fill in the poster and decorate it how he or she would like. Encourage the patients to share the information if they would like. When they return to their rooms, they can display the completed sheet for staff to see.

3. Medical Collages (Hart & Rollins, 2011)

Therapeutic Goals: Provide opportunities for desensitization to medical stimuli by using medical equipment in a nonthreatening context.

Materials Needed: diverse medical supplies such as band aids, tongue depressors, medical tape, and gauze, scissors, glue, construction paper, markers/crayons

Process: Lay the materials on the table for the patients to work with. Invite them to select objects for the collage and adhere them to the paper. Encourage the children to give their finished product a name.

4. Interviewing each other

Therapeutic Goals: Explore feelings, concerns, and fears each child has experienced throughout hospitalization. Allow patients to learn about other children who share similar experiences.

Materials Needed: paper or notebook, writing utensils

Process: Provide a list of preset writing prompts for the patients to use as guidelines for what they want to ask the other one. Examples include "being in the hospital is like…" or "the scariest moment of being in the hospital was when…" Have the children interview each other and record the answers in their notebook.

5. Hospital Jenga

Therapeutic Goals: Utilize a diverisional activity in a therapeutic way to allow patients to explore feelings related to hospitalization as well as providing a group activity that will foster socialization.

Materials Needed: Jenga set with prewritten questions related to hospitalization, feelings, or getting to know each other prompts. Some examples are: I feel sad when…, The worst part about being in the hospital is…, How many people are in your family…, What helps you relax?...

Process: Build the Jenga set using all the pieces in a 3x3 manner. Explain the rules of Jenga: the object of the game is to remove a wooden piece without knocking over the entire building. When the child pulls a piece, they have to answer that prompt.

Reflecting with Mentors

Adolescent mentors may need an opportunity to reflect on the experience and enhance its meaning by debriefing about the sessions. Through this reflection, they can discuss what they learned about themselves and others.

- When the younger patient leaves, allow a few minutes to debrief with the adolescent. It is important to ask open-ended questions before verbalizing your own feedback. Use open-ended prompts to discuss how the session went such as what they did well, what could be worked on, and possible issues that came up. Provide a safe and private environment for this discussion.
- Possible obstacles that may arise: for example, if one patient in the relationship is discharged or dies.

  These situations may be particularly difficult because of privacy and HIPAA policies within a hospital setting. In order to adhere to these policies, we cannot disclose this information about patients. If the patients ask, however, there should be a standard response in place. For example, "I am sorry but there is actually a hospital policy that says I am not allowed to discuss personal information about other patients."
- Just like in the daily occurrences of the hospitalized setting, child life specialists cannot control if hospitalized children and families are exchanging personal information. Moreover, we cannot control if these families continue that relationship outside of the hospital. We are not responsible for the mentoring relationship unless it is being developed within a child life program under the supervision of a CCLS.

Evaluation

Program evaluation is a key part of any peer mentoring initiative. It is important to have a standard tool that can be used to gather information about how the program is running and ideas for ways to improve it.

- The first part of the evaluation is to have the mentor complete both a pre and post test. These responses will help gauge the validity of the program. Using this assessment tool will allow the CCLS to see what is working and what is not, and how the program can be modified and expanded to better serve the patient population. (Appendix B)

- Secondly, you could do a verbal evaluation with the school-age child to gauge their interest in the program. Although they may not be able to articulate their critique as well, a conversation about what they liked and didn't like can be helpful.

- Due to the fact that this is a short-term intervention, we may not be able to follow up and test our hypothesis long term to see how this intervention affected the patient. We can only hope that this intervention provided both the hospitalized adolescent and school-age patient with a positive experience within the hospital setting and spread the seed for leadership and empathy.

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Appendix A

Attendance Form

	Mentor's Name and Age	**Mentee's Name and Age**	**Activity Completed**	**Comments**
Monday April 1, Time:				
Monday April 8, Time:				
Monday April 15, Time:				
Monday April 22, Time:				

Appendix B

Evaluation Form

Mentor's Name: _____ Age: _____

Please answer the following questions before the session begins and return it to the child life supervisor. We encourage you to complete this with a caregiver.

1. What are you expecting to get out of the session?

After the session, please answer the following questions and return to the child life supervisor.

1. What was the experience like for you?

2. Did the session meet your expectations?

3. What could be done next time to improve the experience?

Appendix C

Example of a Mad Lib:

Noun _____

Emotion _____

Noun_____

Verb in Past Tense _____

Adjective _____

Noun _____

Noun _____

Name _____

Body Part _____

Noun_____

Plural Noun_____

TV Show Character _____

Number _____

Adjective _____

Fruit _____

One day a young child woke up with a pain in his _____. He felt very _____ so his mother decided to take him to the doctor. When he got to the doctor, he saw a lot of _____ and so he _____ around the office. The nurse came out and called the boy's name in a _____ voice and she brought him to the exam room.

First she took his body temperature using a _____ and then took his blood pressure with a _____. The boy felt ____ so he sat on his mother's lap to make him feel better.

Then Doctor ____ came in the room and asked the boy to open his _____ wide. He listened to the boy's _____ beat with a stethoscope. Next the doctor explained why he needed to draw the boy's blood so he could see if there were any ____ in his body.

The boy was scared so he wanted his mom to tell him a story about _____. Although he cried a little, the boy used the story to distract him. The doctor counted to ____ before the poke. The doctor gave the boy a ____ band-aid and a ____ flavored lollipop when he was done. They boy was very brave and was no longer scared of going to the doctor.

Appendix D

You can create a "contract" for the mentor to sign that they have read the goals, guidelines, and training documents. This creates a more official responsibility and may empower the adolescent on a deeper level. The following areas should be included for the adolescent to read and sign off on:

Mission Statement

A hospital mentorship program provides a short-term intervention for hospitalized children in an inpatient setting. Mentoring can meet the developmental needs of school-age and adolescent patients by addressing aspects of identity formation, cognitive processing, and emotional and social advancement. Using a strength-based approach to highlight the similar experiences and challenges that patients face with hospitalization, adaptive coping, developmental growth, and empowerment can be achieved through mentorship.

Program Objectives

The goal of creating a mentorship program is to address the developmental needs of school-age and adolescent patients. The first step is to pair an adolescent patient with a younger patient using the needs assessment guidelines. A certified child life specialist will introduce the idea of mentorship and supervise the session. The aim is for the mentorship program to bring patients together to build community among children sharing similar experiences, learn about oneself and others, and increase empathy and life skills.

Program Guidelines

RESPECT Each participant must be respectful of one another, the supervisor, the physical space, and the mentorship process. It is important to be aware and politely accepting of the feelings and beliefs of others. We can show respect by actively listening, being considerate, having manners, and being fair.

APPROPRIATE BEHAVIOR Particularly from the adolescent mentor, it is expected that your behavior reflect your position as a role model. This includes refraining from cursing, providing positive language and compliments when necessary, and acting in an overall polite and caring way towards others.

CONFLICT RESOLUTION If at any time either patient feels uncomfortable, the CCLS will be present to make the assessment for how to proceed. It is not the job of the mentor to discipline the other child if perceived misbehavior occurs.

SAFE ENVIRONEMNT There should be a general policy in place at the given facility for how to treat the space in which the session is being done such as no running. The safety of the patients is top priority.

Training for Mentors

STRENGTH-BASED APPROACH You have been selected because the supervisor assessed that you would be responsible and demonstrate positive behaviors with a sense of maturity that makes you a strong leader.

COMPLIMENTS/PRAISE Compliments should be used as a way to intrinsically motivate people. Avoid giving compliments out of habit. Save praise for a child's positive behavior and

effort, and be sure they mean what they say. Praise does not always have to be verbal; the same message can come across through 'thumbs up' or 'high five' gestures.

EMPATHIC RESPONSE Respond to a child in a way that reflects what the child is feeling. You want to indicate to the child that you have heard their concerns and understand them on an emotional level. For example, if the school-age child expresses how much he or she misses school and peers, you can say, "You seem really sad about not being able to go to school and hang out with your friends. Being in the hospital can be really hard because we miss the things that we were used to at home."

VALIDATING FEELINGS/EXPERIENCES Promote empathy by validating possible emotions the child is feeling. The child needs to know that they are not alone in their hospital experiences. If you notice that the child has an IV like you do, you can point it out and say something about how you coped with getting an IV.

PRIVACY & CONFIDENTIALITY It is not your role to inquire about a child's reason for being in the hospital or other private details. You can share as much or as little about yourself as you want. If medical information comes up in natural conversation, we request that you do not disclose it to anybody else.

I, _____, have read the above statements and agree to the expectations and guidelines of my role as mentor.

If at anytime I have questions or am unsure I am able to be a mentor, I will inform the child life specialist.

Signature _____ Date_____