

The Development of Rapport with Children and Families in Hospital Settings

Masters Thesis

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Abstract

The focus of this research study was to interview child life specialists in order to a) better understand the meaning of the concept of rapport, b) identify ways in which rapport is established and maintained, as well as c) determine the purpose and outcomes following the establishment of rapport between child life specialists and children. Relationships that have established a level of rapport are described as comfortable, supportive and welcoming (Gurland & Grolnick, 2008; McCue, 2009). Twelve certified child life specialists participated in the interview process. Thematic analysis was used to review the qualitative data for basic and organizing themes which resulted in the development of global themes. The six global themes identified are 1) academic and childhood experiences, 2) description of rapport, 3) initiation of rapport, 4) maintenance of rapport, 5) indicators of rapport, and 6) rapport is essential. Respondents agreed that building rapport is an essential foundation for establishing and maintaining relationships between child life specialists and children. The study results may be used by students, clinicians and academicians to initiate the discussion on the concept of rapport within the child life context. Research in a variety of clinical settings with child life specialists of varying years of experience is needed in order to better understand the role that rapport has in child life practice. Additional research methods such as face-to-face interviews or clinical observations may also provide opportunity to expand the findings of this study.

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Table of Contents

Abstract.....	2
Acknowledgements.....	3
Chapter 1	
Introduction.....	6
Definition of Terms.....	10
Child Life	10
Child Life Specialist.....	10
Developmentally Appropriate Practice (DAP).....	10
Preparation.....	10
Rapport.....	11
Chapter 2	
The Story of Mya.....	12
Early Care of Children in Hospitals.....	13
The Development of Child Life.....	15
Theoretical Foundation.....	18
Child Life Specialists' Roles and Responsibilities.....	21
Building Rapport.....	25
Therapeutic Alliance.....	28
Current Study.....	32
Chapter 3	
Methods.....	33
Participants.....	33
Procedure.....	34
Recruitment.....	34
Interviews.....	35
Interview Questions.....	35
Data Analysis.....	37
Basic Themes.....	37
Organizing Themes.....	38
Global Themes.....	38

Chapter 4

Results.....	40
Academic and Childhood Experiences.....	40
Describing Rapport.....	43
Initiation of Rapport.....	45
Maintenance of Rapport.....	51
Indicators of Rapport.....	54
Rapport is Essential.....	57

Chapter 5

Discussion.....	61
Understanding the Meaning of the Concept of Rapport.....	61
Ways to Establish and Maintain Rapport.....	63
Purpose and Outcomes Following the Establishment of Rapport.....	67
Summary.....	68
Implications.....	69
Limitations.....	71
Future Research.....	71
References.....	73
Appendix A: Invitational Email.....	80
Appendix B: Consent Letter	82
Appendix C: Interview Questions.....	84

Chapter 1

Introduction

Child life specialists are professionals working within pediatric settings to provide services focused on the psychosocial wellbeing of children during times of stressful events such as hospitalization and illness. Exposure to unfamiliar medical encounters can inhibit a child's ability to effectively handle feelings of stress and anxiety and lead to emotions including fear, loneliness and confusion (Child Life Council, 2009). Child life specialists develop relationships with children and families described as comfortable, supportive and welcoming that facilitate the child's ability to adjust to hospitalization and illness (McCue, 2009). During interactions with children and families, child life specialists help support children to process new events and cope with unsettling feelings (Goldberger, Luebering Mohl & Thompson, 2009). Before child life specialists are able to develop effective relationships with children and families, a foundation of rapport needs to be established.

Practical and academic training grounds the child life specialists' ability to understand the perspective and developmental needs of children as well as design developmentally appropriate support services. Developmentally appropriate practice (DAP) is a perspective within early childcare that nurtures all aspects of a child's wellbeing including social, emotional, physical and cognitive development (Canadian Child Care Federation, 2011; National Association for the Education of Young Children, 2011). Three main responsibilities that guide child life specialist's ability to support children's psychosocial needs in developmentally appropriate ways focus on relationship development, opportunities for children to engage in play and activities, as well as provide educational interventions to help children better understand unfamiliar medical events (American Academy of Pediatrics, 2000; Pond Wojtasik & White, 2009). In order to provide both developmentally and individually appropriate interventions, child

life specialists are “experts on building relationships with children and their families” (Child Life Council, 2011).

Onlookers observing child life specialists as they interact with children in outpatient settings, in wards and playrooms will see activities that involve opportunities for play and educational preparation for medical events and procedures. Play is understood to be a natural activity that is within a child’s daily routine, often serving as an outlet to express a range of feelings. Preparation interventions are used to help children understand the roles of health care personnel, the purpose of health care equipment and procedures, and the sequence of events such as procedures and therapy (Jessee & Gaynard, 2009). Research findings have shown a decrease in anxiety levels and distress behaviors exhibited by children during stressful events after they have participated in interventions such as pre-operational tours and preparation (Brewer, Gleditsch, Syblik, Tietjens & Vacik, 2006; Gaynard, Wolfer, Goldberger, Thompson, Redburn, & Laidley, 1990; Kain, Caldwell-Andrews, Mayes, Wang, MacLaren & Blount, 2007). Child life specialists require a range of skills in order to develop rapport with children and families in a variety of settings.

According to McCue (2009), the role of rapport development is valued as an essential responsibility of child life specialists; however few researchers have explored the relationships that are developed within child life practice. Gaynard et al. (1990) described the skills that professionals use to gain trust with children including the use of choice and the expression of genuine interest. In a study by Turner and Fralic (2009), child life specialists reported that the relationships formed between themselves, the child and the child’s family were the foundation from which assessments regarding needs and support services were derived. Although the role of relationships was discussed, the researchers suggested that further investigation into the topic

was necessary in order to document the role of rapport building in the establishment of relationships and the ways in which rapport is initiated and maintained.

Because there is limited literature regarding the process, purpose and effectiveness of relationship formation, the current research study was conducted in order to establish an understanding of the child life specialist's perspective on the concept of rapport. Therefore, related disciplines including adult psychology were sourced to find the meaning of the concept of rapport. Rapport in adult psychology is referred to as having been established when a relationship between two adults is described as comfortable and respectful (Gurland & Grolnick, 2008; Tickle-Degnen & Rosenthal, 1990). When discussing the relationship between patient and therapist, the term therapeutic alliance is often referenced. Therapeutic alliance describes the relationship between patient and therapist as *affective* and *collaborative* in establishing therapeutic goals (Kazdin, Whitley & Marciano, 2006). Research on therapeutic alliance can be found in social work and psychiatry but is limited in the child life literature (Cantos, Gries & Slis, 1997; Kazdin et al., 2006).

The researcher interviewed certified child life specialists working across Canada and the United States to begin the discussion on rapport. The aim of the study was to a) better understand the meaning of the concept of rapport, b) identify ways in which rapport is established and maintained, as well as c) determine the purpose and outcomes following the establishment of rapport between child life specialists and children. Twelve child life specialists participated in the interview process. Thematic analysis was used to identify global themes among child life specialists' perceptions and experiences. The six global themes identified are 1) academic and childhood experiences, 2) describing rapport, 3) initiation of rapport, 4) maintenance of rapport, 5) indicators of rapport, and 6) rapport is essential. The research findings help open the

discussion on how rapport is established and maintained as well as the role rapport has in the supportive care of children and families experiencing medical encounters. Findings may be informative for students, clinicians as well as educators working in child life.

Definitions of Terms

Child Life: Child life is a profession within the area of pediatrics that offers psychosocial care for children and youth experiencing medical events and procedures (Canadian Association of Child Life Leaders, 2011). Child life specialists promote a positive experience in health care settings by forming supportive relationships with children and families, encouraging play and providing preparation activities.

Child Life Specialist: Child life specialists have an expertise in supporting children and families through experiences related to health care, particularly hospitalization. Certified child life specialists are individuals who achieve academic and practical experience after obtaining a minimum of a Bachelor's degree, completing a supervised internship and passing a certification exam (Child Life Council, 2009). The Child Life Council is the certifying body in North America.

Developmentally Appropriate Practice (DAP): Developmentally appropriate practice is a perspective on learning that focuses on the developmental needs of the child. Caregivers are concerned with making sure learning activities are both age-appropriate and individualized. Aspects of every learning activity focuses on the child's emotional/cognitive/physical and social development, the child's individual strengths and needs, as well as family background including culture and language. Children are seen as active learners who learn new information best by interacting within their environment to develop new knowledge and skills (Canadian Child Care Federation, 2011).

Preparation: The term preparation represents a range of interventions provided by child life specialists to reduce the potential fears and anxieties of children and families around

potentially stressful medical events. An example of preparation includes a play based intervention where children are provided with authentic medical equipment; under the guidance of child life specialists, children are encouraged to explore the function and purpose of equipment and procedures.

Rapport: Rapport refers to feelings of comfort and respect being exchanged between two individuals (Gurland & Grolnick, 2008). While the ease of rapport development is affected by the experiences and expectations that each individual brings to a relationship, it is possible to be developed between individuals of varying authority levels, ages and can occur in any type of setting. (Johansson & Jansson, 2010; Tickle-Degnen & Rosenthal, 1990).

Chapter 2

The Story of Mya

Mya's tummy has been upset for several days now but last night it was really hurting her. Early in the morning, before the sun was up, Mya's dad bundles her with a blanket and takes her to the hospital. Mya is sleepy so she rests her head on her father's chest while he carries her in and speaks to the nurse. Once Mya feels her dad sit in a chair, she peers out from the blanket and is startled by the bright lights. She starts to feel nervous as she sees lots of people around her. Just as Mya settles to rest on her father's chest again, a lady approaches them with a smile and introduces herself as Amanda, a child life specialist.

Amanda talks to both Mya and her father and lets them know that the doctor will be coming to see them very soon. Amanda asks Mya's father if he would like to move to a quiet room where they can be more comfortable. As she leaves, Amanda places some picture books on the chair beside Mya's father and lets them know she will be back shortly. Amanda comes back with a teddy bear in her arms that she offers to Mya. Amanda begins a process of getting to know the young patient and her father.

Hospital experiences can be stressful for both children and families (Child Life Council, 2006; Melnyk, 2000). However, contemporary pediatric practices in North America encourage policies and programs that help to alleviate stress and increase adaptation of children and families. One program that has existed since the 1960s providing specific services and programs for children and youth is Child Life. Child life specialists are members of the health care team who support the adjustment of children and families through play-based services such as opportunities to play and preparation for medical events (Child Life Council, 2009). The role of the child life specialist includes the establishment of meaningful relationships from which the provision of a variety of play experiences and the presentation of educational opportunities is initiated (Turner & Fralic, 2009). Trained in developmental theory and humanistic care, child life specialists are able to understand and advocate for the perspective of children as they encounter new and often uncomfortable situations during health care experiences, particularly

hospitalization. Although the foundations of child life practice are well documented in the literature, many facets of child life practice have yet to be explored and shared through research.

Consider the story of Mya, a young girl and her father arriving to the emergency room. A range of hospital staff may interact with Mya and her father as she is triaged and settles in the crowded waiting room: but one staff stops to attend just to the psychosocial needs of the young child. This type of scenario is repeated in pediatric health care centers across North America as children and families are unexpectedly introduced to a member of the health care team whose main role is to provide opportunities for play and preparation with children during the health care experience. Child life specialists interviewed by Turner and Fralic (2009) indicated that the process of developing rapport with children and families is the foundation from which they conduct ongoing assessments and maintain relationships necessary for the delivery of child-focused interventions and services. Their investigation, however, was preliminary suggesting that further research is necessary in order to enhance our understanding of ways in which child life specialists develop rapport with children. The current study included a sample of child life specialists who were interviewed to explore the ways in which they develop rapport as children and families experience health care events.

Early Care of Children in Hospitals

Some of the earliest reports of children experiencing hospitalization come from a time following the industrial revolution in the early 1900s. With a boom in urban settlement, cities became overcrowded and poverty rose, leaving families and children vulnerable to disease that infected their homes and food (Pond Wojtasik & White, 2009). As germ theory became known, cleanliness measures in hospital settings were intensified to control the spread of infections (Davies, 2010; Pond Wojtasik & White, 2009). Hospital protocol left children isolated within the

single space of their hospital beds and interaction with parents and health care providers was limited (Davies, 2010).

When children and infants experienced limited social contact, negative physical and emotional behaviors were reported. The inability of infants to gain weight, failure of children to meet developmental milestones, irregular sleep patterns and increased accounts of acquired infections were some of the consequences associated with isolation during medical stays (Hägglöf, 2007; Pond Wojtasik & White, 2009; Roberts, 2010). The term ‘hospitalism’ was coined by René Spitz to describe the negative impact on the developmental growth of children exposed to restricted hospital protocol (Spitz, 1945). Spitz studied the effects associated with a lack of nurturing and found environmental factors such as human contact to be as important to the successful treatment of a child as the medical care they received (Pond Wojtasik & White, 2009). Harry Bakwin, a pediatrician, also suggested human relationships as a key component of the health care process, advocating for unlimited parental visits and encouragement of staff to develop friendly relationships with young patients (Bakwin, 1941). Both Spitz and Bakwin welcomed the continuation of social interaction in order to provide children with the necessary levels of physical and emotional stimulation and avoid many of the unhealthy consequences associated with isolation (Pond Wojtasik & White, 2009).

Research and advocacy expanded into the 1950s, drawing attention to the effects of separation on children’s behaviors and relationships with caregivers (Palmer, 1993). Bowlby was interested in the emotional and behavioral reaction of children who experienced separation from caregivers. He recognized human intimacy to be a primary component of human life suggesting that interruptions in loving relationships challenged the healthy psychological development of children (Alsop-Shields & Mohay, 2001; Koller, Nicholas, Goldie, Gearing & Selkirk, 2006).

Fellow advocates, James and Joan Robertson also supported the need for human intimacy when they observed and documented the hospitalization of a child whose parents were unable to visit her often. The child displayed a full range of emotions associated with separation issues including protest, despair and detachment (Alsop-Shields & Mohay, 2001). James and Joan Robertson, argued that the fear of separation or abandonment felt by a child experiencing limited contact with their caregivers unnecessarily added to the child's stress level that is already elevated from the experience of being hospitalized (Alsop-Shields & Mohay, 2001). As a result of the work of Bowlby, the Robertson's and others, changes in health care practices that emerged during the 1960s focused on providing humanistic care for children and their families in children's hospitals (Alsop-Shields & Mohay, 2001; Koller et al., 2006).

The Development of Child Life

A separate division within the health care system known as pediatrics became the context from which child life programs could provide services that were more child and family friendly (Pond Wojtasik & White, 2009). Child life professionals took on the responsibility for providing a more humanistic health care experience by attending to the psychosocial needs of children and families including psychological confidence and resilience and social relationships in contrast to caring solely for the health of the body (McCue, 2009). By establishing relationships and providing play and educational supports, child life professionals help children and families better overcome stressful encounters and achieve optimal development during such stressful times.

Emma Plank at Cleveland Metropolitan Hospital began the first formalized child life program in the 1960s. The child life and education program highlighted opportunities for play, socializing and school-based activity (Plank, 1962). Maintenance of the child's social support system was an important aspect of the program as well as advocacy for family visitation and

presence. Plank (1962) suggested that child care workers develop their own caring relationship with each child in combination with child-parent relationships in order to provide successful care. The routines of hospitalized children were planned to follow the normal patterns of daily living as much as possible. Although a child's day may include medical procedures, conversation and activities throughout the entire day were not to evolve entirely around expected medical events. Overall, the objectives of the program were to form relationships with children and families, facilitate play, and provide opportunities for education around diagnosis and medical care.

Following the establishment of the first formalized child life program, the child life profession has shown an increase in the number of professionals and institutions directing their attention towards children's reactions to hospitalization. Pond Wojtasik and White (2009) provide a comprehensive overview of the story of the child life profession. Initially, a multidisciplinary organization including physicians, nurses, social workers and child life professionals called the Association for the Care of Children's Health (ACCH) was formed in 1965 thanks to a large influence from the pediatric health care community. The ACCH promoted the inclusion of psychosocial care based on the developmental needs of children. In 1982, an interdisciplinary group separated and formed what is now known as the Child Life Council (CLC). The CLC directly focused attention towards the discussion of the child life experience, child life programs, and professionalization of child life. Educational and professional requirements, including certification and supervised internships, were also the focus of the Child Life Council at that time. Although informal terms such as *play program* or *play lady* are still commonly used by patients and families, the official term *child life specialist* refers to

professionals dedicated to improving health care experiences for children by providing programs based on relationships, play and education (Pond Wojtasik & White, 2009).

Research supporting child life practice has been slow to emerge (Thompson & Snow, 2009). In the 1980's, ACCH provided funding to a team of child life specialists and researchers to answer the question, "When a child life program is designed and implemented on the basis of theory and research, will it make a positive difference for children and parents (Gaynard et al., 1990, p. 2)?" Child Life initiatives including relationship building, education and play were provided to an experimental group consisting of children between the ages of three and thirteen years old; the control group did not receive child life care. Through the application of an experimental design, results of the research demonstrated that children in the experimental group experienced significantly less emotional discomfort, an increased understanding of medical procedures, to have more coping skills to handle potentially overwhelming situations and to better adjust to routines after discharge from the hospital compared to a control group (Gaynard et al., 1990). This study, commonly referred to as the Phoenix Project, represents the most comprehensive child life research to date.

The Phoenix Project authors also produced a manual for child life professionals and students (Gaynard et al., 1990). The manual serves as a resource documenting the theory and research that grounds the profession; additionally, the establishment of supportive relationships is emphasized as the foundation for all child life interactions. Both formalized tasks, such as meeting the child and parents before admission, or informal interactions, such as reading a book, allow child life specialists to develop supportive relationships that are essential to the provision of effective care (Gaynard et al., 1990). The research and manual were influential precedents from which future child life programs have been established.

Subsequent to the Phoenix project, child life programs have grown to become accepted as standard practice in inpatient pediatric settings (American Academy of Pediatrics, 2000).

Working in a multidisciplinary team, child life specialists contribute to providing quality care to pediatric patients and their families. Child life programs across North America can range from one-person programs to large teams of professionals. The foundations of child life practice including program standards, ethical principles and certification of specialists provide a guiding framework to unite child life care and services across programs.

Theoretical Foundations

The approach of child life specialists to the care of children and families in hospitals is guided by a number of prominent developmental theories. Specifically, Attachment theory, Piagetian theory and the stages of psychosocial development established by Erikson provide a framework from which child life specialists assess and guide children's activities while hospitalized. Developmentally appropriate practice (DAP) requires an understanding that children are social learners who actively construct meaning and knowledge as they interact with their environment (National Association for the Education of Young Children, 2011).

Throughout their daily interactions, child life specialists engage in activities that allow them to create and maintain positive relationships and facilitate effective learning environments for children in hospital.

For example, a one year old will not understand when their parents verbally explain that they must leave temporarily but will return soon. Instead, the young child may become upset that their parents are leaving them and unsure if they will return. A child life activity that will help the young child understand that their parents will return involves play around the idea of disappearance/reappearance (Gaynard et al., 1990). This may involve playing peek-a-boo or

demonstrating that although a doll may be out of sight because it is placed in the playhouse, the doll does not disappear altogether but rather can reappear at a later time. Activities such as these demonstrate child life specialists' ability to understand the child's perspective and arrange play activities around helping the child best learn and reduce emotional distress.

Attachment theory serves as a foundation for the emergence of child life practice in children's hospitals as the progression of changes towards the provision of humanistic health care directed greater attention to the needs of hospitalized children (Turner, 2006). In theory, the concept of attachment refers to the quality of the parent-child relationship as represented through a child's confidence in the ability of their primary caregiver to respond to their needs (Bowlby, 1973). Children will explore and learn in new environments when they perceive their caregiver to be available to respond to them if they become upset. Illness and separation are experiences that elicit attachment behaviors in children as they react to experiences in ways that serve to solicit the attention and care of their caregiver. Child life specialists are knowledgeable and sensitive to the needs of children in relation to the parent-child relationship and are able to observe and provide appropriate services to meet the needs of children while parents are present and during times of separation (Turner, 2006). For example, at times when a caregiver cannot be present (e.g., while at home caring for siblings) an item such as a blanket can symbolize the presence of a caregiver. Activities including peek-a-boo for young children or telephone contact for youth, can also reassure the child that the parent is available and will come back. Maintaining a connection and sense of security helps children explore new environments and feel confident when doing so. In part, the relationship that a child life specialist establishes with both the parent and the child enhances their ability to support children during times of separation and or distress.

The skill of child life specialists in addressing the needs of children is further grounded in a developmental perspective. Piagetian theory suggests the need for learning interventions to focus primarily on the child's stage of development (Turner, 2009). Piaget established a model of cognitive development emphasizing the idea that a child's ability to learn and become emotionally mature occurs after actively participating in new experiences. When a child enters a new experience they take in new information. When a state of disequilibrium occurs, a state which may occur during health care experiences, the child must take both the new information and old ideas and adapt them to represent a new understanding. The ability of child life specialists to observe, assess and respond appropriately is grounded in their understanding of child development (Gaynard et al., 1990). Further, the use of developmentally appropriate practice requires the child life specialist to consider both the developmental appropriateness and the individual appropriateness of an intervention in order to address the needs of children. This applies to their approach to children and families as they establish relationships.

Eriksons' psychosocial theory of development emphasizes a sequence of issues encountered as individuals grow and develop. Child life specialists are guided by the stages of development outlined by Erikson to both identify parallel issues for children in hospital and also provide interventions that promote positive pathways for children at various stages of development. For example, during the first year of life, young children learn to trust in the caregiver's availability and ability to help them overcome fears and avoid stress related symptoms including disturbances in sleep and eating patterns (Hägglöf, 1999). Child life specialists understand the importance of having primary caregivers present during both daily routines and medical procedures whenever possible (Bell, Johnson, Desai & McLeod, 2009). Alternatively, when parents cannot be present, staff, volunteers or programs designed to meet the

needs of infants are provided. During later stages, child life specialists aim to address developmental needs related to the establishment of autonomy, initiative and identity. By providing children and youth with opportunities for play and exploration, typical routines, peer interaction, parental and peer support, success, connections with home and school and relationship building, child life specialists support adjustment to issues that arise at key interaction points (Hägglöf, 1999; Turner, 2009).

Child Life Specialists' Roles and Responsibilities

Child life specialists have three essential responsibilities when helping children and families effectively cope with stressful medical events (Kain, Caramico, Mayes, Genevro, Bornstein, & Hofstadter, 1998; Madhok, Scribner-O'Pray, & Teele, 2011; Pond Wojtasik & White, 2009). The first responsibility is to establish relationships. Relationships between pediatric patients, their families and health care providers are essential to quality care (Stratton, 2004; Stuart, 2009). Opportunities to discuss questions and share emotions are encouraged when health care providers establish trusting relationships with children and their families (Gaynard et al., 1990). The information that child life specialists learn from children and families influences the support services they provide which in turn helps alleviate anxieties and foster optimal development of children.

Relationships begin to form during the initial introductions when child life specialists inform children and families about their roles. During introductions it is common practice for child life specialists to offer simple activities such as games or movies to initiate interaction with children (Gaynard et al., 1990; Turner & Fralic, 2009). Relationships are established with each interaction as child life specialists offer different forms of therapeutic activities and interact with the child and family. Relationships can be strengthened for instance while preparing a child for a

procedure by role playing with a doll or having an informative conversation with the family about the child's needs. While play and educational activities appear to be the child life interventions that enable children to overcome stressful situations, according to Stuart (2009) the relationships formed between the child, family and workers *are the intervention*. Opportunities to learn and practice coping strategies occur within the process of creating these relationships.

The second essential responsibility of child life specialists is to facilitate the participation of children in play activities. The therapeutic nature of play has been an interest of many psychoanalytic theorists including Sigmund and Anna Freud as well as Erik Erikson (Jessee & Gaynard, 2009). Play is seen as a time for professionals to form relationships with children as they explore feelings or thoughts that they would otherwise be too nervous to mention to an adult. Erikson saw play as a time for children to think over difficult situations by reenacting situations; children can gain a sense of mastery over them and reduce anxiety.

Play provides children with outlets to 'work out' their emotions during self-expression activities, achieve temporary distraction, and gain knowledge about medical equipment and procedures (Jessee & Gaynard, 2009). Child life specialists use play as an outlet for children to express their concerns around health care issues. For example, throwing paint or banging on drums can be an outlet for children to release tension while also expressing emotions including anger and sadness that are hard to voice. When children have an opportunity to express built up emotions at their own pace, distress can be reduced (Gaynard et al., 1990).

At the same time, children may also want to play either by themselves or with other children to focus their thoughts away from their medical situation. Play can allow children to return to a place of comfort where they can calm their fears and regroup their thoughts that can to promote healing (Jessee & Gaynard, 2009). When child life specialists identify a child's favorite

comfort activity, they can help the child take a break away from stressful events. For instance, a child may find comfort in watching a familiar movie or drawing. The goal here is not to explore unsettling emotions but rather have the child focus their attention towards an activity that balances their emotional state to one of comfort and relaxation (Jessee & Gaynard, 2009).

Structured play opportunities can be planned to familiarize children with unfamiliar objects allowing for the reduction of anxiety as familiarity is enhanced. Ideally, playrooms are supplied with both age appropriate toys and authentic medical equipment such as syringes, stethoscopes, gowns, gloves and medical dressings. When children are introduced to authentic materials, the interaction can facilitate the systematic desensitization of items that previously may arouse discomfort and anxiety (Goldberger et al., 2009). For example, medical procedures such as getting a leg cast can be demonstrated with a child through play activities. Having a child feel the casting material, see how the cast hardens and feel what it would be like to have their leg temporarily enclosed with a cast will help familiarize the child with the procedure and reduce fears and anxieties.

The third essential child life responsibility is to use developmentally appropriate education to inform children about medical events they will encounter (Madhok et al., 2011; Pond Wojtasik & White, 2009). When providing information about events, people and places in the hospital, child life specialists are preparing children through sensory, hands-on learning, sequential and accurate information in order to instill a sense of predictability and control. Educational opportunities aim to have children understand what they should expect to feel, smell, hear, and see during a particular event before actually experiencing it. Likewise, actual events should represent the same details that a child was prepared to encounter in order to allow the child to maintain a sense of predictability and control.

The benefits of child life interventions are documented in studies comparing children who are not provided with child life services to children who experience different degrees of child life interventions. Activities such as role playing and hospital tours have been shown to significantly decrease the level of distress for children as measured both pre and postoperatively (Brewer et al., 2006; Gaynard et al., 1990). Koller (2008) summarized research on play based interventions and found research outlining the benefits of both therapeutic and medical play. Therapeutic play allows children and youth an opportunity to participate in creative activities such as art. For children who engaged in therapeutic play; physiological responses including decreased pulse, blood pressure and body movements were documented. Higher reports of children freely expressing emotions such as fear and anxiety were also reported in studies of children engaging in therapeutic play (Koller, 2008). In terms of medical play, where the use of authentic medical equipment are used; such opportunities encouraged greater exploration of the child's concerns and questions resulting in stress being more effectively alleviated (Koller, 2008).

Child life specialists work with children and families as they navigate health care systems. Guided by developmental theory, child life specialists are professionals with a unique skill set that enables them to support children and families facing the challenges of medical experiences. In order for child life interventions to be successful, relationships between the child and professional must be established. McCue (2009) suggests that the concept of therapeutic relationships, although valued, remains vague and generalized. Theory and research from fields such as psychology, dentistry and social work can provide insight into ways in which other professionals build rapport with children. Because child life scholars have yet to explore the

concept of rapport in child life, literature from these fields will be examined for findings that may serve to inform research with child life specialists.

Building Rapport

Consider the story of Mya and the child life specialist Amanda. As a professional with the responsibility of addressing the psychosocial needs of children, Amanda can focus her attention on the child and her father. Research by Turner & Fralic (2009) involved child life specialists talking about their process of developing rapport. Respondents indicated that they typically carried play materials with them (e.g., stuffed animal), used a system of coming-and-going (e.g., *I'll see you in a few minutes*) and used features of the environment to promote a sense of belonging (e.g., moving to a comfortable room). Further, the respondents felt that their behavior communicated a sense of genuine interest to the child and family, created a sense of connection between themselves and the child, as well as provided opportunities for choice and control. Through these initial interactions, a sense of rapport was established early and would serve as the foundation for specific child life interventions.

The concept of rapport has also been studied in related professional service areas such as adult psychology. Here, rapport refers to a relationship formed between two individuals that has reached a level of comfort and mutual respect (Gurland & Grolnick, 2008; Tickle-Degnen & Rosenthal, 1990). A relationship with a high degree of rapport is described as comfortable, supportive and welcoming (Gurland & Grolnick, 2008; McCue, 2009). Researchers suggest that multiple factors influence the ease of rapport development including the experiences and expectations each individual brings to the relationship (Johansson & Jansson, 2010; Tickle-Degnen & Rosenthal, 1990).

Tickle-Degnen and Rosenthal (1990) acknowledge that while experiences and expectations are influential in the process of developing rapport, they suggest the nature of rapport to always consist of three components. These components include mutual attentiveness, positivity and coordination. The components, while consistently present, will vary in degree depending on the developmental progress of a relationship. Feelings of rapport are reported more readily when all three components are relatively high.

The first essential component of rapport is mutual attentiveness. Mutual attentiveness occurs when each individual's primary focus is directed towards one another's verbal and physical expressions (Tickle-Degnen & Rosenthal, 1990). Rapport is reported when one individual feels that the amount of focus they are expressing is reciprocated by the other person's attention. For the most part, Tickle-Degnen & Rosenthal (1990) describe initial interactions between two people to display mutual attentiveness as both parties behave with socially acceptable behaviors that are respectful, polite and attentive. Polite behaviors such as nodding one's head during conversation and eye contact help to indicate a level of mutual attentiveness. People also pay attention to the items each other may be wearing or holding as a way to build an understanding of what the other person represents (Tickle-Degnen & Rosenthal, 1990). Child life specialists report the practice of carrying objects such as toys or bubbles into initial introductions with children as a technique for gaining the child's attention and conveying the image of themselves as a nonthreatening individual (Turner & Fralic, 2009).

On the other hand, a low degree of rapport occurs in situations where one person prefers to terminate an interaction (Tickle-Degnen & Rosenthal, 1990). In these types of situations, one party is genuinely uninterested in what the other person is saying or doing but they may express false attention for a limited amount of time before choosing to end an interaction. In medical

environments, children can experience interactions with numerous adults including doctors and nurses and may become uninterested in forming individual connections with every additional medical staff they come into contact with. By having child life specialists connect with children through the presentation of materials such as toys, follow up interactions can be more easily facilitated. Standing out as a unique staff member who offers stimulating activities may capture the child's attention and facilitate movement toward activities such as medical play and preparation. Those situations when rapport-building initiatives by a child life specialist are difficult or met with resistance have yet to be explored in research studies.

If one or both individuals are genuinely uninterested in forming a relationship but remain focused, at least partially, there is a lack of the second essential component of positivity. Tickle-Degnen & Rosenthal (1990) describe positivity to occur in situations where each individual shares a mutual level of care and friendliness towards one another. Although the degree of mutual attentiveness and positivity can change, both components remain present in the overall nature of rapport (Tickle-Degnen & Rosenthal, 1990). Child life specialists value the expression of genuine interest when forming caring and friendly relationships with children (Turner & Fralic, 2009). Expressing a true interest in the child's desires comes from asking questions, offering choices and respecting the child's decision (Hallstrom & Elander, 2004; Turner & Fralic, 2009). With every additional interaction between two parties, the need to portray continuous positivity decreases (Tickle-Degnen & Rosenthal, 1990). Expressions of anger or upset from children during interactions with child life specialists does not result in termination of the relationship but may symbolize that the relationship has advanced past the initial stage of polite behaviors often performed to portray oneself in a positive light.

The third essential component of rapport is coordination. Coordination usually occurs beyond initial introductions and describes equilibrium in the relationship (Tickle-Degnen & Rosenthal, 1990). Each individual's conversational input and behaviors are immediately responded to by one another. Immediate responses are appropriate because multiple interactions between the two individuals have allowed for opportunities to gain a sense of predictability about one another's behaviors. Relationships with a high degree of rapport can be described as having rhythm where each person understands and respects the other's behaviors and emotions (Tickle-Degnen & Rosenthal, 1990). This allows two people to carry on a conversation without awkward silences or interrupting one another frequently.

The concept of rapport refers to the feelings of comfort and respect being exchanged within a relationship which is formed between two interested people. Rapport can be established between two people of differing ages, authority levels or professional roles and can be initiated and fostered in any type of community setting (Tickle-Degnen & Rosenthal, 1990). In clinical environments specifically, the quality of a patient-therapist relationship is not described by degrees of rapport but rather is referred to in terms of therapeutic alliance (Martin, Garske & Davis, 2000).

Therapeutic Alliance

Therapeutic alliance refers to the bond between a patient and therapist as affective in identifying patient needs and collaborative in agreeing upon therapeutic goals (Kazdin et al., 2006). The therapeutic alliance is also recognized as both the most essential (Baylis, Collins & Coleman, 2011; Martin et al., 2000) and frequently studied component (Kazdin et al., 2006) of patient-therapist relationships. Indeed, a strong therapeutic alliance is linked to positive therapeutic change (Martin et al., 2000). Although the positive impact of therapeutic alliance has

been demonstrated, the number of studies involving therapeutic alliance and children compared to studies with adults remains low (Shirk & Karver, 2003). However, available research does provide resources for identifying common skills used by professionals when developing a strong alliance with children and their families.

Unlike adult-therapist interactions, when children encounter professionals such as dentists, doctors, therapists and social workers these encounters are seldom experienced without the presence of the child's guardian. Despite the additional attention from health care providers, family members are supported to remain in the primary care giving role (Bell et al., 2009). This practice is the foundation from which family centered care practices are implemented. Family centered care presents the healthcare process as a mutual partnership between the patient, family and professionals. By treating the patient and family with dignity, health care professionals are engaging in family centered care (Bell et al., 2009). In pediatric health care settings, the benefits of family involvement include improvements in medical treatment outcomes, increased patient, parental and professional satisfaction and more effective use of support resources throughout the treatment process (Bell et al., 2009).

The parent-therapist alliance has an impact on the child as treatment goals are developed collaboratively. Within the social service sector, Cantos and colleagues (1997) identified the benefits associated with increasing the time spent between caseworkers and families. Benefits included more frequent parental visitations with children in foster care and decreases in total foster care placement times (Cantos et al., 1997). Within psychiatry, the stronger the parent-therapist alliance, the greater the improvements in parenting skills including participation in the child's treatment at home (Kazdin et al., 2006). A strong alliance between parents and

psychiatrists has also been linked to greater improvements seen in the child at the end of their treatment (Kazdin et al., 2006).

Some professionals also recognize children's previous experiences with, and expectations of, clinical environments as influential on the development of therapeutic alliance (Gurland & Grolnick, 2008). McGrath and Huff (2001) specifically looked at how school-aged children's previous experiences with medical events affected their level of comfort around medical equipment and their description of photos displaying medical situations. Children who had family members previously experience a medical procedure avoided toys resembling medical instruments as well as described photographs of hospital scenarios in a fearful manner (McGrath & Huff, 2001). When investigating the process of assessment, Turner and Fralic (2009) found child life specialists to refer to either gathering information about children's experiences prior to introductions or having informal conversations upon introductions in an effort to gain information. Unique opportunities for identifying a child's previous experiences or expectations of medical events can also be found in the items and pictures children use to decorate their hospital bedside environments (Lewis, Kerridge & Jorden, 2009).

By expressing a genuine interest for supporting children through a stressful encounter, health care professionals can facilitate the formation of a strong therapeutic alliance. Professionals often use choices when appropriate to help children feel a sense of independence and control (Gaynard et al., 1990). Choices can range from deciding what movie they would like to watch to decisions around positioning during medical procedures. Not only is it important to provide opportunities for choice but professionals need to respect the child's decision once it is made (Gaynard et al, 1990; Hallstrom & Elander, 2004). Having a child's space and decision be respected allows for the child to gain trust towards the professional.

Many techniques are used by professionals to initiate a relationship between themselves and children. Child life specialists talked about the materials they carry with them to help communicate their unique role in the health care setting (Turner & Fralic, 2009). Dentists, for example, may use magic tricks to encourage children to sit up in the dentist chair and to facilitate cooperation. Peretz & Gluck (2005) used an experimental design to compare traditional practices, for example explaining and demonstrating desired behavior, with child-friendly approaches. They found child friendly approaches useful in minimizing the need for restraint that caused more discomfort and anxiety in children.

Authors that discuss therapeutic alliance with children describe the benefits of having a strong relationship between the child and professional, the parent and the professional and maintaining the child and parent relationship (Cantos et al., 1997; Gurland & Grolnick, 2008; Johansson & Jansson, 2010; Kazdin et al., 2006; Martin et al., 2000). One of the most recognized benefits highlighted is the enhanced treatment outcome for the child. Few reports explicitly describe the *how to* process for building strong therapeutic alliance with children and their families, as it is understood that every patient-therapist relationship is unique. Some common themes in the development of therapeutic alliance can be identified in disciplines such as social work, dentistry, psychiatry, and child life. Techniques include providing choices, interacting with the support of materials, gathering information on children's previous experiences and respecting family as integral members of the health care team. The recognition of successful verbal and nonverbal behaviors used by professionals when developing relationships can contribute to training and skill development of individuals working with children and families in health care related settings (Norfolk, Birdi & Patterson, 2009).

Current Study

Child life specialists working in health care settings provide services and supports that are intertwined with the relationships that are developed with children and families. Prior to this research study, the concept of rapport has yet to be explored in the child life literature. As a result, insight into the meaning of the term rapport, the mechanisms and processes that result in the development (or not) of rapport and the perceived outcomes that result as relationships grow and change across time are drawn from allied health literature. This gap in the child life literature has an impact on students, entry-level and seasoned professionals as well as professionals in teaching, supervisory and administrative roles. The enhancement of current child life training, practice and professional development requires investigation of some of the most basic elements of humanistic care: the development and maintenance of meaningful and effective relationships. Thus, this qualitative research study was conducted in order to a) better understand the meaning of the concept of rapport, b) identify ways in which rapport is established and maintained, as well as c) determine the purpose and outcomes following the establishment of rapport between child life specialists and children.

Chapter 3

Method

The current research study involved the use of semi-structured interviews to explore the ways in which child life specialists develop and maintain rapport as children and families experience health care events. In total, twelve certified child life specialists working throughout Canada and the United States participated in interviews. Thematic analysis was applied to identify basic themes, organizing themes and global themes that arose from the interview process.

Participants

Twelve certified child life specialists currently working throughout Canada and the United States participated in the research study. On average, this group of child life specialists had been working for seven years at the time of the interview. The total number of years' experienced ranged from seven months to twenty eight years. Work in related fields prior to child life included experience as preschool workers, social workers, early childhood educators, researchers, special education workers, teachers, a nanny and a therapist. Educational credentials obtained by the participants varied with focused degrees in child and youth care, psychology, social work, education, recreational science and public health. Six of the participants reported having undergraduate degrees with the other six having obtained degrees at the graduate level. Approximately a third of the participants identified themselves to currently hold a supervisory or management role within their child life programs including being internship supervisors or internship coordinators.

Procedure

Recruitment

Approval was obtained from the Mount Saint Vincent University Research Ethics Board (UREB) prior to contact with potential participants. An initial selection criteria for participants was exclusive to certified child life specialists working in freestanding children's hospitals throughout Canada and the United States. Due to an initial low response rate, the study criteria was extended to include any certified child life specialist working in Canada and the United States. Potential participants were identified to meet these specific requirements on the Child Life Council's online member directory. In total, 1,936 potential participants were identified on the member directory to meet the initial requirements.

Using the Statistical Package for the Social Sciences (SPSS) version 17, a list of 150 random numbers was generated. From this, a mailing list was compiled using the names from Child Life Council online member directory. In total, 150 emails were sent to potential participants. The invitational email outlined the student as the primary researcher of the study, the focus of the study, the selection criteria for participants, benefits for participating and the process for participating in the interview (Appendix A). Attached to the invitational email was the consent letter that informed participants of the purpose for the study, relevant child life literature and ethical considerations specific to the interview process (Appendix B). The consent letter outlined that participation involved minimal risk and included an audio-recorded single telephone interview lasting approximately 30-45 minutes. Participation was voluntary and the participant had the right to refuse to answer any question(s) during the interview or withdraw from the research study at any point during or after the interview without penalty.

Upon receiving signed consent forms via an electronic PDF file or fax from interested participants, the researcher responded with an email asking to schedule a time to conduct the interview at the participant's earliest convenience. The interview questions were attached to the email sent to the potential participants (Appendix C).

Interviews

At the time of the interview, the researcher initiated a telephone call to the participant. All interviews were conducted by the researcher. Prior to asking interview questions the researcher reviewed ethical considerations by stating that participation was voluntary, the participant had the right to refuse to answer any question(s) during the interview or withdraw at any point and information used in written reports would assume anonymity and confidentiality. The length of interviews ranged from 16 to 50 minutes with the average time being 25 minutes in length.

All interviews were audio-recorded and saved as digital files on the personal computer of the researcher. The audio-recordings were transcribed verbatim within days following each interview. The thesis supervisor reviewed two audio-recordings and transcripts to check for accuracy prior to the destruction of audio-recordings. During transcription, all identifiable information including names and place of employment were removed to anonymize the data. Alphanumeric codes were used to replace participant's names. All quotes used in the study's results were anonymized.

Interview Questions

The interview questions (Appendix C) were developed by the researcher and based upon knowledge gained from the review of related literature on the concept of rapport and the development of rapport in health care related settings. In providing the questions prior to the

interviews the researcher intended to obtain rich details from the participants who would have an opportunity to review and reflect on the topics being discussed (Burke & Miller, 2001).

The questions focused on child life specialists' perceptions and experiences building relationships with children and families. For example, the participants were asked to recall if material objects were used during initial introductions with a child or adolescent. Although interview questions remained in a constant order for all interviews, prompts were used when needed to encourage participants to discuss particular questions further. For instance, a prompt was used when providing an example of a specific academic degree such as Bachelor of Arts in Psychology when asking the participant to describe their educational accomplishments.

All interviews were conducted in a conversational style with the researcher voicing a nonjudgmental tone. The interview questions made up three sections. The first section focused on child life interactions the participant had experienced, the second focused on the concept of rapport and the third was specific to demographic questions. Asking for demographics post-interview questions was done to avoid participants from answering questions in ways they believed the researcher expected. Burke and Miller (2001) offer the suggestion that interview questions may be answered in a way the participant believes someone of their gender, educational background, or person with the number of years of professional experience they have is expected.

At the conclusion of the interviews, the participants were thanked for their time. The researcher also stated that if the participant had any further comments or questions they could contact the researcher or thesis supervisor. All contact information was included in the emails exchanged between participant and researcher. The participants were reminded that a URL link

to an electronic document of the researcher's thesis uploaded on Mount Saint Vincent University's library's website would be sent to them following completion of the research study.

Data Analysis

The theoretical framework of phenomenography was chosen for this research study. Different from phenomenology, which is a philosophical method that has a philosopher investigate their own experience, phenomenography is a qualitative method to research that investigates the experience of others (Marton & Pong, 2005). Most often phenomenography is used in studies investigating how experiences of learning and/or teaching are described differently by people of a similar group (Marton & Pong, 2005). By using in-depth interviews with open ended questions, researchers using phenomenography aim to gain full descriptions of how people experience a particular phenomenon such as rapport (Attride-Stirling, 2001; Marton & Pong, 2005). Although the analysis process varies slightly with the use of different terminology (Marton & Pong, 2005), the extraction of data from interview transcripts resembles that of thematic analysis.

Throughout the data analysis process, several *basic themes* were identified and grouped into larger *organizing themes* which were then combined to create a larger *global theme*. See Figure 1 for graphical structure of data analysis. The positioning of categories from basic to global themes is based on advanced qualitative ideas or more sophisticated descriptions of a phenomenon.

Basic Themes: First, the student researcher read the transcripts line-by-line identifying basic themes. Basic themes can be singular words or phrases found within the transcripts that are simple characteristics of the phenomena being discussed. When read alone, basic themes do not hold much meaning for the reader. Not until several basic themes are grouped together to create

an organizing theme, was the researcher able to identify commonalities among basic themes (Attride-Stirling, 2001). The thesis supervisor reviewed a selection of transcripts to confirm the identified basic themes.

Organizing Themes: The researcher then took the basic themes and organized them into more descriptive categories known as organizing themes. The organizing themes helped highlight perspectives regarding the phenomena of rapport by grouping several basic ideas together. Perspectives and experiences that were either similar or different from one another ultimately constructed the organizing themes. The thesis supervisor reviewed a selection of transcripts to confirm the identified organizing themes.

Global Themes: The main perspectives that came from organizing basic themes together formed the basis for a global theme. Global themes are the overall main arguments or viewpoints (Attride-Stirling, 2001) found throughout several interviews with different people about the same phenomena. Using the steps of thematic analysis to build on categories of ideas found in transcribed interviews, the researcher was able to identify similarities and differences in the perspectives of child life specialists responding to questions about a) the meaning of rapport, b) ways in which relationships are established and maintained as well as, c) the purpose and outcomes of relationship development with children and families experiencing hospitalization. The thesis supervisor reviewed a selection of transcripts to confirm the identified global themes.

Figure 1: Thematic Analysis

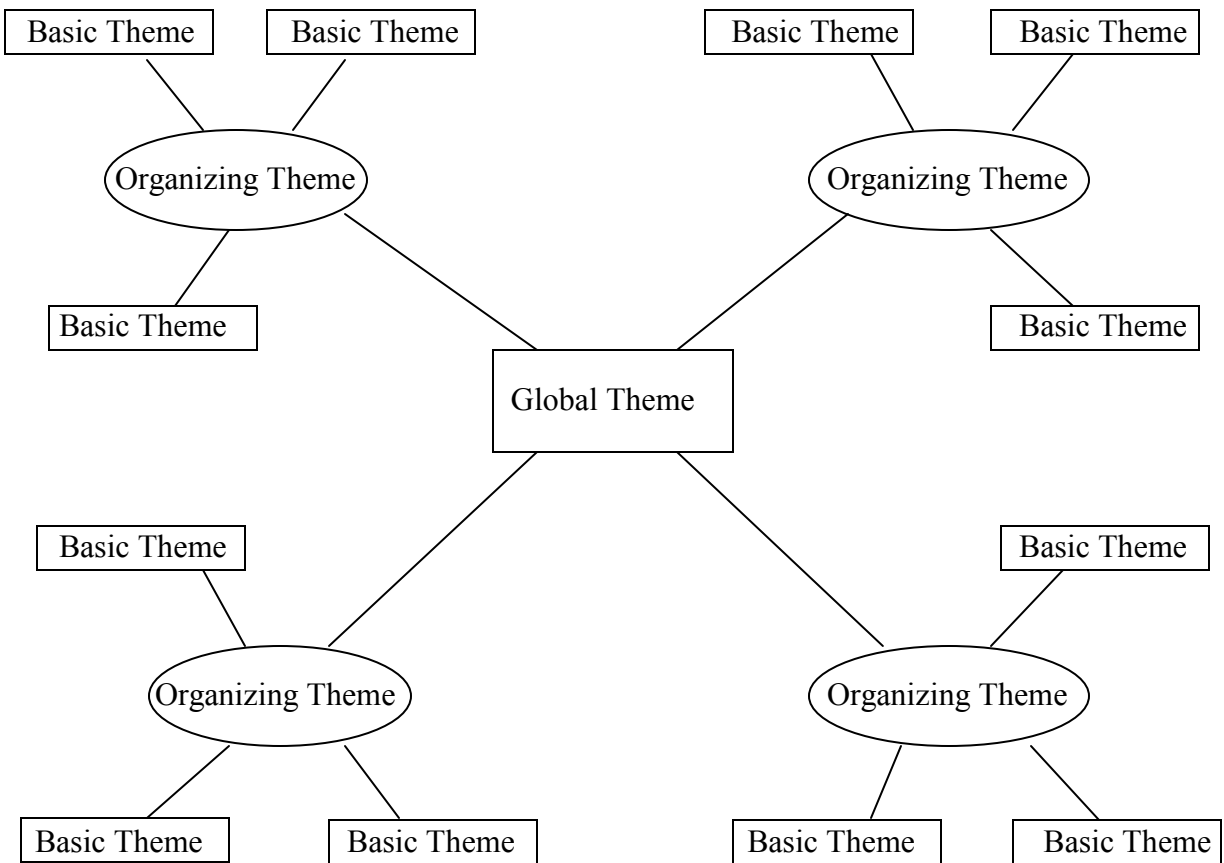


Figure 1. *Structure of a thematic network.* From Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1*, 385-405.

Chapter 4

Results

This research study was designed to explore the concept of rapport within the context of child life practice. A sample of certified child life specialists working throughout Canada and the United States participated in interviews exploring the concept of rapport. Thematic analysis was used as the method to identify global themes or reoccurring assumptions found throughout the qualitative data (Attride-Stirling, 2001). By asking child life specialists to discuss personal experiences and perceptions, the researcher was able to identify six global themes. The global themes included: 1) academic and childhood experiences, 2) describing rapport, 3) initiation of rapport, 4) maintenance of rapport, 5) indicators of rapport, and 6) rapport is essential. All themes are described below with particular emphasis on the organizing themes which developed each global theme.

Academic & Childhood Experience

The first global theme identified from the research data was that academic and childhood experiences impacted child life specialists' perception of the concept of rapport. The organizing themes that constructed the first global theme are: formal education, internship opportunities and childhood experiences (see Figure 2: Education & Childhood Experience).

Formal education. When initially asked to recall any formal learning experiences, the majority of child life specialists responded with an uncertainty to recollect a specific course taken during college or university that focused their attention on the concept of rapport. Reoccurring statements of uncertainty included "never had a class" and "don't remember having anything in school." One child life specialist indicated that the concept of rapport was touched upon but was "not anything more formal than just having conversations."

After taking a moment, four child life specialists did suggest psychology, counseling and communication courses as possible sources for where they acquired their knowledge about the concept of rapport. One child life specialist specifically recalled a communication class on active listening as an influential source for understanding the concept of rapport:

We would do role playing and you introduced yourself and talked about something and then you would do some active listening so that you are listening to what they are saying and responding to that, what they are asking.

Internship experience. The majority of child life specialists reported their experiences as a child life intern or practicum student to be the most influential in helping them build their understanding of the concept of rapport. When asked about experiences that focused their attention on rapport, one child life specialist shared “I would have to say my internship opened my eyes most to rapport” while another reported that “90% of it would have been from my internship.” More frequently, specific “weeks” or “modules” completed during internships directed child life specialists’ attention towards the importance of building rapport with children and families.

Two child life specialists summarized the influence of formal learning such as university coursework as well as their internship opportunities when stating “definitely in the curriculum that was focused on attachment... I use that information a lot for rapport building and then in my internship, the education that I got on therapeutic relationships and building rapport” and “I don’t remember having anything in school but when... I did my internship; I was in an outpatient clinic... so I had to build rapport with kids within probably less than five minutes.”

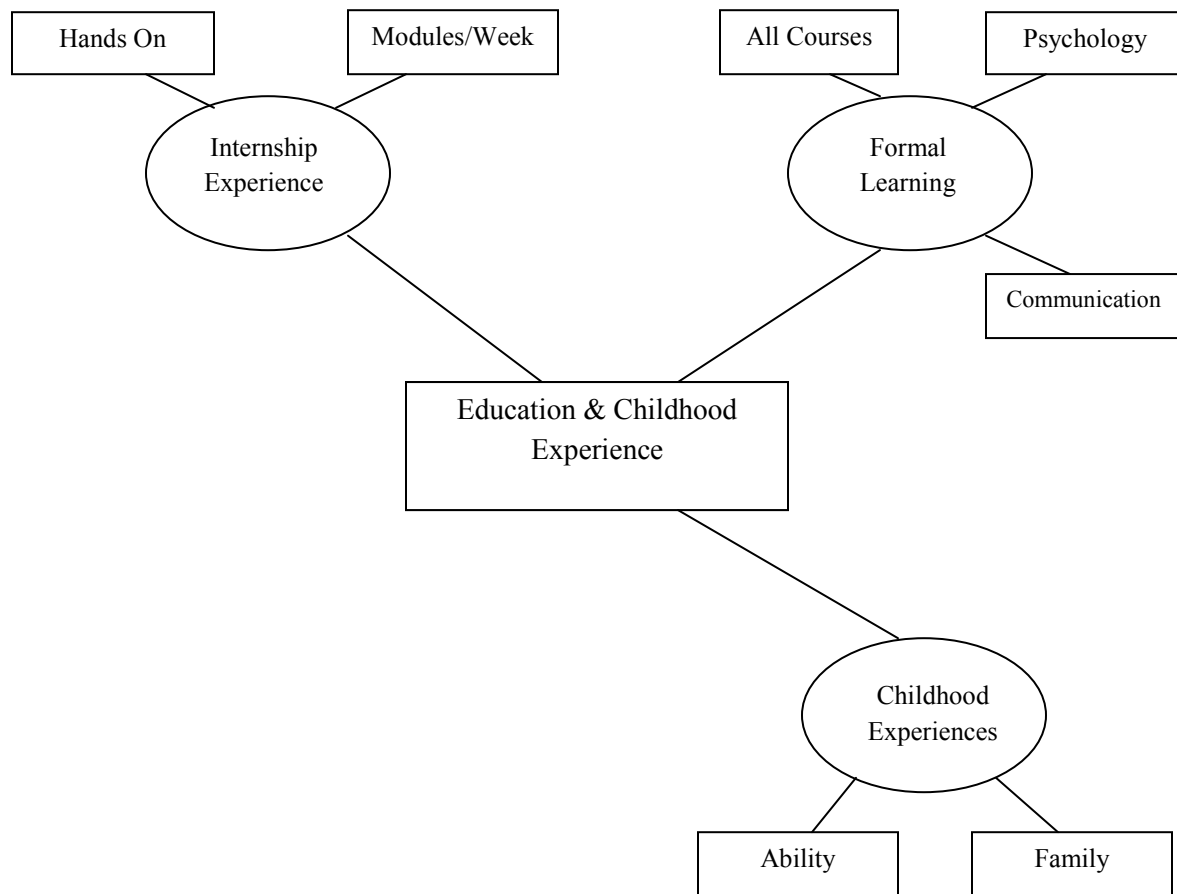
Childhood experience. Three child life specialists spoke of their childhood experiences and family background to be influential in teaching them about the concept of rapport. One of

the three child life specialist stated that coming from a “big family” allowed her to develop the skills necessary to interact and build relationships with people. Another child life specialist included childhood experiences as well:

I think definitely rapport building comes from like some of the classes you take and my internships but I think a lot of it comes from... how you are raised as a kid and how you chose to walk through and interact with other people in your life.

The ability to gain rapport with people was suggested to be “engrained in us since we were at a young age” and is a skill you continue to develop from when “we were young.”

Figure 2: Education & Childhood Experience



Describing Rapport

The second theme that emerged from the interviews with child life specialists included the expressions used to describe the concept of rapport. The organizing themes that developed the second global theme are: words and actions. (see Figure 3: Describing Rapport).

Words. When asked to describe the concept of rapport, the majority of child life specialists responded with single words. The most common words expressed were trust, respect, supportive and comfortable. One child life specialist extended her response by stating that “rapport is building a foundation of trust.” This participant went on to speak about how it is easier for a child life specialist to provide effective preparation to patients of all ages after a foundation of trust and honesty is established. Multiple child life specialists also mentioned respect as a word to describe the concept of rapport. One child life specialist expressed that “rapport is about being able to build a relationship that is built with trust and respect and understanding between anyone who is taking part in the relationship.”

While the singular words used to describe rapport have a positive connotation, one child life specialist acknowledged that the process of building a relationship with a child maybe “friendly” or “unfriendly.” The idea that children may not always respond positively to child life services or specialists will be further discussed in Theme four.

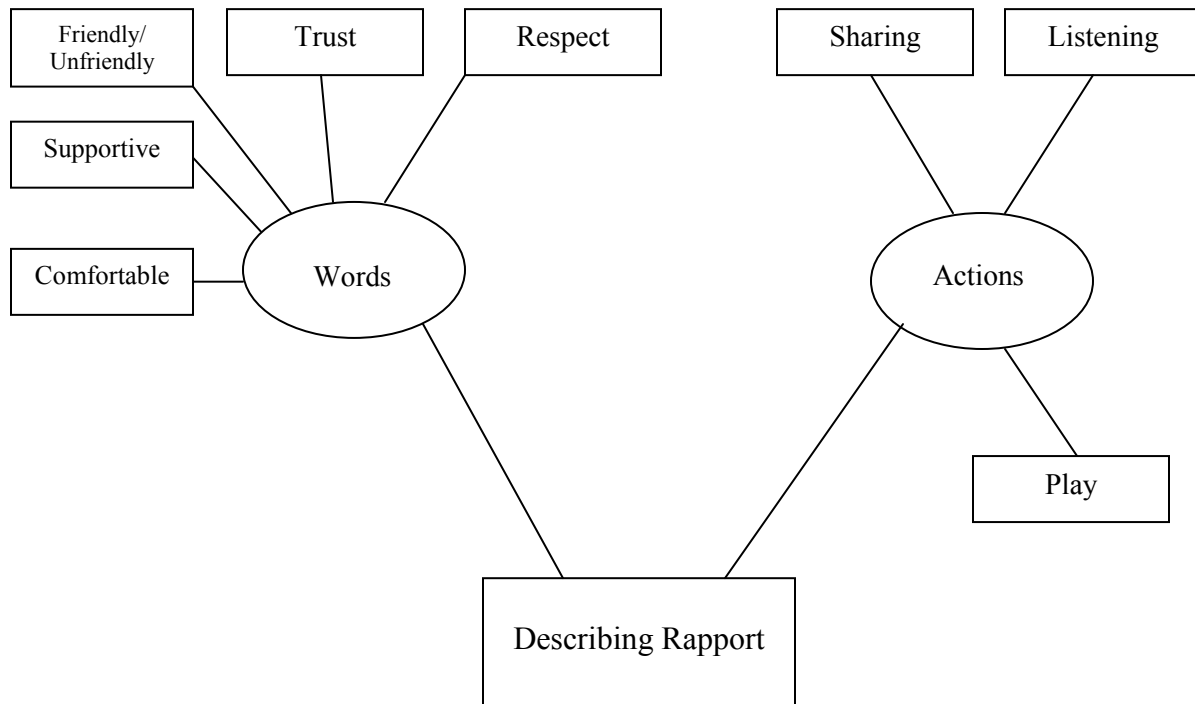
Actions. Several behaviors were described by child life specialists when explaining what the concept of rapport meant. A common behavior identified in the interviews was the ability and willingness to share information between child life specialists and children. Particularly for the teenage population, one child life specialist explained that when an adolescent is able to “openly discuss what is happening with them... their concerns, their needs” then rapport is present. With the adolescent population, the idea of sharing information included talking about their concerns

regarding medical procedures as well as sharing information about their social lives. One experience included having an adolescent discuss why they chose to tell only particular friends about their health care process.

Child life specialists also indicated the ability to listen as a component of the concept of rapport. One child life specialist shared her perception of the concept of rapport when stating:

I would say the concept of rapport and rapport building is allowing me, the person that does not know the other person, to have the opportunity to listen and get to know someone else.

The third action that child life specialists associated with rapport was playing. The same child life specialist who spoke of interacting with an adolescent during open conversation described rapport between child life specialists and younger children to include play based activities such as “parallel play.” By participating in play based activities, child life specialists established themselves as a “nonthreatening” and “fun play person” to the child. Play also provided a time to restore some “normalcy back into their life.”

Figure 3. Describing Rapport**Initiating Rapport**

The third global theme that emerged from the interviews was the ways in which child life specialists initiated rapport development during introductions with a child. The organizing themes that helped develop the third global theme are: physical behaviors, materials, conversational content and overall approach (see Figure 4: Initiating Rapport).

Physical Behaviors. The interviews began by asking child life specialists to recall an initial interaction that they had with a child or adolescent who was new to them. Details of the introductions emphasized the child, the situation and the ways in which the child life specialists approached the child and introduced themselves. All of the child life specialists mentioned at least one of the following three aspects when describing their initial introductions with a child; i)

positioning within the child's eye level, ii) kneeling down beside the child's bed or chair and iii) coming in close proximity of the child.

Common words used to illustrate how child life specialists positioned themselves in relation to a child (usually referenced to be lying in a hospital bed) included "kneeling," "squatted," "crouch down," and "bend down." The intention of getting down on the child's level was referred as a way to align their eyesight with the child. Introductions initiated by all child life specialists interviewed closely resembled the experience of one child life specialist who described an interaction she had with a young boy who was at the hospital because of a laceration on his knee:

I typically come in and take kind of a kneeling stance or I put my knees on the ground so I am right there at their level. I feel that it is kind of intimidating all the people that come in...but I usually try and come in close proximity to kneel down. Another child life specialist described how she approached both young children as well as adolescents:

I will come closer to the bed but I usually am not standing and hovering, I am usually kneeling so that they are either looking down... or that we are looking eye to eye at each other and then with teens I will either come in and stand at the end of the bed or at the corner of the bed and then as we start to talk more... I will pull up a chair.

Often before child life specialists came within close proximity of a child or adolescent they asked permission to come into their "personal space." This was illustrated as two child life specialists mentioned the ritual of "knocking" on the child's room door or "stand" at the door to introduce themselves before entering the room. When asked the significance of knocking, the

idea of “asking permission” and “giving warning” were both mentioned. Respect towards a child’s personal space was talked about in detail by one child life specialist when asked the significance of pausing at the doorway before entering:

If I have not met them before, um just giving them a little bit of space, everyone has personal space so know that coming into their room, that is their safe space and that is their personal space. So coming into the room um I want to make sure that if I am not accepted that I am not really stepping into their space. I am giving them that time to feel comfortable with me and if they do not feel comfortable with me and they don’t want me to be there then I have not totally infringed on their comfort zone.

By asking permission the goal was to let the child “be in control of the situation... because a lot of the stuff that they are going to have done they won’t have a lot of control over.”

Acknowledging the child’s personal space and asking permission was also discussed in another interview:

I can ask appropriate questions that might allow them to soften up the walls that they have and if they chose not to soften up the walls and I acknowledge that I always... tell the kids and tell the teenagers, you know at any point when I come into your room you are more than welcome to kick me out. My feelings will not be hurt I am totally fine with that. I would say 90% of the time I get a smile from that comment.

Materials. When describing a first time interaction child life specialists had with a child or adolescent, about half of the participants reported that they carry materials in the room with them. Some general materials that were brought into introductions included brochures or

pamphlets that described the role child life programs have in supporting children and families. Providing brochures or pamphlets was mentioned by four child life specialists.

Toys or books were also mentioned as common objects that child life specialists use during introductions with children. In the majority of these situations the child life specialists used the objects for preparation purposes. For instance, one child life specialist used a cloth doll and a photo book to prepare a child for a kidney transplant. Another child life specialist carried a “distraction bag” with her when an initial introduction also involved preparation for a medical procedure. This bag was described to hold a range of age appropriate objects that could be adapted to the specific needs of the child and procedure. Only one child life specialist reported bringing an iPad for the child to use during initial introductions; the iPad can be modified to match the child’s developmental needs as well was used during procedural preparation. After getting a report from a nurse that a child may be highly anxious, one child life specialist reported bringing in a “normal play item” so that the familiar object would be associated with the child life specialist and establish her as a “nonthreatening presence right away.”

Several participants who expressed not carrying materials into their initial introductions provided reasons for not doing so. Two child life specialists expressed that this was done in an effort to not “assume” what the child would want to be occupied with. “I always ask before bring in any of the supplies” one child life specialist reported out of fear of offending a child with a “stereotype” game or activity. Another child life specialist suggested that when they bring in an item the child will get “stuck on that object” and it makes it harder to capture their attention and prepare them for the medical procedure they are about to experience. Personal items worn on an ID badge that had small games and stickers was also used instead of external objects. Finally,

simply having a “smile on my face and a listening ear” was the approach that another child life specialist took when limiting the use of material during initial introductions.

Conversational content. All twelve child life specialists interviewed reported including their name and professional role when introducing themselves to children and families. Aspects of the following introduction can be seen in all twelve versions shared by child life specialists:

My name is (name) I am one of the child life specialists here. Part of my job is to help you to be more comfortable while you are here in the hospital and also to help you to understand how the doctors are going to help you today while you are here.

Following introduction of one’s name and professional responsibilities, the majority of child life specialists reported asking children questions as “ice breakers.” Asking a child questions was mentioned as an avenue to “easily” build rapport. When speaking about a strategy to build rapport with a child, one participant stated:

Ask them about themselves. Find out what they are like. Obviously you don’t want to force them to share information but encourage them to talk about things they know. Kids love to talk about themselves and love to tell you about things they like. They don’t like for you to assume that they like something.

Most likely the questions pertained to something the child had in the room with them, what they were wearing or their personal lives at home. For instance, one participant shared that “a great conversation starter is do you have a pet?” Asking about the child’s favorite activities outside of the hospital was also common. One child life specialist expressed gearing questions towards the child’s favorite inside activities. This child life specialist was trying to “link” the conversation to activities the child could take advantage of while at the hospital.

Overall approach. A desire to establish oneself as a “nonthreatening” person was also identified in the majority of child life specialist’s introduction with children. One of the most common ways to establish oneself as nonthreatening was to identify as a “fun” person and “unique” member of the medical team. A reoccurring method to establish oneself as unique was to ensure the child that the child life specialist would not be doing any medical examination or procedure on the child. One participant spoke of the stress that children face when encountering numerous unidentified adults upon entering a hospital:

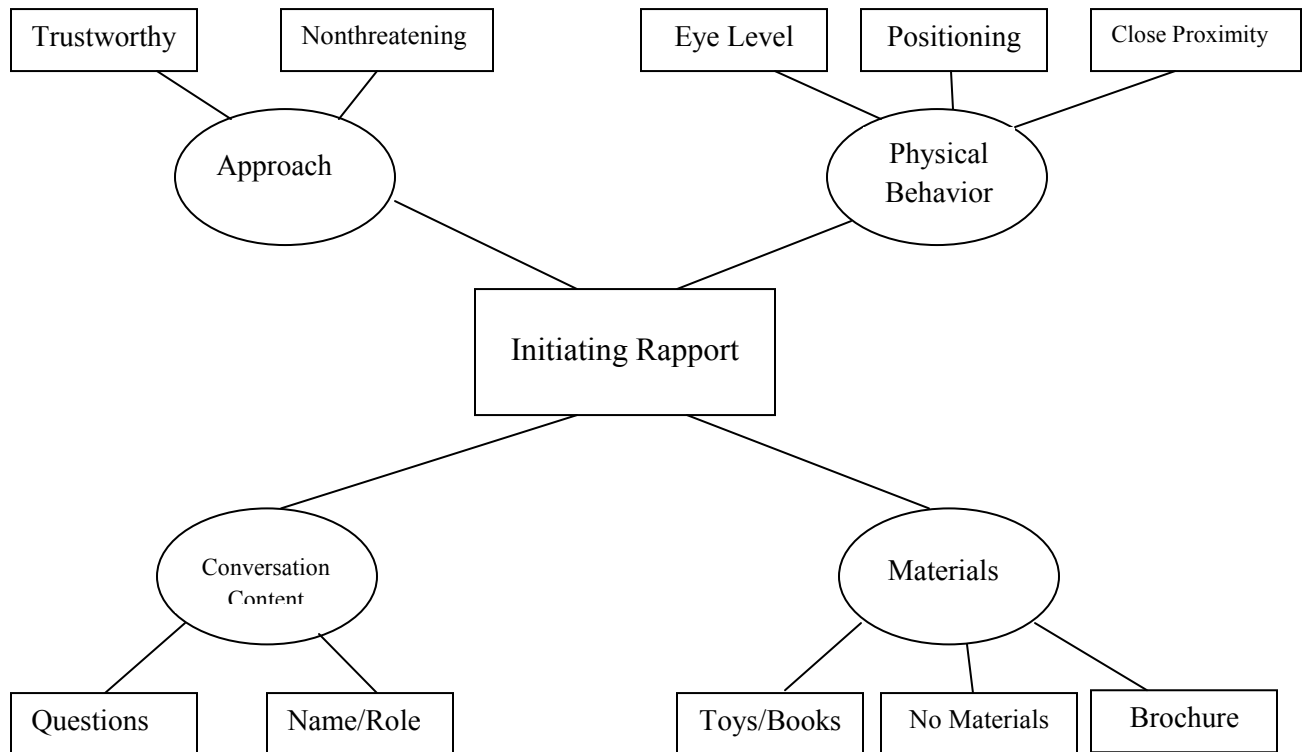
When they come here, unfortunately, as you know, in the hospital environment, you meet so many people within even the first ten minutes of being in this environment. So here I am coming in as another person so I am quick to say, *you know my hands are not going to touch you.*

Another participant acknowledged approaching a child’s fear about medical staff inflicting pain when telling the child that she was “*someone that did not give, you know a fun play person, I do not do any owies, not going to do anything to her.*”

When there may be a language or cultural barrier, identifying the child life role separately from doctors or nurses responsibilities was also mentioned:

Reassure them that I am not a nurse or doctor...especially for a Spanish speaking family to explain that I am more like a teacher that I am not going to do anything. You know, to develop kind of a safe environment.

Several child life specialists also expressed working to “establish myself as a person that is going to be a consistent part of their journey.”

Figure 4: Initiating Rapport**Maintaining Rapport**

The fourth global theme that emerged from the interviews was the ways child life specialists maintained rapport with children beyond initial introductions. The organizing themes that developed the fourth global theme are: check-ins and materials. Obstacles encountered by child life specialists when working to maintain rapport were also identified (see Figure 5: Maintaining Rapport).

Check-ins. When asked if child life specialists have subsequent interactions with the children they previously introduced themselves to, many had more than one interaction with the same child. After a procedure one child life specialist reported “following through” with the child by offering him a drink or snack.

When children or families did not show any interest in engaging with the child life specialist initially, many reported “going back” and reoffering to leave activities in the child’s room or take them down to the play center. One participant also indicated that she would send a child life volunteer in to check on a family that had previously denied an interaction with the child life specialist the day before. This was done in an effort to provide another opportunity for the child to receive activities in case the denial of support the first day was in reaction to the child life specialist’s personal approach.

Sometimes subsequent interactions are done to provide the child with honest information about their medical stay. One child life specialist recalled having to go back into a child’s room and let her know that she would be staying in the hospital under isolation measures for a longer period of time than the child had expected. Although the child became upset with the extended hospital stay, the child life specialist expressed that they “were able to establish a relationship and she was able to, to trust me because I was honest.”

Materials. Many child life specialists spoke of subsequent interactions with the goal to “gear the session around” things the child mentioned as an interest of theirs. For instance, one child life specialists spoke about talking with and encouraging a young girl to write songs and develop her skills playing a new guitar she got. Child life specialists also reported asking children questions like “what is your favorite board game” or “what is your favorite color?” The answers to such questions would determine the type of activity they would bring back for the child. Providing toys or activities which interested the child was used as “the bridge that connects you with them.”

Obstacles. When trying to maintain a level of rapport with children a few accounts of obstacles were mentioned. Family resisting child life services was the most notable obstacle faced by child life specialists. In regards to this subject, one child life specialist reported:

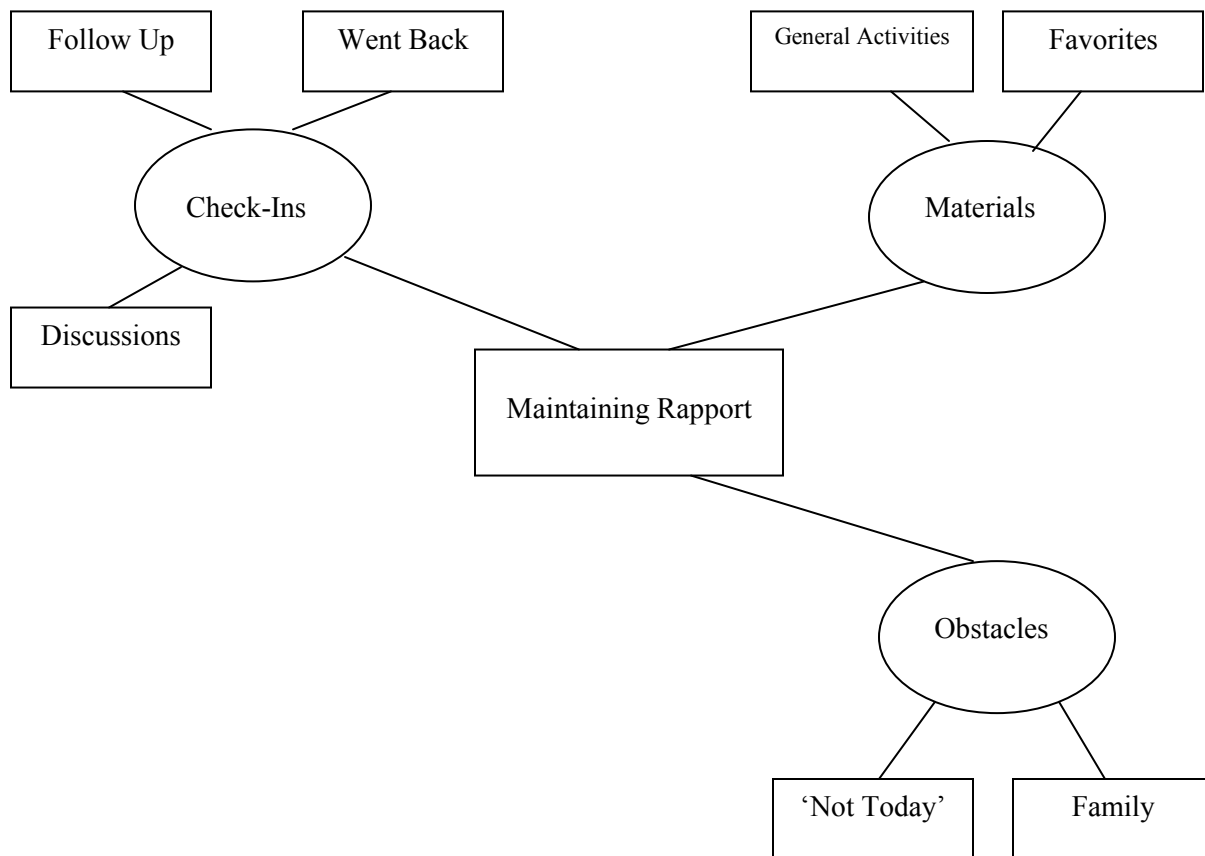
I have had experiences where the parents are really resistant to child life services and then the child is just referencing to the parents and they just... they don't want to develop a rapport with me because they are getting cues from their parents that they shouldn't.

Several child life specialists also spoke of instances when children expressed a desire to not participate in any child life activities at least one day during their medical experience. Sensitivity to a child and family's right to refuse to cooperate was spoken about by one child life specialist:

I am really very aware, I think that in the hospital children and families are made to feel like they need to be really cooperative and really positive and they... essentially perform for every person that comes in and that is not a realistic expectation.

The same child life specialist went on to speak about how when a child sets boundaries within their relationship; this is a good indicator that rapport has been established:

She trusts me enough to know I am going to be part of her journey here, regardless of her...not wanting to do something together that day is not going to negatively affect our relationship. And I think that, that is an indicator of rapport that is being built with that patient. When they are comfortable enough in saying 'I am not feeling well (name) please come back' I think that is a good sign. I don't take that as a negative at all, I think it is a good sign.

Figure 5: Maintaining Rapport

Indicators of Rapport

The fifth theme to be identified from the interviews was indicators that rapport had been established between the child and the child life specialist. The three organizing themes which developed the global theme are: nonverbal expressions, verbal expressions and relationships quality (see Figure 6: Indicators of Rapport).

Nonverbal expressions: Child life specialists focused particularly on body language and facial expressions as indicators that rapport had been established with a child. The most common indicators were having the child smile, having the child sitting up in their bed, holding eye contact with the child, having the child nod their head, shrug their shoulders and shake their head

during conversation. One child life specialist reported children wanting to be in close proximity to them as a good indicator that rapport was established; “they try and get closer to me either by scooting in the bed...open their arms to me.”

Verbal expressions. When interacting with children, there were several verbal expressions that child life specialists perceived as indicators rapport had been established. The first was that conversations and activities would be “child directed.” In these cases the child was talkative, led the conversation and asked questions.

Several child life specialists also indicated that children who have rapport with them will either seek out the child life specialist by asking for them or have their parents inquire about the whereabouts of the child life specialist. One child life specialist suggested that a child “continued to ask about me on a daily basis and would light up pretty much every time I would walk into the room.” While another indicated “they ask the nurses when you are coming by and they get their parents to come to the child life office and see if you are around.”

Relationship quality. The most common words used to describe a situation when rapport has been established were engaging, enjoyable and open. When asked to speak of ways one could tell rapport is established one child life specialist responded:

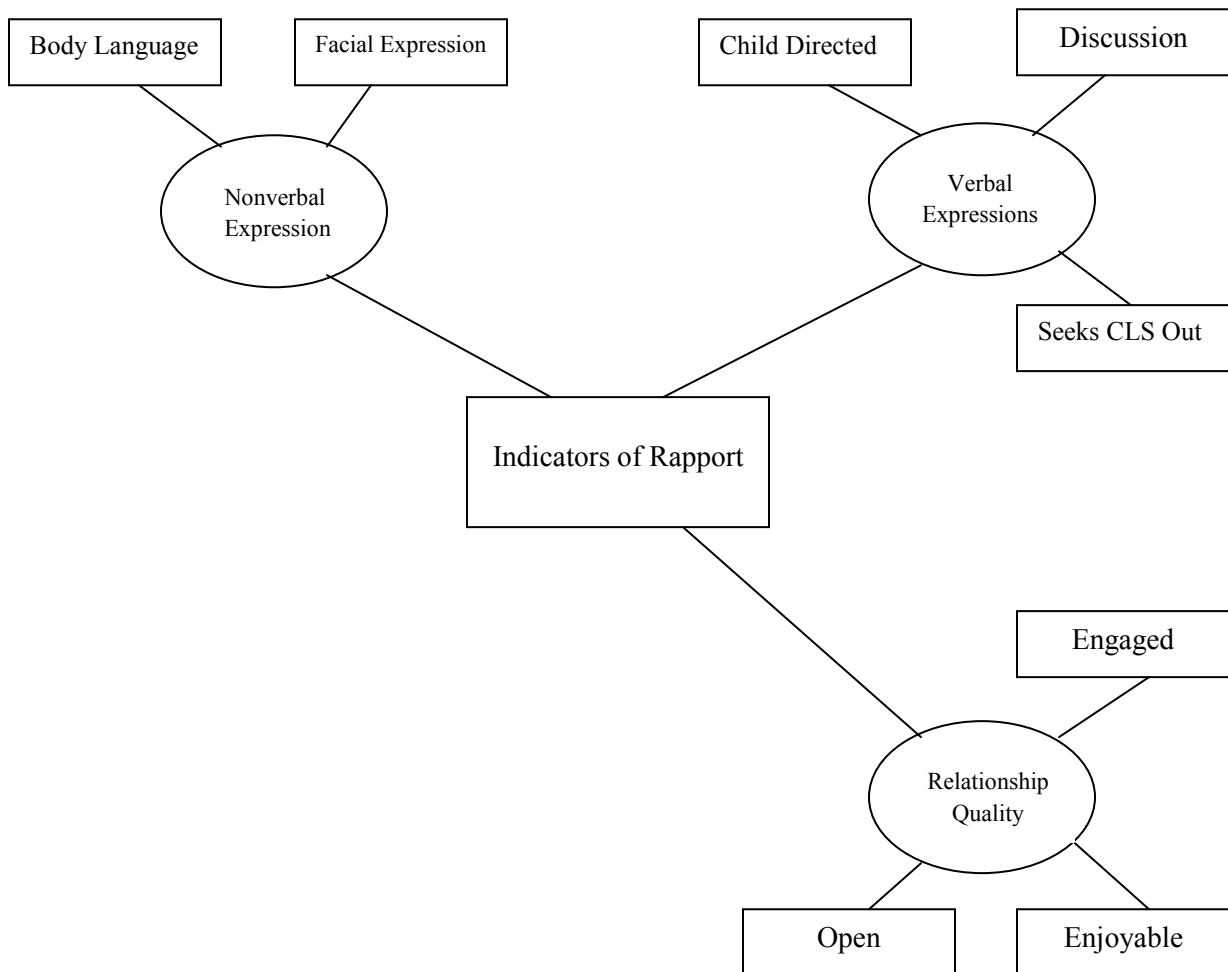
They are really engaged with you and with activities, you can tell they are engaging because they are enjoying themselves and they are smiling and not wanting to stop the activity.

Another child life specialist described similar indicators when also discussing the time it takes to build rapport:

There are some kids that are very, very easy to form rapport with. Some that are a little bit, take a little bit more time. I would say one of the biggest things for me

is, when I feel like a patient is able to kind of openly express whether it is through play or through...speaking or writing..., kind of what they are going through, what they are feeling and also...having them actually invite you in to do things as opposed to turning you away and not wanted to do anything. And, again I think you can take um sometimes it takes a day sometimes it takes a couple of weeks to get different patients and families to build rapport with.

Figure 6: Indicators of Rapport



Rapport is Essential

The final global theme that emerged from the interviews was the idea that rapport is essential for the provision of effective care. The organizing themes that constructed the sixth global theme are: favorable impression, cooperation and team approach (see Figure 7: Rapport is Essential).

Favorable impression. Child life specialists spoke of trying to “get it right the first time” when interacting with children and families and developing rapport. In environments such as outpatient clinics where procedural preparation is time sensitive, child life specialists found it important to build rapport quickly and most often this meant having a good first impression with the child and family. Specifically one child life specialist spoke about creating a favorable impression with the family as a way to build rapport with the child:

I feel like you always want to get it right the first time and you automatically want the family to uh I guess be welcoming to you as well and feel comfortable with you so that they can um I guess so you can kind of work better with the with the patient and family and kind of uh they can kind of gain your trust.

Cooperation. In regards to engaging children in procedural preparation and educational play based activities, child life specialists spoke of this process being “easier” after rapport had been established. For instance, one child life specialist stated that “once we have the trust it is easier to go back in and provide that education.” Another child life specialist added that a feeling of trust is important for a child to continue in preparation activities with you:

Because of the interaction that we had initially, the rapport we had built just a few minutes before this, there was an element of trust there that don't think otherwise would have been there.

If a level of trust is established child life specialists reported being able to communicate information effectively. For example, one child life specialist spoke about how she would offer different preparation activities to a child. While exploring the different activities however, the child life specialist was able to communicate to the child that preparation probably might not “make it any easier but it might smooth...out some of the things that you might be feeling or going through.”

Interactions where children responded positively during preparation were also reported if the child life specialist remembered to include a favorite thing of the child. When discussing a young girl having a procedure in a tub, one child life specialist revealed that:

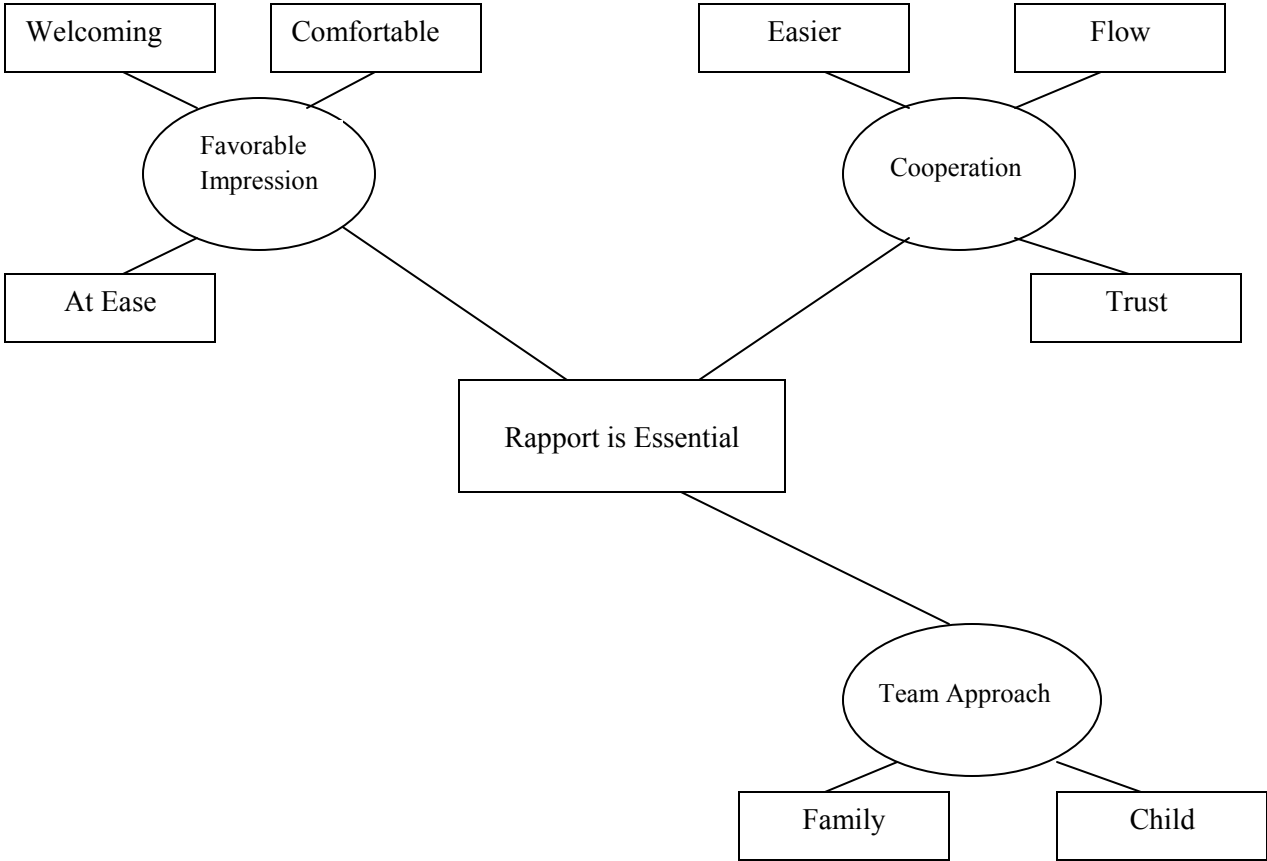
She was able to communicate with me about how she was feeling and I think because I had taken the time to get to know her, what she liked, that when I took out the mermaid to have in the tub she smiled the biggest smile I have ever seen and said ‘I love mermaids, how did you know?’ so we played with the mermaid and she coped positively throughout the dressing change and long term she continued to ask about me on a daily basis.

Team approach. Approximately one third of the child life specialists interviewed identified themselves to be in professional roles that required them to teach, train or supervise novices learning to work with children and families. When speaking about training interns, one child life specialist touched on the importance of involving the child’s parents and ultimately empowering them as critical care agents for their child “in my training I actually have that line written in that I really want to encourage them to say ‘*you know your child best*’.” As mentioned, when asked about obstacles experienced when trying to maintain rapport, the topic of family reluctance was identified. Children were said to get “cues” from their parents as to whether the

child life specialist was someone the guardians wished to communicate with or not. Children were suggested to emulate the guardian's reactions and behaviors towards the child life specialist. The importance of gaining rapport with the child's family was mentioned to be the "gateway" into building a relationship with the child.

When asked about whether child life specialists have participated in any professional development activities focused on rapport, the majority referenced workshops designed to enhance the relationships between coworkers rather than activities which focused on rapport development between child life specialists and children. Interviews suggested that it was important to have a strong team atmosphere, especially because child life specialists are just one of the many professionals working within pediatrics to care for the patient and family. When talking about working in a collaborative environment, one child life specialist spoke about building a sense of team atmosphere and how this can benefit the child when stating "I think if teams can cultivate a sense of safety..., that can only enrich their personal ability to positively influence and effectively support their relationships with patients and family."

Figure 7: Rapport is Essential



Chapter 5

Discussion

This study used the qualitative method of phenomenography to analyze the data obtained from interviews of twelve certified child life specialists. Phenomenography is used by researchers when investigating the experience of others to gain full descriptions of people's perceptions of a particular phenomenon (Attride-Stirling, 2001; Boulton-Lewis et al., 2008; Marton & Pong, 2005). The phenomenon of rapport was the focus of the current study. The purpose of this study was to explore the concept of rapport within the context of child life and a) gain an understanding of the concept of rapport, b) identify ways in which rapport is established and maintained, and c) determine the purpose and outcomes of establishing rapport between child life specialists and children.

Understanding the Meaning of the Concept of Rapport

Child life specialists revealed their understanding of the concept of rapport as they discussed their work with children and families in hospital. From the perspective of this group of child life specialists, the concept of rapport means having formed a relationship with a child that is trustful, respectful, supportive and comfortable. The relationship is the foundation that facilitates opportunities for sharing, listening and participating in play based activities. The basic themes that constructed the understanding of the meaning of rapport, from the child life specialist's perspective, draw similarities to the components of rapport described by Tickle-Degnen and Rosenthal (1990).

Tickle-Degnen and Rosenthal (1990) propose three components of rapport to include mutual attentiveness, positivity and coordination. Mutual attentiveness describes two individual's focusing their primary attention towards one another's verbal and physical expressions (Tickle-Degnen & Rosenthal, 1990). Although the term mutual attentiveness was not

used by the child life specialists, the interactions with children and the relationships they described are consistent with the definition. One example of mutual attentiveness includes the description of the child life specialist supporting a child during a medical procedure; one little girl responded positively because a child life specialist had thought to bring the child's favorite toy to the procedure (mermaid doll). The doll became the focus from which mutual attentiveness could be achieved.

The component of positivity was also indicated within the interviews with child life specialists. Child life specialists acknowledged the presence of a positive attitude when interacting with children. Positivity is described to occur in situations where mutual care and friendliness are expressed by both people in the relationship (Tickle-Degnen & Rosenthal, 1990). Respondents described situations where there were high levels of friendliness or low levels of friendliness. This is consistent with Tickle-Degnen and Rosenthal's (1990) description of positivity; it varies in degree of intensity. The child life specialists attributed situations of low positivity to parents giving the child signals to avoid interaction or when the child was not feeling well enough to engage. Similarly, positivity was illustrated when the respondents talked about using humor, for example. These details extend Tickle-Degnen and Rosenthal's (1990) description of positivity by placing it in the context of interactions in the hospital.

The coordination of the interactions between a child life specialist and a child were illustrated particularly when the respondents talked about preparation for procedures. Because play based interactions were facilitated, props such as distraction toys and medical dolls allowed for a combination of talking, listening and doing. For example, a child life specialist may bring a medical doll and explore the process of getting a plaster cast with the child. During this time, a back and forth of questions and answers occurs between the adult and child. Because child life

specialists are able to describe scenarios where rapport is apparent an extension of Tickle-Degnen and Rosenthal's (1990) definition can be applied to the context of child life.

The components of rapport described by Tickle-Degnen and Rosenthal (1990) are illustrated in the basic themes that constructed the understanding of the meaning of rapport, from the child life specialist's perspective. Because the child life specialists were able to provide illustrations of their early interactions with children and families this concept of rapport has been enhanced. The complex environment of health care settings and the relationships that are developed within that context add a dimension to Tickle-Degnen and Rosenthal's (1990) description of the concept of rapport. Mutual attentiveness, positivity and coordination can be observed within the examples provided by the respondents. The integration of the two areas strengthens the understanding of rapport as it is conceptualized by child life specialists.

Ways to Establish and Maintain Rapport

Investigating how child life specialists initiate rapport with children involved discussion around introductions facilitated by child life specialists with children. Portraying themselves as a nonthreatening person was the main focus of child life specialists when introducing themselves to children. The most common method of portraying oneself as nonthreatening was by positioning themselves in close proximity and at eye level with the child. Depending on the comfort level of the child, child life specialists would kneel down at the side of the bed, sit on a chair beside the bed or on a couch with the child during introductions. By respecting the child's comfort level, child life specialists attend to the psychosocial needs of the child including psychological confidence and social relationships rather than focusing solely on medical aspects of care (McCue, 2009). Portrayals on how to initiate rapport support the discussion presented by

McCue (2009) that all psychosocial aspects of the child are supported during child life interactions.

The focus of the interview questions was placed on relations with children. During medical events, child life specialists described the tendency for all the focus to be directed towards the child. However, many child life specialists reported connecting with both the child and family as an effective strategy to gain rapport when entering the child's personal space for the first time. When initiating a relationship with children, a few child life specialists referred to a strategy of talking to guardians first before interacting with the child. By asking the parents to discuss the child's needs as well as the family's concerns, child life specialists in this study respected guardians as primary caregivers.

During introductions with children, it is common practice for child life specialists to offer a variety of materials used to facilitate the interaction with the child and family. Child life specialists in this study often referred to using toys or books when introducing themselves to a child or supplying informational brochures or pamphlets. This discussion of offering materials is consistent with the previous literature (Gaynard et al., 1990; Turner & Fralic, 2009). However, in this study a few of the respondents suggested they are cautious about using play materials when meeting a child and family for the first time. One respondent mentioned not wanting to offend children by bring stereotypical toys. Another respondent explained how bringing a toy to an initial visit may result in decreased opportunity for the child life specialist to gain the child's attention. The exploration of multiple perspectives around the use of toys and materials to facilitate relationship building provides additional information around the ways child life specialists establish and maintain rapport.

Child life specialists discussed ways of maintaining rapport during subsequent interactions with a child. Several child life specialists spoke about follow-up interactions that included a continuing development of the relationship, focused play based interactions and educational interventions such as preparation for medical events. Building on the initial rapport was facilitated when child life specialists used details gleaned from the initial interaction in subsequent interactions. The example of the child's reaction to the mermaid doll during her bath illustrates how mutual attention, positivity and coordination are maintained. Although the bath had the potential to be a negative experience for the child, the presence of a familiar person, a favorite toy and communication around the purpose and experience of the bath demonstrate efforts to maintain the rapport. The examples provided by child life specialists during the interview contribute to our understanding of rapport within the complexity of a hospital setting.

The descriptions that child life specialists gave about their interactions and interventions with children reflect the application of developmentally appropriate practice. For example, a book describing how a young child copes with a medical experience can be adapted for use with an older child. Because child life specialists have developed competencies around child development, communication and family centered practices they are skilled in modifying information to meet the needs of individuals (Gaynard et al., 1990). The child life specialist who actively gathered details about the child's likes and dislikes at the first meeting rather than risk offending the child by bringing a stereotypical toy is demonstrating competence in the area of developmentally appropriate practice. The child life specialists in this study did not apply the specific term developmentally appropriate practice (National Association for the Education of Young Children, 2011) although they certainly did demonstrate a parallel practice. It is unknown whether the participants are familiar with this concept from the early childhood education

literature. Therefore, this study may draw attention to aspects of practice that can be further enhanced through exploration of related disciplines such as early childhood education.

Child life specialists also maintain rapport with children by offering choice and by checking-in on them. The practice of offering choice is consistent with the findings of Turner and Fralic (2009) and Gaynard et al. (1990). Child life specialists in this study reported asking permission from the child before entering the room and sitting down. Although the term ‘coming and going’ was used in Turner and Fralic’s (2009) findings, the theme of checking-in resembles the same practice. Child life specialists would check-in on a child as follow-up to maintain rapport and support the provision of services. One aspect related to both follow-up and the presentation of choice is the notion that once rapport has been established a child may feel comfortable in saying no to a visit or intervention by a child life specialist. One child life specialist emphasized her belief that once children are able to communicate their own boundaries (for example being able to say yes or no), then rapport has been established. According to Gaynard et al. (1990), rapport is also facilitated when the child life specialist consistently respects the wishes of the child.

Child life specialists attend to the psychosocial needs of the child including psychological confidence and social relationships rather than focusing solely on medical aspects of care (McCue, 2009). Efforts to establish and maintain rapport with children and families include a number of components. First, the respondents presented themselves as nonthreatening visitors. Second, they used a variety of materials, both play and educational, in order to coordinate their interactions with the child. Third, child life specialists engaged in a variety of follow-up activities specifically to meet the needs of individuals. Four, developmentally appropriate practice was evident as a means through which relationships were developed and maintained.

Finally, the combination of presenting choices and checking-in with children provided opportunities for child life specialists to gauge whether or not rapport was established or under development.

Purpose and Outcomes Following the Establishment of Rapport

The main purpose for the development of rapport with children and families is to initiate relationships that can be carried forward as the child and family experience health care. Child life specialists described rapport to be essential in providing effective care for children experiencing the health care setting. Martin et al. (2000) reported that the establishment of therapeutic alliance is linked to positive therapeutic change. Again, although the language differs, child life specialists did indicate the value of established rapport with children and families. Child life specialists expressed that encouraging participation in play activities and effective preparation for medical events was more easily achieved after rapport had been established with a child. Child life specialists assert that rapport is an essential foundation to the provision of quality care.

Although not a primary focus of this study, some child life specialists spoke about how the possibility to form a relationship with a child is negatively impacted when rapport between the child life specialist and the child's guardians has not been established. Children were suggested to gain cues from their guardians. If the child sensed hesitation towards the child life specialists by the guardian, they too would avoid contact with the child life specialist. Within social services, when guardians and social workers have a good relationship, benefits for the child include reduced amounts of time spent in foster care (Cantos et al., 1997). Although the respondents in this study focused their attention on building rapport with the child, it appears that greater attention to the establishment of rapport with guardians is also important.

Summary

The perspectives of the child life specialists interviewed for this study have contributed to the discussion of the meaning of the concept of rapport, ways of establishing and maintaining rapport and the purpose and outcomes of rapport development. The concept of rapport was described to mean having formed a relationship with a child that is trustful, respectful, supportive and comfortable. Rapport was commonly initiated by child life specialists during introductions by portraying a nonthreatening presence and using materials to inform children and guardians about the role that child life specialists have in supporting children and families through medical experiences. Maintenance of rapport is achieved by incorporating materials, offering choices and checking in on the child to inquire about their needs. Child life specialists in this study suggest the establishment of rapport to be essential in providing effective care for children who are experiencing a medical event.

This research study has initiated the discussion on rapport within the child life context by gathering the experiences and perceptions of twelve certified child life specialists working throughout Canada and the United States. Efforts to better understand the topic of rapport can lead to students and experienced child life specialists to identify techniques often successful in developing rapport with a child. For example, exploring research and scholarship from allied fields can both reinforce and strengthen child life specialist's ability to articulate their practice. Through reflection and dialogue around the concept and practice of rapport building, child life specialists can share their knowledge and skills with colleagues, students and allied professions.

Implications

One of the main responsibilities of child life specialists is the development of supportive relationships in order to support children's psychosocial needs. In order to provide both developmentally and individually appropriate interventions, child life specialists develop expertise around building relationships with children and families. Previous research has indicated that building rapport is an important first step in establishing relationships and performing assessments (Gaynard et al., 1990; Turner & Fralic, 2009). The current study contributes to the existing body of literature by extending our perspective on the concept of rapport, our understanding of ways that rapport is established and maintained and the purpose and outcomes following the establishment of rapport. Students, clinicians and educators can benefit from this new knowledge.

Students entering the field of child life come from diverse backgrounds and experiences. Although they may have skills and knowledge related to working with children in a range of settings, health care settings are complex environments. A number of the respondents could not recall course content where the topic of rapport was addressed directly. Similar to the findings of Turner and Fralic (2009), both the concept of rapport and the process of building rapport exist in the realm of implicit knowledge. Through documenting the responses of child life specialists a practical resource can be developed for students as they move into entry level positions. Recognition that rapport is a skill to be developed should be introduced to students in order to promote reflection and discussion of approaches to relationship building as they develop their professional practice in the field.

Child life specialists working in health care settings acknowledge the need to approach each child and family with the understanding that relationships take time to build. Many could

not think of times when they were specifically trained to build relationships, rather they developed their skills as they encountered each child and family under the guidance of their internships supervisor. The participants in this study were interested and enthusiastic about sharing the ways they approach children and their efforts to establish rapport. The current study's results represent the first attempt at compiling details on the physical behaviors, overall approach, conversational content and materials used during introductions. Additionally, details on follow-up contact, the use of play and educational materials as ways to maintain relationships were included. Of interest to clinicians responsible for volunteers, students and novices, is the discussion around obstacles that challenge a child life specialists ability to establish and or maintain rapport with children and families. This initial documentation of the rapport process may be used by clinicians during department meetings, inservices and professional development workshops as a foundation from which colleagues can explore and examine approaches and procedures.

The importance of internships as a context for learning is apparent when the child life specialists discussed their foundations. The content of this study may inspire educators to review their program, including curriculum, resources and opportunities for experiential learning. The inclusion of content related to the concept of rapport, ways to initiate and maintain rapport and the purpose and outcomes following the establishment of rapport can benefit students. The link between academic study and internship opportunities should be made explicit as both contribute to the ability of individuals as they develop as professionals. The respondents agreed that the establishment of rapport is essential in order to provide effect care for children. The researchers findings help open the discussion on how rapport is established and maintained as well as the role of rapport during medical events. Findings may be informative for entry-level as well as

seasoned professionals working in child life while also being helpful for program development and expansion for those in teaching, supervisory and administrative roles.

Limitations

There are three specific limitations for this initial exploration of the development of rapport with children and families in hospital settings. As this was the first experience with qualitative research, the researcher acknowledges areas for which improvement could be made in future studies. First, the interviews were limited due to the inexperience of the researcher in using cues, probes and follow-up questions to extend the discussion. Second, the researcher now recognizes that both the minimal diversity and the overall general focus of the respondents are limitations. In the future, attempts to recruit both men and women at various stages of professional development may extend the perspectives documented in the literature. Additionally, studies that target people working in specific settings, for example emergency room, outpatient or chronic care wards, may contribute further as the establishment and maintenance of rapport may vary in different settings. Finally, hindsight offers insight into missed opportunities to ask questions that may have allowed respondents to reflect on a broader range of experiences. For example, respondents tended to focus on either a recent event or an event that had a powerful impact on them. Attempts to access day to day interactions and practices in future studies could further extend the literature.

Future Research

This study discussed the experiences and perceptions of the twelve child life specialists interviewed. The child life specialists were open and enthusiastic when discussing the concept of rapport. Exploration of the experience of a more diverse sample of child life specialists could lead to the development of a body of research specifically on child life and rapport. A more

diverse sample could include both men and women, individuals from outside North America as well as child life specialists working in alternative settings. Face to face interviews and opportunities for observational studies would allow the researcher the opportunity to examine mutual attentiveness, positivity and coordination in more depth. The ability to observe a child life specialist as they approach and interact with a child and family for the first time could provide important details that are missed when respondents attempt to access procedural knowledge.

Including a review of academic and internship curriculum and practices could provide rich opportunities to detail how students are trained and develop into child life specialists. A number of unanswered questions remain. Potential areas to explore include the background and training of educators in the field, the interview and selection process for potential child life interns as well as the interview and selection process of new employees. Future research could provide opportunities not only to build a body of literature but also to develop practical teaching and resource materials (role plays, scripts, videos, or interactive media). As the concept of rapport has yet to be explored in detail the potential for future research opportunities at the undergraduate, graduate, professional and academic level are wide open.

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Appendix A

Invitation Email

Dear Potential Participant,

You have been contacted as one of several certified child life specialists invited to participate in a research study exploring the relationships that child life specialists establish with children and families. Your name was located on the Child Life Council on-line directory and randomly selected as a possible respondent for the research study, The Development of Rapport with Children and Families Experiencing Hospitalization.

At this time I invite you to review the following information to learn more about the purpose and procedure of participating in the study.

What is the research study process?

I am contacting Certified Child Life Specialists across Canada and the United States and asking them to participate in an interview with questions about their experience as a child life specialist developing and maintaining rapport with children and families experiencing hospitalization.

Who is conducting the research study?

I am a graduate student in the Master of Arts- Child & Youth Study program at Mount Saint Vincent University in Halifax, Nova Scotia, Canada. As a graduate student, I am supervised by Dr. Joan Turner, CCLS, Associate Professor in the Department of Child and Youth Study at Mount Saint Vincent University.

What is the focus of the research study?

I am interested in exploring the following themes related to child life specialists' practice with children:

- The meaning of the concept of rapport from a child life perspective
- Ways in which rapport is established and maintained by child life specialists
- The purpose and outcomes following the establishment of rapport between child life specialists and children

Who can be involved in this research study?

For the purpose of this research study, I am narrowing the selection criteria to participants who meet the following requirements. Only those who meet the criteria will be asked to continue in participating in the study. Future research studies may focus on additional populations of individuals working in the field of Child Life.

- Certified Child Life Specialist (CCLS)
- CCLS working in Canada or the United States of America

Individuals who are not certified or work outside Canada and the United States of America will be excluded from this study.

Benefits and Risks of Participating in the Research Study

You may enjoy having an opportunity to share your experience and expertise during the interview process as well as contribute to the emerging child life literature.

If you are interested in joining the study please complete the following steps:

1. Review the attached informed consent form.
2. If you understand and agree to the research study process, please sign the informed consent form in one of two ways:
 - i) Insert an electronic signature and return the form to me by email at lacey.roberon@msvu.ca
 - ii) Sign it and Fax it Attention: Dr. Joan Turner, Child & Youth Study FAX # [REDACTED].

Following receipt of the signed consent form, I will contact you to schedule a convenient telephone interview and share the interview questions for you to review.

In the event you have further questions or concerns about the research study, please email Lacey Robertson at [REDACTED] or my thesis supervisor, Dr. Joan Turner at [REDACTED].

If you have questions about how this study is being conducted and wish to speak with someone not involved in the study, you may contact the Chair of the University Research Ethics Board (UREB) c/o MSVU Research Office, at [REDACTED] or via e-mail at [REDACTED].

Lacey Robertson B.A.
Graduate Student: Master of Arts-Child & Youth Study
Mount Saint Vincent University
Halifax Nova Scotia Canada
msvu.ca/cyc

Appendix B

Consent Letter



Child and Youth Study

Informed Consent Form

I am inviting you to participate in an interview designed to explore the concept of rapport from the perspective of child life specialists working in free standing children's hospitals in North America. The purpose of this qualitative research study is to (a) gain an understanding of the concept of rapport, (b) understand ways in which rapport is established and maintained, and (c) identify the purpose and outcomes following the establishment of rapport between child life specialists and children.

As you know, child life specialists working in health care settings provide services and supports that are intertwined with the relationships that are developed with children and families (McCue, 2009). Although relationships with children and families are the foundation for the work of child life specialists, little research has been conducted to document or explore child life practice (Thompson & Snow, 2009). The study results are expected to be of interest to child life professionals and students, as well as academic and training programs in Canada and the United States.

There are no risks anticipated from your participation in the study. Benefits may include enjoyment of the process of sharing your experience and expertise with the researcher and contributing to the emerging Child Life literature.

In agreeing to participate, your participation will consist of a single telephone interview which will take approximately 30-45 minutes. You will be asked to answer a series of questions about your experience working as a Certified Child Life Specialist. The telephone interview will be audio-recorded. When the interview is transcribed, all identifiable information will be removed and the file will be anonymized using an alphanumeric code. Audio recordings will be deleted following transcription and all other data will be destroyed five years after the completion of the study. These steps are taken to respect the confidential nature of the interview and your right to privacy.

Your participation is voluntary. You have the right to refuse to answer any question(s) during the interview or withdraw from the study at any point during or after the interview without penalty. The results of the study will be published in a Master's thesis and may be presented at a professional conference or published in a professional journal. After the research has been

completed a copy of the thesis will be available electronically through the Mount Saint Vincent University library.

If you have any questions or concerns about the research study, you may email the researcher ([REDACTED]) or thesis supervisor, Dr. Joan Turner at [REDACTED].

If you have questions or concerns about how this study is being conducted and wish to speak with someone not involved in the research study, you may contact the Chair of the University Research Ethics Board (UREB0 c/o MSVU Research Office, at [REDACTED] or via e-mail at [REDACTED].

Informed Consent

I, _____ (print name) am interested in participating in the study The Development of Rapport with Children and Families Experiencing Hospitalization conducted by Lacey Robertson, graduate student and thesis supervisor Dr. Joan Turner, CCLS, Associate Professor in the Department of Child and Youth Study at Mount Saint Vincent University.

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

Please contact me at the following email address to schedule an appointment:

If interested in receiving the link to the Masters Thesis available through the MSVU Library ([REDACTED]) following completion of the research study, please provide an appropriate email to send the link to.

The link can be sent to the following email address:

Audio Recording Consent

I agree to be audio-recorded during the interview for the study, The Development of Rapport with Children and Families Experiencing Hospitalization, conducted by Lacey Robertson, graduate student and thesis advisor Dr. Joan Turner, CCLS, Associate Professor in the Department of Child and Youth Study at Mount Saint Vincent University.

Participant's Signature: _____ Date: _____

Halifax Nova Scotia B3M 2J6 Canada

Tel [REDACTED] • Fax [REDACTED]

msvu.ca

Appendix C

Interview Questions

The focus of the interview today is to explore the concept of rapport and ways in which child life specialists develop rapport with children youth and families in health care settings.

A.

1. I would like to open our discussion by asking you to talk about a child life interaction with a child or adolescent who was new to you (someone you have never met before), with particular emphasis on describing as best you can the situation, the particular child/adolescent, and the ways in which you approached the child/adolescent, introduced yourself and sustained the interaction over a course of your responsibilities in the setting.
2. Thinking about this particular interaction, I would like you to elaborate on the following characteristics of the interaction:
 - a. Did you carry or bring in materials with you when you initially interacted with the child/adolescent? In subsequent interactions with the child/adolescent?
 - b. Did you have a single interaction with the child/adolescent or did your interaction extend across a series of interactions?
 - c. Can you tell me more about each interaction? For example, the purpose and duration of each contact?
 - d. I am interested in ways in which features of the environment influenced your approach to the child/adolescent and the manner in which you interacted with the child/adolescent.
3. Would the interaction you described reflect your typical interactions with a new child/adolescent? In what ways is it typical? In what ways is it not typical?

4. If it is not typical, please describe what you believe to be your typical approach to initiating a relationship with children and families that are new to you.
 - a. Probes: direct the interviewees' attention to include details related to materials, coming and going and features of the environment.
5. To close this section, I would like you to share perhaps your most affective strategy when trying to initiate a relationship with a child or youth.
 - a. Probes: suggest materials they may always have on hand such as bubbles or stuffed animal.

B.

- 1) I would like to shift our discussion toward the concept of rapport. I am interested in your interpretation of the meaning of the term rapport.
- 2) How would do you describe the concept of rapport?
- 3) Please tell me about ways in which you can tell whether or not you are gaining rapport with a child/adolescent.
- 4) Can you describe the features of an interaction that you would say are indicators that rapport is being established? How about features of an interaction that you would say are indicators that rapport is not being established?
- 5) Can you recall any formal learning experiences (university course, practicum, internship, professional development activity) that focused your attention on the concept of rapport?
- 6) Perhaps rapport was not the focus: would you have any formal learning experiences related to, for example, supportive relationships, therapeutic relationships, therapeutic alliance? Can you describe what that learning experience involved?

- (1) Probes: direct the interviewees' attention to include details related to coursework, practicum, internship and professional development experiences).
- 7) Do you engage in any professional activities that require you to teach, train or supervise novices working with children/adolescents? Can you tell me about the ways in which you may, directly or indirectly, influence the understanding and behaviors of these novices working with children/adolescents?
- 8) Each child life specialist has their own unique ways of approaching children/adolescents and initiating relationships with them. What are some of your strategies for building rapport with children and families?

C. I would like to close the interview by asking some for some basic background information.

- 1) How long have you been working as a child life specialist?
- 2) Do you have experience working in a related field in the past? If so, what field and how long? For example, I taught preschool for four years
- 3) What is your educational background?
- (I) Probe direct interviewee to include level of formal training, field of formal training, for example, Associates degree in early childhood, Bachelor of Arts in Psychology, currently taking courses toward a Masters of Child Life.
- 4) Do you regularly participate in professional development activities that are specific to the development of rapport or relationship building?
- a) Probe direct interviewee to include level of formal training, field of formal training, for example, rounds, in-services, workshops, and conferences.

- 5) Do you teach, train or supervise students working with children/adolescents in health care settings? Are there specific resources (texts, videos, websites, magazines/journals, articles) that you use to support others who are learning to work with children/adolescents in health care settings?
- 6) Is there anything else you would like to share about your experience as a child life specialists that could better inform us about your understanding and practices around rapport building and child life practice?
- 7) Are you interested in receiving a copy of a brief summary of the research findings? If yes, provide an email address.
- 8) Thank you for taking the time to participate in this study. If you have any follow thoughts on comments related to rapport and child life concepts please contact us at:

Lacey Robertson at [REDACTED]

Joan Turner at [REDACTED]