

WORKING WITH DIVERSITY: THE EXPERIENCES OF CHILD LIFE
SPECIALISTS

by

Amarens Matthiesen

M.A. (Honours), University of Dundee, United Kingdom, 2013

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF ARTS
in the School of Child and Youth Care

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University of Victoria

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Supervisory Committee

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Abstract

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Canada's increasingly diverse population requires healthcare providers to become responsive to cultural differences within the provision of healthcare services, including Child Life Specialists (CLSs), who are committed to providing psychosocial and family-centered care to hospitalized children and their families. A fundamental process of family-centered care involves responding to the ethnic, cultural and socioeconomic diversity of patients and their families. The field of child life generally remains under-researched and, in particular, studies to support the link between child life practice and culturally adapted care are lacking. To address this gap, this study explores the ways in which CLSs perceive and conceptualize the construct of diversity in their practice by utilizing *cultural safety* as a guiding framework. Through an exploratory research approach, semi-structured interviews with six CLSs working at a prominent children's hospital in Alberta, Canada, were completed. A thematic analysis of the qualitative data indicated that CLSs conceptualized *culture* as a broad construct that is not limited to factors associated with ethnicity. Although CLSs also experienced various challenges in their practice as a result of cultural factors, their perceived level of comfort, confidence and desire to overcome such challenges were highly notable. This study also yielded insight into institutional- and practice-level resources and strategies that may improve the ability of CLSs to provide culturally-safe care.

Keywords: child life specialist, cultural safety, culture, diversity, healthcare

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Acknowledgements

First and foremost, I want to thank my supervisor(s), Dr. Doug Magnuson, for your insightful feedback and guidance, and Dr. Jessica Ball, for your initial support and guidance in shaping the theoretical underpinnings and recruitment strategies of this study. I am grateful to have been able to implement the cultural safety framework as a direct source from your work. Also, I want to express my gratitude to my committee member, Dr. Roy Ferguson, for your long-term guidance, mentorship, and encouraging words not only during my time as a graduate student, but also during my journey of becoming a Child Life Specialist. Drawing on each of your areas of expertise, I have learned a great deal.

Also, I want to express my sincere gratitude to all Child Life Specialists who participated in this study. Thank you for your honesty, openness and willingness to take time out of your busy workday to complete an interview. Your insightful perspectives will hopefully shape future research and initiatives in this field. Also, thank you to the Child Life Team Lead for supporting me in the process of setting up my research at your site.

Lastly, I am grateful for the support of family, “*want wêrt wy op’e wrald ek binne, oer ús skynt deselde sinne*”.

“To care for someone, I must know who I am.

To care for someone, I must know who the other is.

To care for someone, I must be able to bridge the gap between myself and the other”

— Jean Watson, as cited by Anderson (1987)

Chapter One: Introduction

Background

As populations become increasingly diverse, the likelihood that healthcare professionals will serve a diverse clientele is increasing (Wells, 2000). For example, it has been projected that three in ten Canadians will identify as a member of a visible minority group by the year 2031. Nearly one in two Canadians over 15 years of age will be foreign-born by the year 2031 (Statistics Canada, 2010). Thus providing health care services that are aligned culturally and linguistically becomes important (Flores, Rabke-Verani, Pine & Sabharwal, 2002). According to the World Health Organization rankings of the world's health systems, Canada ranks 30th out of 190 countries (WHO, 2000). Canada's system of universal health insurance has largely addressed financial barriers to access in health care for all citizens. However, persistent inequities in health status remain as a result of the multitude of factors influencing health (Health Canada, 2001). Such factors, or determinants of health, may include living and working conditions, the physical environment, health services, early childhood development and social support, for example. In addition to these factors, psychosocial factors such as gender, culture and membership in a specific population group may also significantly affect one's health status (Health Canada, 2001).

Healthcare services are fundamental determinants of health. For some populations, significant inequalities exist in the accessibility and quality of healthcare services. Population groups such as immigrants and refugees encounter difficulties in accessing services (Guzder, Yohannes & Zelkowitz, 2013). In addition, underserved populations, such as First Nations communities, suffer from more chronic diseases, such

as diabetes, when compared to non-underserved populations in Canada (Cameron, Plaza, Salas & Hungler, 2014). Health systems that fail to provide equitable care exacerbate social disparities and contribute to lower health status. To date, the focus of health policy and research in Canada has predominantly been placed on removing financial barriers in accessing healthcare services, whereas psychosocial barriers to care have been inadequately explored (Health Canada, 2001).

Psychosocial barriers to healthcare can include factors such as socioeconomic status, gender, and ethnicity. The factors of race and ethnicity in particular have been identified as being capable of influencing the attitudes, perceptions and behaviors of individuals seeking mental health care (Ojeda & McGuire, 2006). For example, stigma and shame have been considered as potential impediments to care-seeking among minority groups (Anglin, Link & Phelan, 2006). Similarly, gender also has implications for seeking healthcare (Ojeda & Bergstresser, 2008), as stigma has been systematically associated with a lower rate of mental health treatment among men (Wang et al. 2005). Other studies exploring psychosocial barriers in healthcare contexts include the fields of counseling (Keyser et al., 2014; Whaley, 2008) pediatric palliative care (Davies, Contro, Larson & Widger, 2010), and nursing (Berlin, Johansson & Tornkvist, 2006; Festini, Focardi, Bisogni, Mannini & Neri, 2009; Grant & Luxford, 2011; Tavallali, Kabir & Jirwe, 2014). In addition, psychological theories in the field of mental health have increasingly recognized the importance of including the notion of *culture* as an important factor in influencing the psychotherapeutic process (Pedersen, 2000). What is still largely neglected in pertinent literature, however, is the attention devoted to culture in the provision of health care services to *children* (Flores et al., 2002), and, in particular, to the

field of child life. Considering the scope of this study, the broad psychosocial factor of *culture* will be examined in relation to the field of child life in paediatric healthcare, in which Child Life Specialists (CLSs) are committed to providing psychosocial, family-centered care to hospitalized children that is sensitive to cultural, ethnic and socioeconomic diversity.

Personal Rationale

The initial rationale for examining this topic stems from early personal experiences as a Third Culture Kid (TCK). A term initially coined by Pollock and Reken (1999), a TCK refers to “a child who spends a significant period of their developmental years in a culture outside their parents’ passport culture(s)” (p. 4). Soon after entering the professional workplace of working with children and youth in educational and therapeutic settings, I became highly aware of the powerful influences that culture(s) may hold on all aspects of everyday life. Upon commencing my professional role as a Child Life Specialist (CLS) in a clinical setting, I utilized my cross-cultural experiences in my interactions with patients from diverse backgrounds. In addition, the MA CYC program at the University of Victoria allowed to critically examine how the element of culture has been examined and integrated into various healthcare domains before focusing on the field of child life. As a result of my experience as a CLS and graduate student, I have identified a need to devote more attention to the topic of culture in child life practice.

Purpose of Study

The main aim of this study is to help fill a gap in literature by focusing on the psychosocial factor of *culture* in child life practice by examining the experiences of CLSs. This remains an important area of focus, as the concept of culture has been

associated with psychosocial barriers to healthcare (Odeja & Bergstresser, 2008), capable of affecting the quality of care perceived by healthcare recipients (Briggs & McBeath, 2010). Considering that cultural considerations in healthcare contexts have largely not been sufficiently examined, novel research, committed to examining current issues facing healthcare providers' abilities to work with patients from diverse backgrounds becomes necessary. In particular, few studies have linked the concept of culture to the relatively novel field of child life. Thus, by focusing on how CLSs conceptualize and implement the concept of culture in their practice, this study aims to contribute to an increase in literature on how and which types of cultural challenges may exist in child life practice.

Although Chapter Two will describe in more detail how the concept of culture has been defined in this study, it must be noted that the terms 'culture', 'race', 'nation' and 'ethnicity', for example, have often been treated as equivalent and used on an interchangeable basis in literature (Spencer-Oatey, 2012). Therefore, this thesis provides a clear definition of culture as it applies to this study in an attempt to ameliorate the often interchangeable use of definitions of culture in literature.

Lastly, this study provides suggestions for improving the ability of CLSs to work 'with' culture on a practice- and institutional-level. On a broader level, the findings of this study may act as a springboard for additional research to be conducted in the under-researched child life field, in the hope to achieve more equitable healthcare services.

Guiding Theoretical Frameworks

This study utilizes two distinct theoretical frameworks. One framework, the social constructionist perspective, offers insight into the philosophical underpinnings of this study. The social constructionist perspective acts as a philosophical theory that has

guided my thinking on the collaborative nature of *meaning-making*. As noted by Gergen (2009) “[there] is no fully private experience... as we exist in a world of co-construction” (p. 15). In this manner, I consider culture as a concept that is learned and deriving from one’s social environment. Social constructionism therefore acts as a particularly suitable theoretical foundation for this study, as this perspective embeds therapeutic relationships in an expanded array of such relations, including ethnicity and religion, thus highlighting one’s cultural background as a critical factor in co-constructing reality with others.

Cultural safety has been selected as useful framework in the implementation of this study, as it provides a clear way of distinguishing between the characteristics and behaviors that may be demonstrated by the practitioner (CLS) and provider (institution) in order to provide culturally-safe care. Focus is therefore placed on the outcomes of healthcare services, namely, on how patients and their families experience the services. This framework was particularly useful in organizing the findings of this study into an overview of the practical behaviours and characteristics that participants identified as contributing to culturally-safe care.

Thesis Overview

This study has been based on five guiding research questions:

1. How do CLSs define culture?
2. Do CLSs actively refer to specific cultural constructs and cultural frameworks in their practice?
3. How do CLSs articulate the impact of their own culture on their interactions with diverse populations in their practice?
4. Do CLSs consider culture in their daily practice?

5. What types of challenges do CLSs experience when interacting with clients from diverse backgrounds?

The main aim of this study is to gain a deeper understanding of how CLSs conceptualize the concept of culture, including their use of theoretical constructs or frameworks. By eliciting accounts on their definitions of this concept, findings will also aim to distinguish between their definitions of culture and the way in which they define their own culture(s). Examining how and why participants consider culture in their practice will gain insight into the potential challenges experienced as a result of cultural factors, as well as the strategies participants used to overcome them. In this manner, the research questions aim to identify specific resources and strategies that CLSs consider as improving their ability to work with patients and families from diverse backgrounds.

This thesis is organized into five chapters. Chapter Two provides a more extensive literature review, which has been divided into sections addressing the following topics: child life practice, clarifying the concept of culture, conceptual frameworks (i.e. cultural competence and cultural safety), and cultural barriers. Chapter Three outlines my research methodology, consisting of a note on qualitative research, my positionality as a researcher, the research sample, as well as the data collection and analysis procedures. Chapter Four presents the findings of a thematic analysis of six interviews, from which five major themes emerged. Lastly, Chapter Five offers a discussion of the findings in relation to the literature discussed in Chapter Two, and provides implications and recommendations for future research and practice, in addition to a final summary.

Chapter Two: Literature Review

This chapter provides an overview of relevant literature on cultural ‘issues’ frequently observed in healthcare, and how they pertain to the fields of paediatric healthcare and child life in particular. The first section will describe the population of interest in this study, namely, Child Life Specialists, and provide an overview of key research and concepts inherent to child life practice. The second section will define the concept of “culture” before discussing the importance of considering culture in healthcare in the third section. Finally, the fourth section addresses two conceptual frameworks that offer specific strategies to address cultural issues in practice (i.e. cultural competence and cultural safety).

Search Description

An initial, broad literature review focused on the concept of cultural competence as it applies to pediatric healthcare in general, in order to gain insight into existing frameworks aimed at ameliorating cultural issues in healthcare. Domains of consideration within this search therefore included nursing, social work and mental health, for example. In addition, this search guided me to the framework of cultural safety for use in this study.

Subsequent to gaining a broad overview of how cultural issues may influence the effective delivery of paediatric healthcare services, the search was refined to focus on the field of child life. Key words in this literature search included: child life, culture, cultural safety, diversity and healthcare. I used the “frequently used databases” in the University of Victoria’s library system. Given the limited amount of research conducted in the field of child life, especially pertaining to cultural issues, I also used Google Scholar and found

two unpublished Master's theses that focus on cultural issues in the field of child life across North America as well as "evidence-based" practice statements published by the Child Life Council (CLC).

Child Life Practice

Defining the population. According to the Canadian Association for Child Life Leaders (CACLL), there are currently 5,248 Certified Child Life Specialists (CCLS) practicing worldwide. Certification is obtained through the CLC, which is the U.S.-based organizing body for the child life profession in North America and established in 1982 (CACLL, 2015). Out of 5,248 global CCLSs, 285 CCLSs are currently practicing in Canada (CACLL, 2015). Additionally, 439 hospitals currently offer child life programs worldwide, of which 42 are offered in Canadian hospitals. The majority of CCLSs are located in the U.S., with the majority of educational programs focusing on child life also being offered in the U.S. For example, Canada currently offers only four academic child life programs (CACLL, 2015).

Outside of North America, professionals with similar job duties as Child Life Specialists in North America are called play specialists in New Zealand, child life therapists in Australia, play therapists in the United Kingdom, and medical pedagogical support workers in the Netherlands. All focus on providing psychosocial support to hospitalized children and their families. Although the field of child life is at the beginning stages of recognition in countries such as Australia (e.g. only 92 Child Life Therapists currently work in Australia) (Association of Child Life Therapists Australia, 2015) and South Africa, its increasing prominence on a global scale offers a promising insight into improving the future experiences of hospitalized children and families.

Notwithstanding the multitude of job titles that currently exist to represent the profession, I will use the North American terminology by referring to the field as “child life”. As introduced by the Child Life Council, professionals in the child life field will be referred to as Child Life Specialists (CLSs).

The development of the child life profession. Since the 1970s, literature has undergone a significant shift in recognizing the notion that major stressors associated with being hospitalized may negatively affect a child’s wellbeing (Gaynard et al., 1998; Thompson, 2009). Major stressors for hospitalized children may include procedures, loss of control, fear of dying, separation from friends and family, the hospital environment and restriction of movement (McCaffrey, 2006). Prior to the 1950s, healthcare professionals paid little attention to such psychosocial and environmental factors in the process of a child’s hospitalization (Thompson, 2009). By conducting observational studies, René Spitz was one of the first researchers to introduce the notion of *hospitalism* in 1945, as a description of a condition of severe physical and developmental decline in hospitalized children (Palombo, Koch & Bendicson, 2009). It is in this interface of a medical and psychological approach to health and illness that fostered the opening of pediatrics to the idea that social and environmental factors influence a child’s response to treatment.

The idea of incorporating play as a healing modality into pediatric units became increasingly prominent in U.S. hospitals during the 1960s. During this period the field of child life emerged with the goal to “help children engage and subdue fears, misconceptions, anger and profound sadness that hospital experiences provoke, to protect and enhance their developmental integrity, and whenever possible, use the experiences of

illness and hospitalization to build strengths rather than compromise them” (Thompson, 2009, p 12). Within child life practice, play is used as the most frequently used tool to promote continuing development among pediatric patients, to normalize the medical environment, to facilitate emotional expression and to enhance children’s understanding of medical events (Thompson, 2009). More specifically, CLSs use *therapeutic play* as a conceptual framework for conducting assessments, as well as a valuable tool in the domains of intervention, relationship-building, advocacy and education. Research studies on the benefits of therapeutic play have documented improved psychological, behavioural and physiological outcomes in hospitalized children (Koller, 2008).

Family-centered care. In addition to the modality of play, the concept of family-centered care is an integral component of child life practice. Family-centered care is an approach to healthcare that is based on mutually beneficial partnerships between patients, families and healthcare professionals (Thompson, 2009). Specifically, a fundamental process in family-centered care involves responding to ethnic, cultural and socioeconomic diversity of patients and their families in the provision of care (Thompson, 2009). Prominent theories underlying child life practice, including Bronfenbrenner’s Ecological Theory (1979) and Weisner’s (2002) Eco-Cultural theory, aid the CLS in recognizing the influences on the development of a child including family, home and community factors (Butterly, 2009). As CLSs subsequently adopt an ecological perspective in the development of therapeutic relationships with children and families, they form an understanding of the *whole* child (Butterly, 2009). In order to form an optimal understanding of the whole child, it becomes clear that the concept of *culture* cannot be omitted from child life practice (Zengerle-Levy, 2006).

Improving cultural ‘skills’. A growing number of professional organizations and agencies have articulated a commitment to family-centered practice through an increasing recognition of the benefits of this approach for both patients and their families (Johnson, Saha, Arbeleaz, Beach & Cooper, 2004). Documented benefits pertain to improvements in medical and developmental outcomes, as well as enhanced patient- and family-identified needs and priorities (Thompson, 2009). However, since culture acts as a prominent factor in the delivery of family-centered and effective child life practice, a number of documents published by the CLC have offered specific strategies to improve the ability of CLSs to work ‘with’ culture. For example, the CLC has identified strategies to increase the level of diversity among child life workforces by increasing the recruitment of individuals who identify with underrepresented demographic groups or who are multilingual, for example (Child Life Council, 2006). Additional documents published by the CLC explicitly identify strategies to enhance the cultural ‘skills’ of CLSs (Child Life Council, 2001). For example, a conference paper published by the CLC, entitled “Cultural Competency in Child Life” (*‘Cultural Competency in Child Life’*, 2005) places primary focus on the framework of cultural competence. In addition, the document urges child life staff to attune to the family culture, by stating:

It is child life practice that an individualized plan is developed for each patient based not only on developmental level, family support, mobility, and age, but also for culture and language. Child Life staff must support the patient and family in continuing to practice their values, traditions, and beliefs.

Similarly, a conference paper presented at an annual CLC conference, entitled;

“Entiendo, Capisco, Je Comprends, I understand: Providing Culturally Competent Child

Life Care” (Desai, 2008) highlights the importance of developing cultural competence through a three-step process. In addition, Desai (2008) considers the necessity of becoming culturally competent at an individual, program/agency, and policy level. On a more practical level, the presenter also offers specific strategies as suggested guidelines to increase one’s cultural competence. For example, suggestions include; “tolerating ambiguity well”, “being open to new learning”, “respecting individuals from other cultures”, and “attempt to understand the world from others’ viewpoints”. Lastly, the author offers an extensive list of contrasting beliefs, values, and practices that may exist between certain cultures and ‘mainstream’ cultures.

Pertinent research studies. In order to gain a deeper understanding of the ways in which culture has been contextualized, albeit infrequently, within child life practice, two unpublished Master’s theses offered insightful results into the experiences of CLSs in specific contexts in North America. For example, a study conducted by Butterly (2009) revealed that seven CLSs from Ontario, Canada, hold a strong *desire* to fully understand cultural influences that may impact the development of a child. CLSs also actively engaged in culturally responsive practices by gathering information from patients and families with regards to family composition, roles, and routines, which were perceived to act as valuable sources of knowledge to inform the planning of the child’s care (Butterly, 2009). The perceived level of comfort and openness in working with diverse families was rated as moderate to high. This suggests that the CLSs engaged in regular opportunities, where possible, to learn, reflect and develop novel skills (Butterly, 2009). Furthermore, Belisario (2014) provided results of an online survey completed by 109 child life specialists across North America. The survey demonstrated that the CLSs considered

cultural competence as an essential factor in their practice and were actively involved in attempting to promote effective, respectful and compassionate support to patients and families (Belisario, 2014).

Institutional barriers. Despite recognizing the importance of cultural considerations and holding a desire to actively incorporate such considerations into practice, the presence of barriers from an institutional perspective act as a primary force in preventing front-line health care providers, such as CLSs, to provide optimal culturally-responsive care (Butterly, 2009). Similar to barriers identified in other healthcare fields (e.g. nursing), prominent barriers for CLSs have been identified as limited access to resources, lack of time, the organizational culture and the clinical environment. Butterly (2009) demonstrated that CLSs were subsequently able to identify resources that would facilitate their work with diverse children and families. The majority of these needs could be met through institutional provisions, such as increased translator services, training/development and educational opportunities (Butterly, 2009). However, due to the reality of low CLS to patient ratios, implementing such institutional provisions may be challenging (Butterly, 2009).

Toward Clarity of Definitions: Culture

Before offering a discussion of specific frameworks that aim to improve the experiences of culturally diverse recipients of healthcare, as well as improve the cultural “skills” of CLSs, the use of the word “culture” itself must be defined. This remains an essential first step, as dangers exist in “[j]umping into a culturally sensitive approach... without first examining what we mean by culture and, even more important, what our own values are with respect to the culture of the Other” (Locke, 1993; as cited in Browne

& Varcoe, 2007, p. 157). Therefore, the terminological meaning behind the concept of culture will be unpacked, which remains a complicated procedure, given a myriad of definitions that remain open to diverse interpretations (Whiting, 1999). The term culture has been frequently associated with terms such as 'race' and 'ethnicity' (Fernando, 1991). Although these terms are inextricably linked, their interchangeable use demonstrates a lack of consistency (Whiting, 1999). In Canada, little available data are linked to ethnic origin, and the construct of 'ethnicity' remains controversial. The primary reason for this is that ethnicity has not been well defined, and that it tends to ignore confounding variables. Differences attributed to ethnicity may be the result of income-related factors or the inability to communicate in a dominant language (Bowen & Kaufert, 2000).

With regards to defining culture, literature predominantly distinguishes between early definitions that consider culture as a static entity, and contemporary definitions that consider it as a changing entity (Dean, 2001). Early definitions view culture as consisting of cultural groups and categories that have defining characteristics which endure over time and contexts (Dean, 2001). For example, *Wester's New World Dictionary* (1988, as cited in Dean, 2001) first defined culture as: "the ideas, customs, skills, and arts of a people or group, that are transferred, communicated, or passed along... to succeeding generations". Such definitions have been critiqued for considering culture as a static and monolithic entity that is not subject to intergenerational change, as well as the inattention paid to factors that may influence its development, such as economic, political or sociocultural forces (Whiting, 1999). In contrast, other views of culture consider it to be individually and socially constructed due to its emergent, transformational and contextual nature. For example, Laird (1998, p. 28-29) considered it as "[a]lways contextual,

emergent, improvisational, transformational, and political; above all, it is a matter of linguistics or of languaging, of discourse (Laird, 1998, p. 28–29). These latter definitions of culture emphasize the continually evolving nature of cultural identities (Dean, 2001).

Currently, a growing body of critical scholarship demonstrates that the concept of culture continues to be applied in ways that diminish the significance of power relations and effects of stereotypical representations of culture on health and healthcare (Browne & Varcoe, 2006). Reimer, Kirkham and Anderson (2002) note that in health care settings specifically, culture continues to be used as a synonym with ‘differences’ that are most often based on stereotypes. In this manner, the cultural ‘Other’ may become constructed in mainstream institutions such as hospitals (Browne & Varcoe, 2006).

Browne and Varcoe (2006) note that definitions of culture that reflect narrow, monolithic views of culture may give rise to *culturalist discourses* in practice. Cultural discourses are referred to as “the complex practices and ideologies that use popularized, stereotyped representations of culture, often conflated with ethnicity, as the primary analytical lens for understanding presumed differences about various groups of people” (p. 158).

In line with Browne and Varcoe (2006), a critical cultural perspective is necessary to combat such narrow, ethno-specific views of culture. Critical perspectives of culture shift the gaze away from cultural Others onto the self, with the aim of examining “how each individual is enmeshed within historical, social, economic and political relationships and processes” (Browne & Varcoe, 2006, p. 163). This may then lead to questions such as; “How am I seeing certain behaviours as ‘normal’ and some as ‘cultural’?”, “How am I serving certain economic and political interests through my daily practices?”, and “How am I reinforcing certain norms (for example, Eurocentric norms

perhaps) within the culture of health care?” (Browne & Varcoe, 2006, p. 163). In line with the work of Anderson and Reimer-Kirkham (1999; as cited in Browne & Varcoe, 2006), this study will define culture as:

[Being] located within a constantly shifting network of meanings enmeshed within historical, social, economic and political relationships and processes. It is not therefore reduced to an easily identifiable set of characteristics, nor is it a politically neutral concept.

Culture will be understood as a broad construct that helps individuals identify the group to which they belong and their core beliefs, including religious beliefs and fundamental values (De & Richardson, 2008). By conceptualizing culture as a broad construct, the term does not become confined to elements associated with ethnicity. Rather, cultural values include broader elements related to one’s way of living, attitudes, behaviors, relationships with others and class, for example (Papps & Ramsden, 1996).

Cultural Considerations in Healthcare

In a healthcare context, an inattention to issues related to diversity may have widespread implications. Healthcare institutions act as key determinants of population health, healthcare services that do not adequately respond to the diverse needs of individuals, populations and communities greatly increase the risk health inequalities amongst a given population (Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004). In Canada, health inequalities are currently predominantly distributed among *underserved* populations, including Aboriginal peoples, people who do not speak either of Canada’s official languages, immigrants, refugees and ethnically diverse

populations, and people with low incomes, for example (Health Canada, 2001). In this context, *underservice* implies an increased likelihood that individuals who belong to an aforementioned population(s), may experience difficulties in obtaining needed care, receiving less care or a lower standard of care, as well as experience different treatment by healthcare providers or receive treatment that does not adequately meet their needs (Health Canada, 2001).

Health inequalities are closely linked to social determinants of health, such as socioeconomic status (SES), lifestyle, gender, and geographical location (Cameron, Plaza, Salas & Hungler, 2014). The combination of such determinants has been suggested to play a role in the creation of barriers within healthcare. Two primary areas in which such barriers have emerged include an individual's ability to *access* healthcare services and the quality of healthcare services (Health Canada, 2001).

Access to healthcare services. The difficulties experienced by members of underserved groups seeking healthcare services are well documented (Ecklund & Johnson, 2007). For example, Guzder et al. (2013) demonstrated that immigrant parents to Montreal, Canada, experienced delayed access to mental health services for their child as compared to parents born in Canada, which diminished immigrant parents' willingness to pursue treatment for their child. Additional studies conducted in Montreal (Kirmayer, Weinfeld, Burgos & du Fort, 2007; Whitley, Kirmayer & Grouleau, 2006) demonstrated that cultural minority groups significantly underutilized mental health services due to fear of stigmatization and concern that health care professionals would reject or poorly understand their cultural beliefs and values. These findings were also obtained in American and British contexts (Bhui, McKenzie & Rasul, 2003; Harris, Edlund &

Larson, 2005). Such difficulties can have lasting effects, as impeded access to health services negatively affects individuals' health outcomes (Ecklund & Johnson, 2007).

In Canada, the issue of equitable access to care, as the “fair and just distribution of resources”, remains inadequately addressed (National Collaborating Centre for Aboriginal Health (NCCAHA), 2011, p. 1). For example, it is widely recognized that there are significant disparities in the health of Aboriginal peoples in Canada compared to other Canadians, and that they face “[s]ignificant barriers to appropriate and equitable treatment” (NCCAHA, 2011, p. 1). In this context, language or cultural barriers have been recognized as a challenge in accessing health services.

A lack of research has aimed to change, rather than solely document issues responsible for impeded access to care. The focus of much of current literature is on redefining the social relationships between healthcare providers and clients in order to promote equality (NCCAHA, 2011). In order to achieve this, it has been suggested that healthcare providers must develop an initial awareness of how unequal relationships are created and sustained in society (Cameron et al., 2014). This study therefore aims to generate insight into CLSs', as healthcare professionals, conceptualizations and awareness surrounding cultural issues in practice.

Quality of healthcare services. As pointed out by the NCCAHA (2011, p. 2); “Not only must individuals have physical access to health services in order to have positive health outcomes, but the nature, quality and appropriateness of such services must also be considered”. Within the idea that health is shaped by particular cultural, social and economic contexts, Rohan (2003) places particular focus on the importance of *communication* in healthcare encounters, as a starting point for making service provision

more culturally appropriate. As noted by Health Canada (2001), communication acts as an essential aspect of health care, and, in turn, cultural competence is an important aspect of communication. As culture can influence communication in varying ways (e.g. verbal and non-verbal communication), “clients from all cultural backgrounds and linguistic profiles must be able to voice their individual needs... to a healthcare provider” (Health Canada, 2001, p. 229) in order to ensure the highest quality of healthcare. As a result, when client and provider are able to successfully communicate, there is greater likelihood that the client will be able to access and receive the necessary quality of care.

The barriers resulting from patient-provider communication are well-documented (Davies et al., 2010). For example, when patients do not speak the same language(s) as their healthcare provider(s), there exists an increased risk of miscommunication, misdiagnosis, inappropriate treatment, reduced patient comprehension and compliance, clinical inefficiency, decreased provider and patient satisfaction, to name a few (Betancourt, Green, Carrillo & Ananeh-Firempong, 2003). Optimal patient-provider communication (i.e. same language comprehension and/or the clinician pays attention to the patient’s condition, treatment and prognosis) can improve overall levels of wellbeing by reducing feelings of stress, sadness and anger among patients (Davies et al., 2010).

It is important to note, however, that other underserved groups, such as people with alternate sexual orientations, report similar difficulties in obtaining satisfactory care within healthcare systems (Health Canada, 2001). Therefore, culture must be understood as being influenced by factors not only related to ethnicity and religion, for example, but also to factors such as disability or sexual orientation. As an example, the language and

non-verbal cues used by individuals with hearing impairments can be considered as a unique culture that must be treated with culturally-attuned services (Health Canada, 2001).

Conceptual Frameworks

Various conceptual frameworks emerged in literature with the overarching objective to address cultural and ethnic diversity issues on individual, educational and professional levels (Betancourt et al., 2003). Pertinent literature often utilize frameworks such as *cultural sensitivity* (Davies et al., 2010; van Dellen et al., 2008; Hoskins, 1999), *cultural competence* (Berlin et al., 2006; Doorenbos & Schim-Myers, 2004; Dreher & MacNaughton, 2002; Festini et al., 2009; Guzder et al., 2013; Keyser et al., 2014; Seeleman, Stronks, van Aalderen & Bot, 2012; Tavallali & Kabir, 2013) *cultural responsiveness* on an interchangeable basis (Whaley, 2008). The main objectives of such frameworks are to improve the overall quality of services by acting as a guiding instrument to “deal with” diversity issues (Seeleman, Suurmon & Stronks, 2009). Considering the wide range of conceptual frameworks that exist in pertinent literature, and scope of this study, the cultural competence and cultural safety frameworks will be discussed in this section.

Cultural competence. This framework has received a great deal of attention in human service professions such as social work, counseling, health and mental health (Yan & Wong, 2005). Within a wide array of multicultural and child life literature, cultural competence is the most frequently utilized framework (Betancourt, Green, Campinha-Bacote, 2002; Carillo & Ananeh-Firempong, 2003). Cultural competence in health care has been defined as the “ability of systems to provide care to patients with

diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs" (Betancourt et al., 2002, p. 5). However, efforts are still ongoing to define and implement this broad concept (Betancourt et al., 2002).

Among various scholars who propose the cultural competence model, three major dimensions of cultural competence can be identified; (a) awareness of and sensitivity to workers' own values, biases, and power differences with their clients; (b) knowledge of the practice environment, the helping methods, and the client's culture; and (c) skills in verbal and nonverbal communication (Yan & Wong, 2005). The emphasis on *knowledge* and *skill* suggest that cultural competence has been perceived as a 'technical solution' to the challenges of cross-cultural work in healthcare (Yan & Wong, 2005).

With regards to child life practice, one of nine elements of family-centered care linked to performance standards for child life specialists, pertains to "designing accessible healthcare delivery systems that are flexible, culturally competent, and responsive to the needs that families identify" (Thompson, 2009, p. 108). Thompson (2009) suggests that such elements offer an avenue for moving from theory to collaboration, and from philosophy to interaction, as a genuine effort to develop indicators of exemplary practice. In child life practice, culturally competent care has been defined as "[being] sensitive to individual family values and avoiding stereotypical models of communication or the assumption that one's own background is the "norm" and the patient and family's background is diverse" (p. 110). In addition, this concept is suggested to encompass a respect for the family's spiritual and religious foundation. Similar to strategies introduced in CLC conference proceedings, Thompson (2009) offers select practice strategies that encompass culturally competent child life care, such as

incorporating cultural celebrations, songs and games into child life programming and environments and using appropriate interpreters, for example. However, empirical evidence to support their effective incorporation into child life practice is lacking.

Cultural safety. The concept of cultural safety has been selected in order to guide the organization of the findings of this study into specific behaviours and characteristics that can be demonstrated by health care providers and institutions in order to achieve culturally safe care. Cultural safety, in a broad sense, emphasizes the importance of analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to health care (Anderson et al., 2003; Kirmayer, 2012; Papps & Ramsden, 1996). In addition, the overarching idea of *safety* also emphasizes a willingness and ability to *learn* from patients (Kirmayer, 2012), with a specific focus on the experiences of the service *recipient* (Ball, 2009).

Historical overview. Originating in the work of Maori nurse educators in New Zealand in the late 1980s, the concept of cultural safety evolved as Indigenous people and organizations adopted the term to define new approaches to healthcare and community healing (Wepa, 2003). Cultural safety draws on the concepts of post-colonial theory to raise awareness on how existing power imbalances shape people's health and access to healthcare services (Browne et al. 2005). The roots of cultural safety reflect a bicultural orientation, emphasizing a relationship between members of a given culture and cultural 'Others' (Ramsden, 2002). The bicultural nature is reflected in its definition;

“Cultural safety aims to counter tendencies in health care that create cultural risk (or cultural unsafety) – those situations that arise when people from one ethnocultural group believe they are demeaned, diminished or disempowered by

the actions and delivery systems of people from another culture” (Wood & Schwass, 1993; as cited in Browne et al., 2009, p. 169).

Cultural safety places particular emphasis on the care that is received by the *end users* (recipients) of healthcare services, and how their experiences may be ameliorated. Cultural safety, therefore, becomes a paradigm that shifts from focusing on the *input* (provision of healthcare services) to *output* (the experience of receiving healthcare services).

Aims of cultural safety. The ultimate aims of this paradigm include producing a workforce of well-educated and self-aware health professionals who are culturally safe to practice, as defined by the people they serve (Crampton, Dowell, Parkin, & Thompson, 2003). As noted by De and Richardson (2008), the key tenets of the cultural safety approach include;

- Healthcare professionals’ analyses of their cultural selves and the impact these can have on therapeutic encounters
- The recognition of power gradient between the professional and service user
- A set of basic skills that can be learned and applied by professionals

Despite gaining ongoing influence in health care contexts, the notion of cultural safety remains poorly understood on both a theoretical and practical level. Johnston and Kanitsaki (2007) note that there is ongoing confusion surrounding how cultural safety should be defined, interpreted and implemented in healthcare contexts. However, there is significant research demonstrating the successful consideration of cultural safety in health care delivery and in Aboriginal community healing projects (Brascoupé & Waters, 2009).

For example, literature has shown that the use of culturally safe healing strategies led communities in crisis to becoming emerging healthy communities (Lane, Bopp, Bopp & Norris, 2002). Within a healthcare context, nursing practice in New Zealand incorporates cultural safety, and studies in Australia found that cultural safety provides a useful framework to improve the delivery of services to Indigenous peoples (Kruske, Kildea & Barclay, 2006). In addition, Smye and Browne (2002) used the concept of cultural safety as an ‘interpretive lens’ to inform mental health policies as it applies to Aboriginal peoples in B.C. In this manner, Smye and Browne (2002) note that the notion of safety aided them to focus on the health *outcomes* of Aboriginal peoples, in terms of whether they are benefitting from the current mental health care system.

Although a lack of literature is currently available to shed light on which specific factors contribute to ‘successful’ culturally-safe practice, it is likely that factors external to the practitioner and provider also play a fundamental role. Culturally-safe approach therefore emphasizes the importance of considering broader social and historical determinants, such factors may relate to power imbalances, institutional discrimination, colonization and colonial relationships (National Aboriginal Health Organization, 2008, p. 3). However, to the extent that the practitioner (CLS) and provider (hospital) may influence the service outcomes, it may be hypothesized that certain characteristics and behaviors may increase the likelihood that a client experiences culturally-safe care. For the practitioner, these may include *characteristics* such as their language capabilities and their ethnicity and physical appearance, and *behaviours* such as engaging in respectful, responsive and informed practice. For the provider, *characteristics* may include having existing policies and standards of practice that address diversity, and *behaviours* such as

accommodating specific cultural needs, respecting confidentiality and using appropriate terminology (Ball, 2009). In order to depict the simplified structure of the cultural safety paradigm, Figure One illustrates the input of the characteristics and behaviours of the practitioner(s) and provider(s), with the aim of resulting in culturally safe practice experienced by the recipients of care.

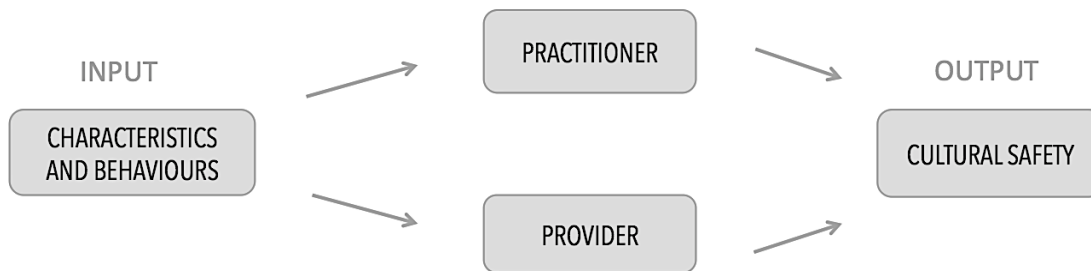


Figure One. *Cultural safety paradigm structure.*

Ultimately, cultural safety provides health care providers with a framework for becoming *willing* and *able* to listen and learn from patients (Kirmayer, 2012). However, although the attributes of openness, respect and attentiveness act as pre-requisites for cultural safety, they are not sufficient (Kirmayer, 2012, p. 158). The cultural competence framework encourages healthcare providers to engage in self-reflexive practice, by increasing their awareness of the cultural embeddedness of all clinical interactions (Ball, 2009). Cultural safety, however, goes further, by insisting on recognition of the social, economic, and political position of groups within society. Attention is therefore shifted towards broader, systemic issues such as the historical, policy and institutional context of health care delivery (Cortis, 2008).

Finally, it must be noted that although cultural safety originally arose as a uniquely Indigenous response to difficulties experienced in the provision of health care

services in New Zealand, it has been contended that the cultural safety framework should be adopted as a general standard of practice when caring for all people of diverse, racial, cultural and language backgrounds (Johnston & Kanitsaki, 2007). The concept has now been embedded in nursing curricula in New Zealand and applied to the concept of research and teaching in Canadian health care. However, the Canadian context differs from the context in New Zealand in two ways (Browne et al., 2009). Firstly, Canada is a pluralistic society dominated by legislation embedded in the Multiculturalism Act (Government of Canada, 1988). This act emphasizes the need to be sensitive to the cultures of all groups living in Canada, rather than reflecting a bicultural relationship that reflects the New Zealand context. Secondly, the sociopolitical context of Canada differs from that of New Zealand with regard to the relationship between the state and Indigenous people. In Canada, few legal agreements in the form of treaties and multiple diverse Indigenous people exist (Browne et al., 2009).

Summary

This chapter provides a review of barriers that have been frequently experienced in pediatric healthcare contexts, and how two frameworks offer insight into strategies to overcome such barriers. In addition, a discussion of pertinent research studies conducted in the field of child life and the importance of adhering to family-centered care principles brings attention to the importance of cultural considerations in child life practice.

Although the CLC has offered specific strategies to overcome cultural issues in practice, this literature review has highlighted that current research in child life, set out to examine the effectiveness of such strategies, is lacking. For example, no existing literature has offered to generate insight into the first-hand accounts of child life specialists on the

challenges they face in practice, arising from cultural issues, and which strategies or resources they use to improve their practice. Therefore, the field of child life could benefit from additional, in-depth research studies that examine how child life specialists might provide optimal, culturally-safe practice on a personal and institutional level.

Chapter Three: Method

This chapter focuses on the methodological considerations of this exploratory inquiry. Categorized into five sections, the first section will provide a note on qualitative research, as well as a discussion of my positionality as a researcher. The second section will discuss the research sample, with a particular focus on the recruitment strategy. The following two sections will outline the data collection and analysis procedures. Ethical considerations, including the elements of voluntary participation, confidentiality and risks will be described in the fifth section. Lastly, the final two sections will discuss the concept of rigour and offer a description of limitations relevant to this study.

Qualitative Research

As qualitative research generally seeks to develop an understanding of complex social phenomena by answering *what*, *how* and *why* questions, this study became particularly suitable to adopt a qualitative approach to research. In order to offer a general definition of qualitative research, Creswell (as cited in Isaacs, 2014, p. 318) defined it as;

An inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting.

An additional key characteristic of qualitative research pertains to its naturalistic and interpretive nature, in that researchers “[a]ttempt to make sense of, or interpret, phenomena in their natural setting(s) and in terms of the meanings people bring to them” (Denzin et al., 2000, p. 3). As a result, qualitative research aims to understand the rich, complex and dynamic texture of social experience (Ritchie, Lewis, Nicholls, Ormston,

2013). Data emerging from qualitative research are therefore well suited to contextualize the perceptions, assumptions and prejudgments of individuals, and to connect such meanings to the wider social world in which they are located (Miles & Huberman, 1994). Collectively, the particular research aims and the characteristics inherent to qualitative research led this study to be considered interpretive and exploratory in nature.

Researcher Positionality

Research can be understood as “an interactive process shaped by [the researcher’s] own personal history, biography, gender, social class, ethnicity, and by those of the people in the setting” (Denzin et al., 2000, p. 4). In addition, Denzin (1989) stressed that all researchers speak from a “particular class, gendered, racial, cultural and ethnic community perspective” (p. 11). Considering these elements, it becomes imperative to expand on my own positionality as a researcher, in order to align with the transparent nature of this social constructionist study (Cassell & Symon, 2000),

My positionality as a researcher primarily reflects an insider stance. I consider myself an insider because I am currently employed as a CLS (Child Life Specialist), as well as due to my role as a former child life intern at a leading children’s hospital in Alberta, Canada, from January to April 2016. As participants for this study were recruited in the same children’s hospital, I formed relationships with the majority of the participants prior to commencing this research study.

I also consider myself as an insider due to my personal experience of attending a European School in Brussels, Belgium over a period of 11 years. Administered by the European Union (EU), the now 14 European Schools located throughout Europe provide primary and secondary education solely for the children of personnel of EU civil servants

at European institutions. This experience provided me with a level of insight into how culture may emerge in educational contexts, but also in many aspects of everyday life. Additional professional experiences of working with children and youth in school, recreational and therapeutic contexts in multicultural areas around Belgium, the Netherlands, Scotland and Canada, have contributed to personal recognitions and understandings of the powerful influences of culture.

More recently, my experiences of working as a CLS in a paediatric hospital setting, focusing predominantly on critical care areas, such as the Paediatric Intensive Care Unit (PICU), have led me to form an understanding of how culture becomes even more pronounced in such emotionally-sensitive contexts. In particular, the inherent sensitive nature of the PICU has exposed me to situations in which families experience the devastating loss of their child, through which I have been able to witness first-hand how the concept of culture interplays with grief and bereavement. In addition, I have also come to appreciate the nature of psychosocial care in the field of child life, as this type of care often naturally creates a space where cultural issues or beliefs come to the forefront. Even though I have become increasingly exposed to various culturally-diverse situations, I believe that the learning curve related to developing an understanding of cultural factors, is, in fact, never-ending.

Sample

The research sample consists of six female CLSs, working as either a Certified Child Life Specialist (CCLS) or Child Life Specialist (CLS). One participant identified herself as belonging to a member of a minority group. The five remaining participants identified themselves as Canadian.

All participants who requested to participate met the eligibility requirements. These were that participants work as either a Certified Child Life Specialist (CCLS) or Child Life Specialist (CLS). The primary difference between a CLS and CCLS lies in the certification status. The CCLS credential is an exclusive certification issued by the Child Life Council, which can be obtained after successfully completing a professional certification exam. Moreover, one's eligibility to complete the certification exam is based on academic requirements and a completed clinical internship. Practicing child life professionals who were hired before the CLC certification requirements currently practice as a CLS.

In terms of the sample size, Braun and Clarke (2013) categorized the size of the research projects as 'small' 'medium' or 'large'. They suggested that small, qualitative projects that revolve around capturing the *experiences* of participants ideally consist of 6 to 10 participants. I therefore became satisfied with six completed interviews, as this allowed me to ensure the sample size was small enough to manage the material, and large enough to provide a "richly textured understanding of experience" (Sandelowski, 1995, p. 183). In addition, my satisfaction with this number not only stemmed from adhering to Sandelowski's (1995) guidelines, but also by making a subjective judgement that was guided by my experience as a new researcher and the particular goals of the research.

Recruitment strategy. Considering my previous involvement as a child life intern at this particular hospital, participants were recruited by utilizing a third-party recruitment strategy. This method of recruitment was chosen as an ethical safeguard in order to mitigate the effects of the intern-employee relationship, as this might compromise the voluntary nature of the participants' decision to participate. Therefore,

the child life manager, as a neutral third party, initially contacted all potential participants by e-mail, on my behalf. This e-mail (see Appendix A) contained information on the study, as well as a recruitment poster (see Appendix B) with an overview of the objectives of the study, and associated benefits of participating. Participants were informed that the purpose of the study is to seek an understanding of their personal experiences in working with diversity in their professional practice, and, in particular, to hear about how they define the concept of culture and their experiences in applying it to practice. By participating, suggested benefits included being able to contribute to new research in the field of child life, as well as helping to fill a gap in literature that may influence future developments on culturally-responsive child life services.

All CLSs who were interested in participating subsequently contacted me by e-mail on a voluntary basis. Out of 7 interested participants, 6 participants completed an interview. One participant was not able to attend the in-person interview due to personal circumstances. I sent copies of the consent form (see Appendix C) and draft interview questions (see Appendix D) to the participants by e-mail. All participants signed the consent form in person prior to commencing the interviews.

As a final step of the recruitment process, interviews were conducted with participants at the hospital in which they worked, so as to minimize the degree of disruption experienced in their workday. The interviews took place in either a quiet, private and secluded area of the hospital in order to ensure optimal levels of privacy and minimize the influence of potential disruptions.

Data Collection

I used semi-structured interviews to collect data. The rationale for selecting this

method stems from its ability to produce detailed narratives and stories by posing open-ended questions (Whiting, 2008). In addition, semi-structured interviews are frequently utilized by researchers in healthcare contexts (Isaacs, 2014; Whiting, 2008). In line with the theoretical framework of social constructionism, the open-ended nature of interview questions led to an interview that was co-constructed by the interviewee and myself, as the interviewer. In addition, the open-ended questions, inherent to semi-structured interviews were used as a *guide* in order to obtain reports of experience from the perspectives of the research participants (Denzin & Lincoln, 1998). As noted by Burck (2005), utilizing pre-set questions as an informal guide ensured that particular areas were covered in addition to “[leaving] room to follow feedback idiosyncratically so as to explore more particular meanings with research participants” (Burck, 2005, p. 240). Examples of interview questions included; “How do you define your own culture?”, “How much importance do you pay to culture in your practice?”, or “Which types of skills or knowledge do you draw on to overcome such challenges?”

Conversations were audio-recorded and I took hand-written notes when points were raised that were of particular interest to me and/or touched upon points that were commonly discussed amongst participants. In most conversations, these notes also acted as useful sources of reference to probe participants to share additional information in more detail. Specific probing techniques, such as, “baiting” (i.e. interviewer giving the impression that she is aware of that information, prompting participant to explain further) (Whiting, 2008) and simple phrases such as “could you tell me more?” or “what do you mean by that?” acted as particularly helpful strategies to elicit more, in-depth information from participants. Each interview lasted between 20 minutes to 45 minutes.

Data Analysis

Data consisted of transcribed audio derived from the interviews, as well as handwritten notes taken during the interviews. Thematic analysis was utilized as a method of “identifying, analysing, and reporting patterns within data” (Braun & Clarke, 2006). Thematic analyses, which address a wide range of diverse understandings and experiences, have been widely used in psychology, healthcare research, social research and beyond (Fugard & Potts, 2015; Isaacs, 2014). Thematic analysis was chosen due to its *flexibility* and *compatibility* with the social constructionist paradigm (Braun & Clarke, 2006). The flexible nature of thematic analysis refers to its theoretical freedom, in terms of its compatibility to be applied across a range of theoretical approaches (Braun & Clarke, 2006). Within the social constructionist paradigm, repeated patterns of meaning across the data were considered as socially produced and reproduced within their sociocultural context (Braun & Clarke, 2006).

My analytical process was influenced by my broader theoretical assumptions, the pre-set research questions, and my personal experiences. However, an explicit attempt was made to create a disjuncture between these three elements, the coding process and data analysis (Braun & Clarke, 2006). The impetus for this disjuncture stems from the risk of using the research questions as ‘themes’ in the analysis, which has been considered as a major pitfall in thematic analyses (Braun & Clarke, 2006). In order to minimize the risk of labelling themes as research questions, the data was analysed in an inductive manner, in which the identified themes were strongly linked to the data themselves (Patton, 1990).

The analysis of the data followed a six-step process, as introduced by Braun and Clarke (2006). The first step pertained to familiarizing myself with the data by transcribing the audio files into written text. In this step, I paid attention to the verbal nuances present in participants' accounts, and therefore "identifying and describing both implicit and explicit ideas" (Guest, MacQueen, & Namey, 2012, p. 10). Once all audio files were transcribed, transcripts were read and re-read in order to create an overview of "where people are" (Briggs, 2002). The second step revolved around generating initial codes that captured interesting features of the data across the entire data set. Codes were handwritten on the margin of each transcript as short words or phrases. Next, step three pertained to collating codes into potential themes. I worked in an upward, inductive manner with the aim of identifying commonalities across the data. All codes were gathered and categorized into seven themes, each of which consisted of several sub-themes. Themes tended to emerge when answering the question, "What is this expression an example of?" (Ryan & Bernard, 2003, p. 87). In addition, in order to establish a guideline for developing themes, I followed Ryan and Bernard's (2003) suggestion of establishing at least two or three mentions of a particular code amongst the participants. Thus, repetition of particular accounts represented the way in which themes were recognized.

Step four subsequently involved reviewing these themes and sub-themes by ensuring each theme addressed a distinct commonality, and thus removing duplicate themes. As a result of comparing the themes to the coded extracts once more, five major themes remained. I established theoretical saturation by recognizing that no remaining accounts within the data added to the themes. Step five consisted of generating clear definitions and titles for each theme. Quotes were extracted from the data and included in

the titles for each theme, as well as several sub-themes. It was during this step that a thematic analysis map was created, in order to provide a clear overview of the obtained themes and sub-themes. Lastly, the final step pertained to producing the final analysis report. This report included a selection of vivid and compelling extract examples to support participants' accounts.

Ethical Considerations

This research study was conducted in accordance with the University of Victoria Human Research Ethics Board (HERB) requirements. Approval was granted prior to initiating the recruitment phase of the study. The participants, as well as the discipline lead of child life (third-party recruiter), were made aware of this ethical approval in writing in the consent form. Ethical considerations pertained to the areas of voluntary participation, confidentiality and risks.

Voluntary participation. Participants were informed in writing in the consent form that their participation or non-participation would not affect their current employment status at the healthcare institute in any manner. It was also explained that they could withdraw at any time, referring to before during or after the interview, and that refusal or withdrawal would have no negative consequences. Should they have refused or withdrawn from the study, participants were notified that all audiotapes and/or transcripts would be discarded and destroyed.

Confidentiality. In order to ensure an optimal level of confidentiality, participants were informed that their anonymity would be protected before, during and after their participation. This was achieved by removing as many identifying variables from the interview transcripts, and by referring to participants as participant One, Two,

Three, etc. However, the nature of this study's topic led participants to reveal personal information related to their ethnicity and/or culturally-related identifiers. Therefore, participants were made aware (in writing and verbally) of the possibility that sharing this information may make them identifiable within the data. This possibility was considered as relatively high due to the small size of the child life department in which the participants worked. It is for this reason that steps were taken to minimize additional identifying factors. These steps include excluding their status as a CLS or CCLS, as well as disguising the location of this study as a "children's hospital in Alberta" or "a leading Child Life service provider in Alberta". Participants were also told that should they be uncomfortable with the risk of being identified within the data, they could withdraw from the study at any time.

Lastly, confidentiality was also protected by informing participants that all data (i.e. audiotapes, transcripts) would be kept on the researcher's password-protected laptop. Hard copies of the transcripts and interview notes would also be stored in a locked cabinet at the researcher's home office. No participants expressed concern over confidentiality issues.

Risks. No known risks were identified for participation in this study. Due to this study's topic, it was deemed unlikely that participants would experience stress, emotional discomfort or fatigue during the interview. Even though no major risks were identified, I informed participants that I would aim to create a safe and supportive environment in order to minimize the potential influence of negative feelings or emotions.

Rigour

In order to discuss how rigour was maintained in this study, I adhered to four distinct criteria that have been explicitly offered for utilization in qualitative research. These categories, first introduced by Lincoln and Guba (1985), pertain to credibility, transferability, confirmability and dependability. Credibility refers to the fact that the results are credible from the perspective of the participants. Thus, I aimed to accurately reflect participants' accounts in the data by solely basing my findings on the accounts provided by participants and including detailed quotes in order to represent their truths accurately. Transferability pertains to the degree to which the results may be generalized to other contexts (Tobin & Bergley, 2004). However, I recognized that traditional perspectives of generalizability have typically been rejected in qualitative studies (Kirby, Greaves & Reid, 2006; Padgett, 2008). Therefore, I considered this exploratory inquiry as being centralized around individual subjective meaning (Creswell & Miller, 2000). In addition, I aimed to provide a rich and vigorous presentation of the findings with appropriate quotations, which has been suggested to enhance transferability (Graneheim & Lundman 2004). The concept of confirmability acknowledges that each researcher brings a unique perspective to their study, and therefore revolves around how the results could be confirmed by others. I ensured that the way in which the data was obtained and analysed were well documented and therefore transparent. Lastly, dependability pertains to whether others could obtain the same results twice. However, considering the context-dependent nature of many qualitative studies, it became necessary to specify that my research occurred in an ever-changing backdrop (Houghton, Casey, Shaw & Murphy, 2013). Similarly to the concept of confirmability, I aimed to ensure that the research

process was “logical, traceable and clearly documented” (Tobin & Bergley, 2003). In order to achieve this, reflexivity has been suggested to act as a key component. I therefore maintained a self-critical and transparent stance throughout all stages of the research process.

Lastly, I have found it useful to expand on the strategy of reflexivity, as literature has recognized it as a “pertinent and valuable strategy for improving qualitative research, and posits strategies to promote rigour” (Darawsheh, 2014, p. 560). Reflexivity, as a process of continuous and comprehensive self-reflection, allows researchers to generate greater awareness of their actions, feelings and perceptions (Anderson, 2008; Davies & Hughes, 2014). In turn, this has been suggested to improve the transparency of the researcher during *all* stages of the research process, from designing the study to disseminating the findings (Darawsheh, 2014). It is for these reasons that I chose to include reflexivity as a key component in all sections of this study, as a strategy to enhance the main criteria of rigour in qualitative research, namely, credibility, dependability, confirmability and transferability.

Limitations

A limitation of this study pertains to its small sample size. Related to the concept of transferability, the small sample indicates that the results of this study cannot be generalized to other contexts. Participants’ accounts are therefore not presented to represent the experiences of all CLSs, in Canada or elsewhere. It must also be noted that participants all identified as female and practiced in the field of child life for 10 years or more. Therefore, the accounts of others, such as male, new-hire CLSs, remain excluded. Recruiting participants from other leading child life service providers around Canada

would have increased the diversity and size of the research sample. However, this was not initiated due to the scope of this Master's-level research project.

Lastly, a limitation of the research process refers to the fact that I was the sole interviewer and researcher to interpret the data. I recognize that I was the sole individual to become immersed with the data, as I determined when the data were saturated and how the analysis of the data evolved. Rigour-enhancing strategies, such as member checking, were not employed. Member checking, whereby the data is presented to the participants in order to confirm the credibility and truthfulness of their accounts, has been considered as "the most crucial technique for establishing credibility" (Creswell & Miller, 2000, p. 127). However, time constraints (on behalf of the participants and I) and the self-funded nature of this study prevented me from involving other researchers or participants in the study.

Summary

This chapter describes the methodology of this study by first describing my positionality as a researcher, and the nature of the study's sample. Next, the recruitment, data collection and analysis processes are discussed. In addition, attention is devoted to ethical considerations pertinent to this study, including voluntary participation, confidentiality and risks. A section devoted to discussing limitations of this study concludes this chapter.

Chapter Four: Findings

This chapter presents the findings of a thematic analysis of six interviews conducted with CLSs (Child Life Specialists) working at a prominent children’s hospital in Alberta, Canada. Five prominent themes emerged from the data. Quotes derived from the participants’ accounts have been included in the titles of the themes and sub-themes, in order to capture the essence of their content. The first theme, entitled “*It’s Absolutely Everything*”—Defining Culture, expands on how CLSs defined the concept of culture, their personal cultures, as well as whether they utilize theoretical frameworks to support their definitions. The second theme, “*It Affects Everything*”—Considering Culture in Practice, addresses the ways in which CLSs address cultural issues in practice, why they believe it is important to consider them, as well as what may make it different for a CLSs to consider culture, rather than other healthcare professionals. The third theme is “*When Culture Just Gets in the Way*”—Challenges in Practice. This theme focuses on CLSs overall levels of comfort and specific challenges they have faced as a result of working with patients and families from diverse backgrounds. The fourth theme, titled “*Just go for it and try*”—Overcoming Challenges, expands on where CLSs may draw support from in order to overcome the challenges they face in practice. Lastly, the fifth theme, Future Considerations, presents an overview of the types of supports and resources CLSs would like to see in the future to improve their practice. Figure Two (displayed below) provides an initial, visual overview of the themes and sub-themes obtained from the thematic analysis. The five primary themes include; defining culture (with 4 sub-themes), considering culture (with 5 sub-themes), challenges (with 4 sub-themes), overcoming challenges (with 4 sub-themes), and future considerations (with 3 sub-themes).

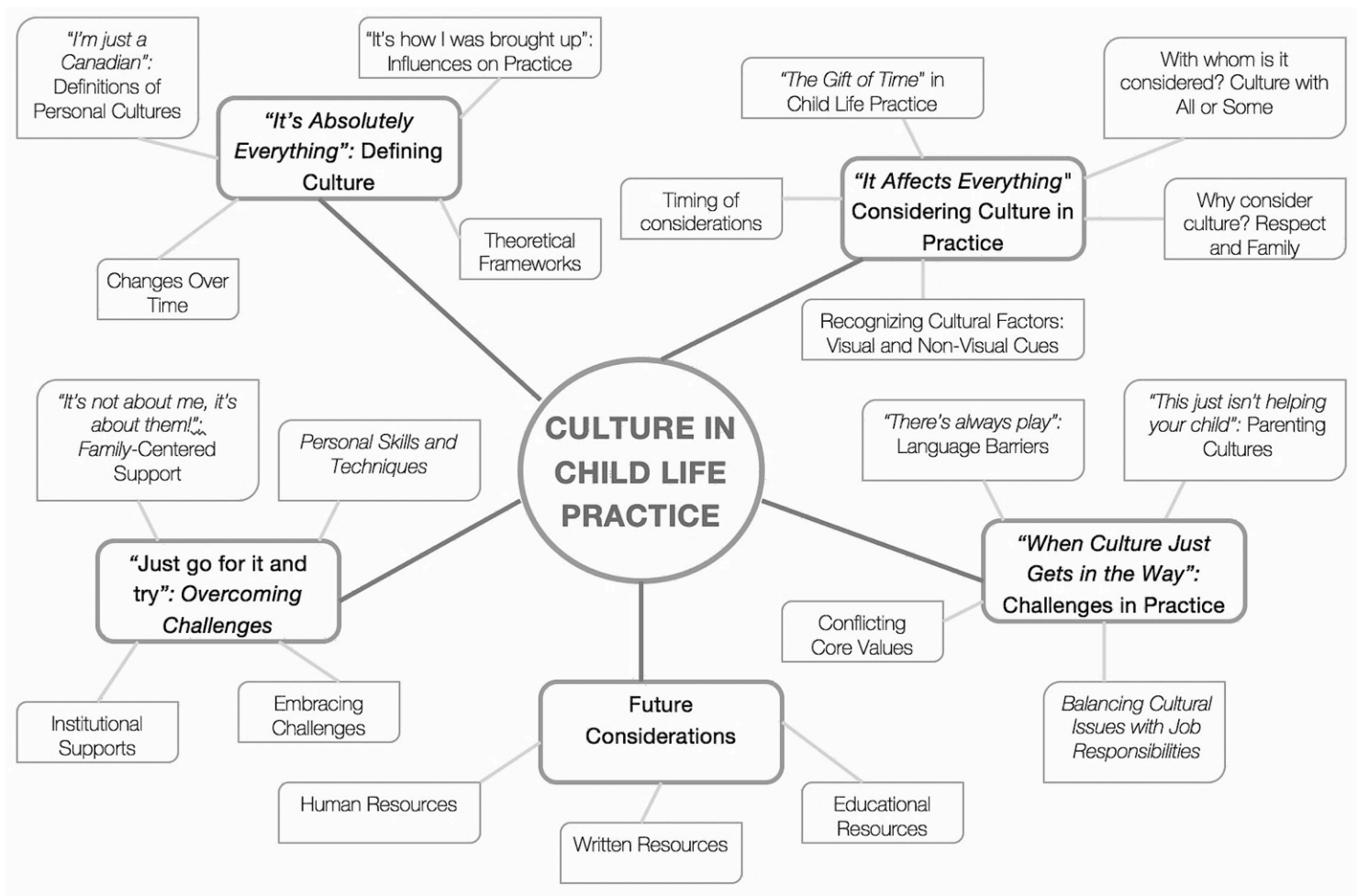


Figure Two. Thematic Analysis Overview.

Theme One: "It's Absolutely Everything"—Defining Culture

The excerpt "*It's Absolutely Everything*" captures the way in which all six participants defined the concept of culture in a broad manner. The broad nature of their definitions gave rise to four sub-themes, including how their definitions may have changed over time, definitions of their personal cultures, the influence their personal cultures may have on their practice, as well as whether they refer to theoretical frameworks pertaining to culture in their practice.

With regards to defining culture, it is noteworthy is that all six participants initially struggled to define the concept of culture to varying degrees. With time spent reflecting on the initial question; “*How would you define the concept of culture?*”, all participants considered the notion of *belief systems* as an integral component of culture. In addition, not only was the concept of culture considered broadly, it also became clear that the concept was associated with *groups*. For example, Participant One defined culture in a broad manner, namely, as an “*overall world view that shapes your beliefs and your actions... both professionally and personally*”. Participant Two associated the notion of culture with groups, by stating; “*Being aware of where people are from, their belief systems, their community and the things they sort of feel are important to their group. To me culture is a group thing*”.

Participant Four provided a detailed description on the broad nature of the concept and how it has changed over time;

To me, I think culture in 2016 culture is everything. It used to be so much more nationality, race, religion and it's still all of those things but looking at it finer than that. It's also looking at the belief systems that come from all of those different areas, the way you conduct yourself, the way you see other people, the way you live your life, what you wear, how you interact with people. Culture is just a real... it's a way of being.

This quote provides an example of how components such as nationality, race and religion may form part of one’s definition of culture. For Participant Four, these components included belief systems that ultimately shed light on people’s behaviours (i.e. “*the way you interact and conduct yourself*”) as well as information related to dress. In addition to

Participant Four, Participant One and Participant Five also referred to *religion* as forming an essential part of their definitions of culture.

Sub-Theme One: Changes over time. Not only were participants' definitions of culture broad in nature, five out of six participants also stated that these definitions have become broader over time. 'Time', in this sense, refers to the time spent practicing as a CLS, which ranged from 10 to 27 years. All participants touched upon the length of their practice as being responsible for changing their definitions of culture, which includes being exposed to an increasing amount of varying cultures. Participant One reflects on being more accepting and aware of different belief systems, as well as how these play a role in a hospital setting through the interplay between elements such as family, culture and hospital;

It's really broadened... I feel like I'm more accepting of so many different beliefs, not that I was unaccepting before, but I didn't understand the full scope of the belief systems and worldviews, as well as the interplay between family, culture and the hospital to this level... not that I was ignorant and didn't think it existed, I just didn't see it as big as I do now.

Participant Four and Six add that "personal opportunities in practice" and increasing exposure resulted in their broadened definitions of culture. For example, Participant Six stated;

I think 10 years ago in the field of healthcare it was fairly multicultural but now given 11 years after that, we're seeing a lot more immigrants come into Canada and a lot more families from multicultural backgrounds come into the hospital.

On the other hand, Participant Five stated that her definition of culture hasn't changed, but that exposure to different cultures in practice has increased, as “[my definition] has always been that way... it's always been included in my thinking but I've only gained more exposure to different cultures over the years”. Participant Four also expanded on the increasing multicultural nature of the hospital setting as influencing her definition;

I've always seen the many different pieces of the puzzle but I think even more now because I come into contact with so many different people who come from so many different cultures that I think you can't lump anybody into one.

Overall, participants' accounts reflect the notion that increasing exposure to multicultural patients and families in the hospital setting have *positively* influenced their definitions of culture, by an increasing *awareness* and *acceptance* of different ‘belief systems’.

Sub-Theme Two: “I’m just a Canadian” – Definitions of personal cultures.

Similarly to defining the concept of culture, all participants expressed difficulty in defining their own, personal cultures. Their accounts initially referred to broad constructs, mainly related to ethnicity, such as “well... I’m just a Canadian”, “I’m a Caucasian female” and “I feel like I kind of fit that stereotype of a Canadian”. Participant Three also referred to ethnic factors by stating; “I identify myself as an Ismaeli Muslim, so from East African descent or born in East Africa, I guess, which brings it's own culture”.

Noteworthy is that all definitions became narrower as they spent time reflecting on the question “How do you define your own culture?”. Personal cultures, therefore, did not become limited to ethnic factors, but also included elements such as “I guess I'd also think of things that are most important to me”, including religion, family and education, as well as personal characteristics. Participant One, who initially defined herself as a

“*Caucasian female living in Canada*”, further defined her culture as including “*a culture of acceptance, love and family*”. Similarly, Participant Six’s definition of her own culture shifted from “*being born and raised in a Christian family*”, to including personal characteristics such as “*being open minded, non-judgemental and seeing people for who they are... trying to be empathetic and see people in their own shoes and walks of life*”. However, it must be noted that Participant Five solely referred to her personal culture as “*just a North American of English descent*”, and did not include additional, more detailed elements in her definition.

Sub-Theme Three. “*It’s how I was brought up*” — Influences on practice.

Most participants stated that the aforementioned personal characteristics that formed part of their definitions of their own culture influenced their practice in some way, including an *awareness, acceptance and open-mindedness* towards different cultures. Participant One expressed that the “*I think the bigger picture is just an openness and an awareness of others that really plays into my practice... that it’s more about mindfulness and openness*”. Moreover, four participants referred to these characteristics as stemming from the way in which they were “*brought up*”. For example, Participant Two reflected on how her own culture influences her practice; “*Open-mindedness, acceptance and flexibility... that there’s not one way of thinking about things, is how I was brought up and help in my practice*”. Participants Three also referred to their upbringing by stating; “*I try to be more aware of other practices and to accept other cultures, that’s how I was brought up*”. Participant Four also attributed the characteristics of being “*friendly, easy-going and accepting*” as stemming from “*the culture of the family that I come from*”.

The characteristics of open-mindedness and an awareness of other people's beliefs and practices have been associated with overcoming difficult situations, such as disagreements, in practice. After reflecting on her upbringing, Participant Three stated that; *"I might not agree with different issues I see out there, but it's just about being tolerant and not being ignorant about it, and learning about other practices"*. Participant Six also reflected on the source of her own values and beliefs, and how she uses the characteristics of an awareness and keeping in check with her own values and beliefs in challenging situations in practice;

I was born and raised into a Western family in Victoria, born in Canada. So being where I came from and the things that were engrained into me as a young child... I think I bring that into my work on a daily basis, whether I realize it or not, whether it's conscious or unconscious, I always try to reflect on it the best I can too... to keep in check with my own values and beliefs and respecting others at the same time too, like I may not agree with a family decision but showing empathy and being open-minded and looking at things a different way I think is really important to do because my way isn't the same as someone else's.

In this way, the majority of participants' accounts reflected the fact that their definitions of their own culture, which primarily included the elements of open-mindedness, awareness and respect, influenced their daily practice. In turn, the source of this influence stemmed from their upbringing, in terms of how certain ideas such as *"respecting and helping other people"* become engrained in participants' way of thinking, and ultimately emerged in their professional practice.

Sub-Theme Four: Theoretical frameworks. In response to the question: “*In what way do theoretical frameworks related to culture play a role in your definition of culture?*”, it became clear that all participants did not refer to any type of theory or theoretical frameworks in their answers. Rather, most participants considered the ‘functional’, human elements, such as developing relationships and respecting others as most essential when interacting with patients and families from diverse backgrounds. For example, Participant Four reflected on such ‘human’ elements by sharing; “*Not a specific cultural framework, no. I think it’s just a human framework of respect, consideration and kindness*”. In addition, Participant One connected the importance of paying attention to ‘human’ elements, namely, developing relationships, to the importance of having a certain level of knowledge of the ‘functional’ aspect of cultures. In this regard, ‘functional’ referred to the content of cultures, such as cultural customs and beliefs, for example. She stated; “*There is no framework that jumps out. It’s more important to understand those functional pieces of cultures and to develop relationships. But you need the first to do the latter*”.

Theme Two: “*It Affects Everything*”—Considering Culture in Practice

In order to gain an insight into *how* and *why* participants paid attention to cultural issues in their practice, this theme addresses five sub-themes, including why it is important to consider culture, with whom cultural issues are considered, when cultural issues might be most prominent, how cultural factors are recognized, and which special types of considerations come into play in Child Life practice. The quote “*It affects everything*”, provided by Participant Four, reflects the collective finding that the participants considered culture because it plays a prominent role in people’s lives and in

their practice. It became clear that cultural considerations were valued highly, as all participants shared that they paid “a lot”, “quite a bit”, or a “very large amount” of importance to it.

Sub-Theme One: Why consider culture? Respect and family. Participants’ reasoning behind the importance of considering cultural issues in their practice included either the elements of *respect* or *family*. For example, Participant One, who was the only participant to include both elements in her answer, shared that;

It’s about the family culture... getting to know the individual but also the relationship between a parent and a child, [as well as] to respect patients and families and not to offend because it affects every interaction and opportunity for the child and the family. It impacts relationships so it’s best to meet the family where they’re at.

With regards to the notion of respect, Participant Two shared; “*I like the idea of treating people equally and with respect, and I want to offer the same types of services to all until I find out otherwise*”. Similarly, Participant Four highlighted the importance acting in a respectful manner by “*[being] a firm believer of looking people in the eye when you meet them, and to follow their lead, to make them feel safe and welcome*”.

On the other hand, Participants Two, Five and Six all highlighted the importance of *family* as their reasoning to pay importance to culture in practice, as illustrated by Participant Six; “*To find out more about the family unit or how they function as a family system is important and to find out about their values and beliefs*”, as well as Participant Two; “*Because it allows families to have a positive experience and to recognize their differing needs and beliefs*”.

Sub-Theme Two: With whom is it considered? Culture with all or some.

This theme expands on whether research participants consider culture with *all* their clients (i.e. pediatric patients and their families) or only selected groups. Four participants shared that they *wished* they considered culture with all patients and families, but solely consider with selected groups. For example, Participant Two stated; “*I’ll probably admit it would only be selected groups...I would like to say it’s all the same but it’s not...and not from any kind of discrimination*”, as well as Participant Three; “*You know I would like to say I did it with everyone but if I really think about it...I only do it with selected groups*”. In contrast, Participant One and Six both considered culture in their interactions with *all* individuals.

Sub-Theme Three: Recognizing cultural factors: Visual and non-visual

cues. As it was noted that some participants considered culture only with selected groups, this sub-theme addresses which factors the participants took into account when identifying culturally ‘different’ individuals. Four participants who shared they only considered culture with selected groups, all attributed this fact to making assumptions based on *visual* cues, including dress, their “visual socioeconomic status” and *non-visual* cues, including language or “*their accent*”. With regards to non-visual cues, participant Two reflected by noting; “*I think it seems a lot more pronounced with some over others, especially if there is a language barrier*”. In addition to paying importance to skin colour, Participant Three shared that; “*It’s about their language, if they speak a different language but also if they have an accent then you can kind of guess they come from a different country*”.

In terms of visual cues, Participant Three highlighted; “*Yes... I think it’s when it’s visible... like when it’s a minority and then you think about culture*”, as well as Participant Five; “*In all honesty it’s based on first appearance, it’s where we usually get our cues from when we’re first meeting a family, like when you’re meeting a Hutterite and it’s very obvious and have that visual cue immediately*”.

A noteworthy element that emerged from the data also pertained to finding it *easier* practice with patients and families who were identified as being culturally ‘similar’. Two participants shared that they found it easier to care for children and families who appeared culturally-similar to them, based on visual cues. For example, Participant Three noted that it is “*truthfully... probably easier when they are culturally-similar because I can identify with them because we’re from such a small group and we’re the same colour*”. Participant Six also described interactions with culturally-similar children and families as being easier, however, she attributed this to “*practicing the same beliefs and values*”, rather than visual cues. However, exceptions to this finding existed, as Participant Five described to experience “*no difference... because I take the approach of accepting people for who they are at face value*”. Similarly, Participant One also did not experience a difference in her ability to practice with culturally-similar clients, by stating; “*It’s the same for all... it’s not just about religion*”.

Sub-Theme Four: Timing of considerations. As many participants noted that they considered cultural factors before, during and after their interactions with diverse patients and families, the sub-theme of timing became a suitable factor to expand on. It was noted that participants paid particular attention to visual cues *before* their interactions with clients, whereas information related to non-visual factors emerged *during* the

interactions through *talking* to patients and families. Although Participant Four acknowledged she focused on visual cues before and during the initial stages of meeting a family, she expressed her concern with the dangers associated with making assumptions based on visual cues before meeting the patient and family. She highlighted;

I try not to let it be that initial reading a piece of paper... because if you meet the family it could be a totally different story. Maybe they're lacking phone etiquette, maybe they just got bad news about something else, who knows, right?

Participant One subsequently expanded on both visual and non-visual cues by stating;

Before you meet them you might speak to a nurse or other professionals... and you have to be careful that you're not just getting some subjective or objective information on their interaction with the family... and then I think some of the visual things will come out when you meet them, like if the family is Muslim or if there is a carpet on the east side of the room and the specific dress, but it is through talking with them on how those practices look in the day to day life and the expectations of the family and the child".

Moreover, Participant Three noted that non-visual cues emerge during conversation; *"If you're talking to them you get to know things about where they're from, like if they say that they're from Italy"*. Noteworthy is that the concepts of *grief* and *bereavement* became highlighted as providing participants with valuable information on a family's culture, as noted by Participant Two; *"[and] then the child passes and you suddenly realize all the cultural norms of the family that you had no idea of, just because it never came up before"*.

Sub-Theme Five. “The gift of time” in Child Life practice. It became apparent that the psychosocial nature of child life practice led participants to state that their experience in working with cultural factors in practice might be ‘different’ from that of other healthcare professionals. The quote “[b]ecause we have the gift of time”, shared by Participant Two, reflected the unique nature of Child Life practice, as she stated;

We really have the gift of time in our practice, where we can get to know our patients, and we have the advantage of changing it around, like we’re not stuck on something and we can change and adapt our practice according to their psychosocial needs.

In addition, Participant One considered the ‘special’ ability of “*viewing the child as a whole, where we don’t just have a medical or a curative focus*” to be conducive to recognizing cultural factors. The remaining participants stated that the nature of Child Life practice, which focuses on “*providing comfort, familiarity and normalization in a creative way*”, facilitates their ability to receive information from families related to culture. However, it must be noted that three participants expressed that an awareness of cultural factors is an aspect they wished *all* healthcare professionals would possess. For example, participant Four expressed her concern by stating; “*That [cultural] awareness and taking all those considerations is something every healthcare professional should have*”, as well as Participant Five, who noted; “*Hopefully it’s all the same... that everyone has that sensitivity and awareness*”.

Theme Three: “When Culture Just Gets in the Way”—Challenges in Practice

The third theme focuses on the challenges the CLSs have experienced in their practice. In terms of the research participants’ overall level of comfort in working with

diverse patients and families, it was noted that participants generally felt “pretty comfortable” or “for the most part comfortable”. The primary area in which the participant practiced, however, did give rise to additional challenges that were specific to those areas only. For example, a participant working in an outpatient setting discussed the additional challenge of being dependent on holding conversations over the phone, rather than in person. Additionally, a participant working in a palliative and respite care setting brought up the challenges related to working in a setting that is heavily influenced by the concepts of death, bereavement and grief. Despite the challenges inherent to specific practice domains, three sub-themes representing the main challenges experienced include language barriers, the parenting culture, and balancing cultural issues with job responsibilities.

Sub-Theme One: “*There’s always play*” – Language barriers.

Five out of six participants considered language barriers as the “biggest cultural barrier”. However, these participants also included the notion of using *play* as a means to minimize the negative effects language barriers may have on their practice. For example, Participant Four associated the concept of play with language barriers by stating; “*Language barriers are the most difficult, but play is such a universal language, which is so helpful in our role*”. Similarly, Participant Five stated; “*When English isn’t the first language, but play is so universal, you don’t necessarily have to speak the same language to play well... so you should be able to adapt and engage a child regardless of language*”.

Participant Three also referred to utilizing play when language barriers were present, as she mentioned; “*Our job is to focus so much on the child, so even with*

language barriers, you can still play because relationship building doesn't need words".

This participant also considered the use of hand gestures and similar skin colours as alternative, comforting methods of communicating when language barriers are present.

She stated;

I don't know why it works, but it just does... there was a patient who spoke very broken English and I went in and we couldn't communicate, and when I used more hand gestures, we managed. And then the doctor told me she seems to understand you better than me. So even though we weren't able to use the same words, the hand gestures and the fact that we were both brown were more of a comfort thing.

Sub-Theme Two. "This just isn't helping your child"—Parenting cultures.

Participants referred to the challenge of "dealing with" various parenting cultures as including the elements of family dynamics, parenting choices, as well as authoritative and dominant figures within families. Participant Four considered a parenting culture to be;

[A] part of culture in terms of what's acceptable, what's not, how a child can act, when and where a parent intervenes and when a child has freedom. I do struggle with that because it can interfere with the success of our goals... and you know if our goal is to support a child in being compliant, that part of culture can really interfere with that.

Participant Two also expanded on the difficulties encountered by parenting cultures, by stating: "As a CLS, parenting culture or choices can be very difficult, and that's a whole ethical thing. Some parents can make it so difficult... and for me personally, it's not so much the parenting, it's more the belief system". Furthermore, this participant also

expanded on the challenge of dominant figures within certain parenting cultures, as she mentioned;

Sometimes in cultures there are very dominant persons that tend to be male, where the culture really seems to indicate that the male or dad has all of the power and the mom is sort of the one doing all the caretaking, and then I can get a little angry and frustrated if it seems to be kind of hitting your head against a wall like you know what... this just isn't helping your child, because that culture is just getting in the way of what needs to happen with that child. [And] sometimes you think, this isn't about the child, this cultural belief system that you're making so important here, bring that in later, when they're all better.

Sub-Theme Three: Conflicting core values. Closely linked to the previous sub-theme, several participants considered “*extreme cases*”, which “*go against your core values*” to represent a significant challenge in practice, and also related this particular challenge to cultural beliefs on the role of medicine. Participant Two stated;

I think if it's an extreme cultural difference I think that can be challenging especially if you make a judgement on it. Like if its something that goes against your core values you know. Say you were a healthcare professional that knew that a child needed a blood transfusion and [the family] came from a culture that doesn't agree with it and it was a lifesaving thing I think those kinds of things of very difficult and that's a whole ethical thing.

Similarly, Participant Three linked the challenge of ‘accepting’ certain beliefs on the role of medicine; “*Belief systems are challenging, as far as what they believe with the role of*

medicine and not necessarily agreeing with some of their beliefs and to be able to accept that the way it is, I think that's probably the hardest".

Participant Four also considered an interference with respect to be challenging in her practice, as she stated;

It's one thing to struggle with a language barrier, that can be tough, but there are options for that, like Google translate... [but] the real challenge to me is when there's an interference with respect. I think that's my biggest issue, because as much as cultures are accepted, when you're within, I mean that clinical culture, there are acceptable and unacceptable behaviours. And bottom line for any culture, acceptable behaviour for me is doing onto others, you treat people the way you want to be treated and you cant tell me you want to be degraded or abused or you know what I mean, so any culture that's saying well I'd be OK if you would do that to me, really?

Sub-Theme Four: Balancing culture with job responsibilities. In addition to experiencing the challenge of cultural beliefs and practices going against 'core' values, several participants also experienced difficulty in finding a balance between 'valuing' a family's culture and being able to perform their job professionally. For example, Participant Two provided a particular example from her practice where she struggled to accommodate what the family's culture seemed to be 'demanding';

[The] dad wasn't there and mom kept handing me the phone to talk to the dad because he wasn't happy with the information I was giving and I said I am absolutely unwilling to talk to you over the phone because I really really didn't feel like that was an appropriate role for me. [I] really wanted to make sure that this little boy felt comfortable in this environment and knew exactly what to

expect but you know I just wasn't willing to change what I was doing for him just for this man on the phone. I decided I needed to focus on what was happening here so maybe I was ignoring their culture a little bit because I don't know how helpful that was for the mom but it just didn't feel like I could value everything their culture seemed to be demanding at the same time as doing my job professionally, not just with him but also the other children of the family that were there too.

Participant One also found supporting a family whilst supporting other families at the same time to be challenging. She provided an example from her practice;

We had a family who stayed here in the hospice who once the child died they came from a culture where you wail and you demonstrate grief by wailing, it's a documented part of the culture and so the mother was literally in the hallway with this visceral wail and so my heart broke for her but I was also hugely cognizant of the impact that had on the other families and children so I think that was one aspect where I found the cultural piece challenging because you want to support and respect her but at the same time it's actually having a negative impact on others, so how do you balance both and respect that with confidentiality... [that] was a challenge because you're just trying to manage so many pieces at once while still being respectful that she has just gone through the worst loss in her life. So how can you support her in the moment while supporting others?

Theme Four: “Just go for it and try”—Overcoming Challenges.

This theme provides an overview of participants’ accounts on how they overcame cultural challenges they faced in practice. In particular, four sub-themes will focus on personal skills and techniques, family-focused support, and institutional supports that helped participants in their practice. The fourth sub-theme will expand on how participants embraced challenges in their practice.

Sub-Theme One: Personal skills and techniques. All participants referred to the act of *asking questions* as helping them in overcoming cultural challenges in their practice. For example, Participant Six mentioned she “[tends] to ask a lot of questions about cultural beliefs and values in the patients and families that I work with as best as I can, so if I don’t know the answer, I’d seek it out”. Participant Five referred to the skill of “*playing dumb in a sense*” as helping her to gain more information about a family’s culture. In addition, demonstrating *acceptance, awareness and openness* were included in all participants’ accounts, as well as the skill of being *flexible* and *adaptable* as a CLS. In terms of these latter skills, Participant Two stated;

I mean regardless of what the reason is, language or behaviours or special needs or whatever, we have to be flexible and adaptable in everything we do. So sometimes you have to ask different questions and you have to find ways to follow different paths and sometimes it’s trial and error but I think I’m more willing to make those attempts and assess whether it’s working or not.

Participant Five also considered the concept of *adaptability* as a CLS by stating; “*I just adapt everything to the needs of the child, I guess it’s just so innate now, that it’s not in the forefront anymore*”. Two participants also believed that *acknowledging individuality*

acted as an essential skill in order to most effectively support diverse patients and families.

Lastly, Participants referred to their professional experience and thus, exposure to different cultures as benefitting their ability to support culturally diverse patients and families. For example, Participant Four expressed that *time* allowed her to learn and develop skills to “*read people and read a situation and the confidence that comes with that*”. She also noted that this has “*come over the 10 years... so now I’m just willing to kind of go for it and try*”. Similarly, Participant Two attributed her 25 years in practice, and exposure to “*diverse communities*” to being able to “*gain a true respect and need to honour people’s cultures*”.

Sub-Theme Two: “*It’s not about me, it’s about them!*”: Family-centered support. This sub-theme emerged as a result of participants collectively considering the importance of creating a positive experience for *families* when reflecting on how CLSs overcome challenges in their practice. The quote “*it’s not about me, it’s about them*”, provided by Participant Two, therefore captures the essence of this sub-theme. As such, it became clear that all participants worked from a strengths-based, family-centered perspective, as evidenced by Participant Three, who stated;

At the end of the day I don’t really think we need to compare ourselves, because we draw on strengths that we need to address for the child. I just think what is going to make the best experience for the families I work with?

Participant Two also continuously considered the needs of the family in her answers.

Quite often here we can’t solve all problems, and we can’t change everything but I am finding families just need to be heard. If they feel like everything is

going sideways, and you're listening and you're trying your best to accommodate them, even if it still doesn't work, they are so appreciative that you went through the effort, that you listened, and tried, and made little adjustments and it might just have changed something only a little bit but they're happy. Those are the skills I think I draw on at this stage in my career, but I would guess early on in my career I wouldn't have known how to do that.

Similarly, Participant Five reflected on overcoming challenges in practice by focusing on the needs of the families;

I just use more of a sensitivity. I'm not going to treat their child or family differently, but it's just about being sensitive to the differences so that I'm not offending families in what I am saying or doing... [because] ultimately, belief systems can influence how they're going to interact with us and how comfortable those parents are going to be within our setting, so you have to approach them very carefully and gently and let it empower them, to say this is your baby, your child and let them know they have a voice.

Lastly, Participant Two considered the importance of creating a “*space or environment that is more positive, warm and a little more appealing to the families*” as being essential in overcoming cultural difficulties in practice.

Sub-Theme Three: Institutional supports. In terms of utilizing supports provided by the institution (i.e. hospital) in which the participants worked, participants' accounts revealed that these types of supports are generally not used on a frequent basis. For example, participants did not actively draw upon the support provided by from training opportunities and workshops. Rather, one participant stated to have taken “a

couple of those diversity courses a while ago". Moreover, participants generally considered colleague-to-colleague discussions on cultural issues as arising on a situational, individual basis only, and therefore did not act as a significant resource from which participants drew support. For example, Participant Five solely discussed a cultural issue "*when it comes up and when it's an issue*". Participant Six considered discussions with colleagues to occur only "*on an individual basis rather than a group discussion*". Translating services provided by the *language line* were also deemed useful by Participant Four and Six only. These participants utilized the language line "*a couple of times*", whereas the remaining four participants expressed not to have used this service "*at all*". These four participants also touched upon the issue of not "*having the need to use translator services, because I'm not giving medical information*". As such, the need for translation services were generally deemed as useful only in cases where healthcare professionals provide families with *medical* information.

When considering how participants *do* draw support from the institution, the majority of participants believed the services provided by the *Aboriginal Liaison* to be particularly helpful in their practice. Participant Six stated;

I know we've had an influx of First Nations patients in the hospital so if there's something that I may not know or if a patient or family has asked a question specifically to their culture, then I would just call her.

Additionally, two participants stated to drawing on information on cultural conceptualizations of death and dying through collecting quick guides and pamphlets provided by the institution. For example, Participant Two stated; "*We got one of those*

pamphlets a long time ago... It doesn't mean that I sometimes don't still question it, but I have more of an awareness of it".

Sub-Theme Four: Embracing challenges. Although participants identified specific challenges in their practice, it became noteworthy that participants embraced these challenges in their practice. For example, participants referred to challenges as “*a nice challenge to rise to*”, “*[they] give me a chance to learn new things*” or “*what people can draw from religion just boggles my mind, I love that*”. Participant Two referred to cultural ‘differences’ in practice as; “*[something] really unique that I hadn't heard of before*”. Lastly, Participant Four believed cultural differences to be ‘empowering’, by stating; “*It's empowering too, because I don't know much about their background, where they're from. And as much as I don't like to lump things together, that often is a starting point for me*”.

Theme Five: Future Considerations.

The final theme provides an overview of the types of supports the research participants would like to have included in their practice in the future. These supports have been divided into sub-themes, categorized as human, written and educational resources. Generally, participants expressed the need for a *diversity coordinator*, additional *pamphlets* in various languages, and *applicable educational opportunities* in the form of workshops.

Sub-Theme One: Human Resources. Five out of six participants believed the services provided by a *diversity coordinator* would benefit their practice. Participants expressed a need for a re-introduction of the services provided by this coordinator, as her position had been removed from the particular hospital in which participants practiced.

For example, Participant One stated; “*We used to have a diversity coordinator, but her job was cut, so I think that speaks to the culture of culture*”. Similarly, Participant Four mentioned;

One thing I feel that is a real void in this area is that we used to have a diversity coordinator, it was phenomenal and I went to her to ask her about cultural things, as a sort of general, like is their diagnosis of epilepsy considered a gift or a special power?

Participant Six also expressed her interest in the re-introduction of services provided by a diversity coordinator; “*She used to talk to us specifically about diversity and various cultures, so that was super helpful*”.

Sub-Theme Two: Written Resources. The written resources that participants wished to see in the future included quick, go-to guides on various cultural beliefs, as well as pamphlets and brochures on child life services, translated into different primary languages. Participant Two also added the need for more medical preparation books, such as OR-prep books, perhaps in different languages. When referring to the need for more brochures and pamphlets on child life services, Participant Six stated;

What I'd really love to see is the child life brochure, so on the brochure it talks about who child life is in the hospital, what we do and what we offer for families, and then it talks about the various group programs in the hospital, and the one to one medical play and therapeutic support and also the distraction and diversion for families. So that's all in English and it would be great to actually see that in different languages even the primary languages that we see more and

more of, Spanish, Cantonese, and I know there's different dialects within Chinese, and French.

Noteworthy is that several participants considered the challenges inherent to creating additional written resources. For example, Participant One expressed the importance of combining both written and human resources, by stating; *“You can read a pre-prescribed note on something but you can't ask questions to it. So I think that is why it's really important to have both”*. The difficulty of covering “all” cultures also became a prominent issue within this sub-theme. Participant Two reflected on this by stating;

Do we need more of that? Yes. I think there's a lot out there and it's hard to develop those materials to address everything because we've all sort of tried but... yeah... absolutely I think we need to keep working on it, absolutely, making it more and more available to people and figuring out how we can give information to people especially from other cultures or different language and the really really different cultures that are coming in like refugees and supporting those kinds of families and making sure that there is something and a place for them to get the information and that isn't all in English.

Participant Five expressed the importance of *“keeping [the guides] current”*, whilst acknowledging the difficulty in *“having something massive enough to cover everything, it would almost be too much or not detailed enough for your zone”*. In order to “manage” this issue, Participant Four suggested that CLSs;

Look at those general, larger populations, and looking at the races, ethnic cultures and countries where people come from as sort of a general, and then

find ways to do something that's manageable, to try to have some sort of understanding of it while still being culturally sensitive.

Sub-Theme Three: Educational Resources. The final sub-theme addresses which types of educational resources the participants deemed to be beneficial in their future practice. Participants generally did not pay a high level of importance to educational workshops/sessions provided by the institution. Most participants took part in these workshops as a “*one time thing*” during the initial stages of their practice. Participant Three subsequently added; “*It's only been a one time thing and I don't know if they're still offering them because I haven't been looking for them*”. In terms of the content of the workshop Participant Three attended, she stated; “*Don't ask me what I remember from it, because I don't. You kind of think it's really common sense, but sometimes it's good to hear right?*” Participants subsequently mentioned that they would be interested in partaking in more workshops on cultural diversity solely if they were *applicable* to their specific area of practice within the field of child life.

In addition, several other participants expressed a desire for more educational opportunities, such as grand rounds or paediatric rounds focusing on cultural diversity. Similarly, Participant Six expressed a particular interest in attending more *lunch and learn* sessions focusing on diversity, delivered by the institution.

Lastly, two participants raised the importance of including cultural diversity in undergraduate and graduate curricula for future child life students. For example, Participant Two stated; “*I am not sure exactly what CLSs do in their education anymore, but I would imagine that adding cultural competency to the curriculum would be extremely important. That should happen early on in the school system*”.

Summary

Defining the concept of culture and one's own culture influenced participants' practice in varying ways. In particular, the way in which participants were brought up acted as a significant element that was brought into their practice on a daily basis. Within participants' definitions of culture, it became clear that participants did not refer to specific theoretical frameworks to support their practice. In terms of considering how and why the participants considered culture in their practice, commonalities such as distinguishing between visual and non-visual cues and considering culture with selected groups versus all individuals, became prominent sub-themes. Noteworthy is that participants also reflected on the "unique" nature of child life practice. This sub-theme gave rise to several factors, such as flexibility, which influenced the way in which the participants worked with diversity. Although participants highlighted several challenges they experienced in practice, participants embraced these challenges as positive opportunities to learn more about specific cultures. Lastly, participants reflected on which types of resources they would like to see in the future and distinguished between human, written and educational resources. It must be noted, however, that participants considered the honing of personal and 'functional' skills such as relationship building, as well as being flexible and adaptable, as being particularly important in *combination* with utilizing resources such as pamphlets.

Chapter Five: Discussion

The aims of this chapter are to: a) discuss the research findings as they relate to existing literature discussed in chapter two; b) offer recommendations for future research and practice; and c) provide concluding remarks. This thesis contends that CLSs who participated in this study generally perceived *culture*, as a broad concept not limited to ethnicity, in a prominent, positive manner by embracing its challenges and associating it with valuable opportunities for learning throughout all stages of child life interventions. Interwoven throughout these predominant findings are a clear commitment to family-centered care and the unique nature of child life practice that often brings cultural factors to the forefront.

Relating Findings to Existing Literature

This section will be divided into sub-sections according to the five themes derived from the thematic analysis in Chapter Four. The themes to be discussed in this section include defining and considering culture, identifying and overcoming challenges, as well as future resources.

Defining culture. Exploring CLSs' conceptualizations of *culture* and *personal culture(s)* remains an imperative area of consideration, as child life literature lacks proper critical examination of the meanings of "culture", even though cultural competence remains an essential 'skill' that is expected to be practiced among CLSs. Yan and Wong (2005) contend that examining how frontline healthcare practitioners define such important, yet often taken-for-granted concepts, is required in order to successfully link theory to practice. Participants in this study defined both the concept of *culture*, as well as their *personal culture(s)* as broad concepts that are not limited to factors associated solely

with ethnicity. Rather, their definitions of culture included characteristics such as nationality, race, religion, belief systems, and one's "way of being" that were consistently associated with *groups* in both their personal and professional lives. In a similar manner, participants' definitions of their own cultures also encompassed other elements, including family, religion, education and personal characteristics. These collective, broad definitions are consistent with the initial definition of culture this study adopted, namely, the "morals, beliefs, attitudes and standards that derive from a particular cultural group" (Papps & Ramdsen, 1996, p. 493). As such, it became clear that participants conceptualized culture in a similar manner to De and Richardson (2008), namely, as a construct that helps individuals identify the group to which they belong and their core beliefs, including religious beliefs and fundamental values. In addition, their broad conceptualizations align with the way in which the guiding framework of cultural safety considers factors such as race, behaviours and class in its definition of culture.

When relating participants' definitions of culture to existing literature, CLSs placed particular emphasis on the fact that the definitions of their personal cultures evolved as a direct result of *time* in practice. As a result of time, and thus, an increase in exposure to diverse cultures in their practice, the majority of participants attributed their time in practice to their ability to develop traits such as being *accepting* and *aware* of individuals from diverse cultures. Considering that participants also incorporated sociocultural factors such as language, race, nationality and ethnicity into their definitions of culture, participants were therefore able to move away from definitions of culture that characterize it as a static entity that is not influenced by such sociocultural factors or time (Dean, 2001; Whiting, 1999). However, as brought forward by Dean (2001), an inherent

challenge to considering culture as being capable of changing over time becomes the question of how one can become “competent” at something (i.e. cultural safety) that is continually changing. Although this question raises a theoretical issue that is beyond the scope of this study, it may offer a starting point for future research to further examine how CLSs perceive this issue.

Theoretical frameworks. Inherent to the importance of linking theory to practice, as highlighted by Yan (2008), an unexpected finding pertains to the absence of theoretical constructs or frameworks (e.g. cultural competence or cultural safety) in CLSs’ definitions of culture. Rather than adhering to theoretical frameworks, participants expressed a preference to combine “human” (e.g. developing relationships) with “functional” elements (i.e. knowledge of cultural customs and beliefs) in their practice with diverse families. It can then be questioned how theory can be integrated into child life practice, when such theory, is, in fact, absent from CLSs’ conceptualizations of culture. Although the theoretical framework of cultural competence is most frequently used in child life literature (Thompson, 2009), its exclusion from participants’ conceptualizations of culture can suggest participants referred to theory in isolation from CLSs’ everyday, “real” practice (Doane & Varcoe, 2005). However, Doane and Varcoe (2005) stress the significance of theory in practice. They suggest that theory has the capability to affect everyday practice and decision-making, thereby “reshaping” everyday moments. In turn, practice experiences also play an integral role in the ongoing development of theory.

The theory/practice dichotomy has been widely documented in other domains, such as nursing (Hatlevik, 2011). In professional education contexts, this dichotomy has been

extended to include an idea, rooted in Greek philosophy, of a moral disposition to act truly or rightly, which requires an understanding of “other people” (Kinsella & Pitman, 2012). This notion has been referred to as *praxis*, and has been explored by many in a variety of professional disciplines. For example, fields include education (Nelson, Polan, Murray & Maticka-Tyndale, 2004), social work (Tarlier, 2005) and CYC (White, 2007). As noted by White (2007), *praxis* refers to the integration of theory and practice by incorporating the added element of “action-oriented self-understanding” (p. 226), or reflexivity (Dutta, 2010). In this manner, in many fields of professional education, the aim has become to embody *praxis*, as a concept that:

[i]nvolves the knowledge that comes to life in the *doing* of practice, the *craft* of practice, and is embodied in the relationship of the practitioner to the practice, and to others involved in and affected by the practice... [as] a kind of *personal* knowledge (Kinsella & Pitman, 2012, p. 147).

In a similar manner, White (2007) has referred to the concept of *praxis* as involving “knowing, doing and being”. This notion holds important implications for future child life education. It can therefore be suggested that the effective integration of *praxis* into educational curricula requires the encouragement of a reflective attitude within the student, as a means of understanding professional knowledge as stemming from both theory and practice (Ekebergh, Lepp & Dahlberg, 2004).

Considering culture. In terms of gaining insight into *why* and *how* CLSs consider cultural factors, results suggested that participants attribute a significant amount of importance to this concept in their practice. The finding that cultural considerations

took place during all stages of their interactions with children and families (i.e. before, during and after) signifies the prominent role that culture plays in their work. The primary impetus for CLSs' to consider culture pertains to *respecting the family*, in order to make them feel safe and comfortable. Similar findings have been obtained by studies conducted by Butterly (2009) and Belisario (2014), whom examined cultural influences in the child life field from the perspective of CLSs. Butterly's (2009) study highlighted how seven CLSs, practicing in Ontario, Canada, held a strong desire to fully understand the impact of environmental influences, such as one's culture, on patients and families. In a study conducted on a larger scale, Belisario (2014) compiled results of a questionnaire distributed to 109 CLSs across North America. Similar to findings obtained in the current study, her findings suggested that CLSs considered cultural competence as an important element in their practice, and are actively involved in promoting effective, respectful and compassionate support to patients and families.

Recognizing cultural 'differences'. Having established *why* CLSs placed high importance on considering cultural issues in practice, findings also provided insight into *how* participants considered these issues. In particular, a distinction could be made between CLSs relying on visual cues (i.e. dress) *before* interacting with patients and families, and relying on non-visual (i.e. language, accent) cues *during* their interactions. Butterly's (2008) findings suggested that CLSs used a similar method, namely, 'observing through visual scanning' as a preferred method to acquire information about children and families' culture. In the current study, five out of six CLSs also stated to consider cultural factors *only* with selected groups, although they *wished* they would consider cultural factors within *all* interactions with patients and families. The basis for

categorizing individuals into groups predominantly stemmed from distinguishing between visual characteristics (i.e. dress, skin colour, socioeconomic status) and non-visual characteristics (i.e. language and accent). In this manner, several participants relied on such visual or non-visual cues in order to form, albeit unintentional, assumptions on a family's culture, which further guided their interactions with a given family.

Awareness of categorizing. Several participants perceived practice to be “easier” when one's own cultural appearance is similar to that of the patient. Although these participants also expressed their concern with solely relying on visual or non-visual cues in making “assumptions” about people, the risks associated with categorizing individuals into *groups* according to specific cultural elements, such as language or dress, can be related back to prominent literature. Risks include perpetuating stereotypes by strengthening the boundaries between cultural ‘groups’ (Banks & Banks, 2010; Kirova, 2008), as well as construing the cultural “Other” as a result of culturalist discourses (Browne & Varcoe, 2006). However, it must be noted that participants appeared to hold a high level of awareness of the importance of acknowledging individuality, by sharing reflective thoughts such as; “[I] don't like to lump things together”, and “I have come into so many different people from so many different cultures that I think you can't lump anybody into one”, for example. This level of self-awareness has been deemed as critical to separate one's self from “cultural baggage” in practice (Dean, 2001). As suggested by Dean (2001), by keeping an awareness of one's own thoughts and biases in the forefront of consciousness, it becomes more likely that its impact on practice becomes limited.

It can therefore be suggested that current findings highlighted participants' (unintentional) perpetuation of stereotypes as a result of categorizing individuals into

cultural ‘groups’. Although participants demonstrated a high level of awareness of the risks associated with categorizing, the negative consequences of an inattention to this issue are wide-ranging. For example, in an American national study, Abdou, Fingerhut, Jackson and Wheaton (2016) demonstrated that stereotypes in healthcare environments can lead to poorer health outcomes (i.e. increased likelihood of hypertension and depression) in individuals being judged by negative stereotypes including race, gender and social class. Thus, considering the effects of practicing in a culturally-unsafe manner, further exploration that focuses on healthcare professionals’ recognitions of how ethnic stereotyping exists and its capability of affecting healthcare interventions is warranted. However, it must be noted that investigating this topic may be difficult to operationalize, as Nelson (2002) suggests that the act of stereotyping is automatically triggered and operates below the level of conscious awareness, and “is intensified by time pressure and complex cognitive tasks - the very hallmarks of much clinical practice” (p. 442). Therefore, further studies focusing solely on the issue of stereotyping in child life practice could bring such subconscious issues to the forefront.

Unique nature of child life practice. An additional finding of this study pertains to the unique nature of child life practice facilitating the consideration of cultural issues amongst the participants. This finding is unique in nature as it has not been obtained in studies elsewhere. Although participants expressed that they wished *all* healthcare professionals should possess a level of cultural awareness in their practice, the *gift of time* in child life practice differentiated the ability of CLSs to work with cultural factors from that of other healthcare professionals. In particular, CLSs shared that they have the advantage of “really getting to know patients”, “changing things around”, “being

flexible” and not having “just a medical or curative focus”. It can therefore be suggested that participants perceived the psychosocial nature of child life practice to increase their exposure to cultural factors in practice when compared to other healthcare professionals that solely adopt a curative focus, for example. In turn, this unique, psychosocial nature allows CLSs to develop an individualized plan for each patient that is based on factors such as developmental level, family support, age, mobility, as well as culture and language (Warren & Lynch, 2008).

Challenges in practice. Participants encountered several challenges that stemmed from cultural issues in their practice. These challenges include language, parenting cultures, conflicting core values and balance with job responsibilities. However, the way in which these challenges presented themselves depended on the specific area in which the CLS practiced. For example, a CLS practicing primarily in an outpatient setting relied heavily on conducting conversations over the telephone. Therefore, language barriers acted as a more prominent challenge to this CLS, when compared to CLSs practicing in other settings. Despite individual differences in the challenges experienced, language barriers acted as the most prominent challenge experienced by all participants. This finding was also obtained by Belisario (2014), and as a significant challenge in findings obtained by Butterly (2009). However, as participants in the current study ameliorated the severity of this challenge by stating that “there’s always play”, as “you don’t need words to play”. As a result, the practicality and prominence of the central tenet of child life practice, namely, play, becomes highlighted.

As an implication for child life practice, it becomes clear that in order to best support CLSs in providing optimal, culturally-safe care, attention must be paid to the

element of individuality. As different areas of child life practice give rise to different challenges resulting from cultural factors, it must be recognized that there may not be one single approach or resource that may ameliorate the effects of a given challenge. Rather, it can be suggested that CLSs may depend on utilizing a combination of resources or strategies. Nevertheless, the finding that *language barriers* acted as a particularly prominent challenge offers a promising avenue for future research to focus on how CLSs, working in varying settings, experience this specific barrier. In addition, this may allow new insight to be gained into which types of resources would best assist CLSs in practicing effectively in the presence of language barriers.

Balancing culture with job responsibilities. Although the findings of parenting cultures and conflicting core values as challenges in practice have not been obtained in other studies, the final challenge brought forward by participants, namely, balancing cultural considerations with job responsibilities, has received attention in pertinent literature. Although “successful” ratios have been proven as one CLS to 15-20 patients, the reality however, is that numbers are significantly higher than this (Child Life Council, 2006; Thompson, 2009). Therefore, the ability of CLSs to devote considerable attention to cultural issues, which is challenging in itself, becomes reduced in light of such high patient ratios. In addition, Munn, Barber and Fitz (1996) bring attention to the “emotional labour” required of CLSs in situations fraught with fear, anxiety and intense grief. This emotionally-demanding nature of child life practice in itself can contribute to burnout and job dissatisfaction rates (Munn, Barber & Fitz, 1996). As such, participants were able to bring attention to the difficulty inherent to balancing cultural issues with other job responsibilities.

Despite the presence of such challenges, participants collectively felt “relatively comfortable” in working with patients and families from diverse backgrounds. This confidence and comfort in their practice has been supported by findings obtained by Butterly (2009), in which 67% of participants felt confident in their ability to work with patients from diverse backgrounds, and Butterly (2009), in which participants rated their overall levels of comfort as “moderate to high”. The perceived comfort in participants’ abilities to work with diversity in their practice is reflected in the myriad of strategies participants employ to overcome potential challenges that result from cultural issues.

Overcoming challenges. Predominant strategies participants employed to overcome challenges in practice include personal techniques, family-centered support and institutional supports. An overarching notion throughout these findings, however, pertains to participants’ desire to *embrace* the challenges they faced in practice. In this manner, participants perceived challenges as “[giving] me a chance to learn new things”, “[it] boggles my mind, and I love that”, as well as “[e]mpowering because I don’t know much about their background”. Once again, Butterly (2009) obtained similar findings in participants who “embraced” and “thrived” on opportunities to work with another culture. Considering these findings, the field of child life, with its “unique” nature that is conducive to eliciting cultural information, becomes a promising and appropriate context in which to explore cultural issues in clinical practice.

Personal techniques. Participants in the current study utilized specific techniques to overcome challenges in their practice. These included asking questions about patients’ cultural beliefs and values, “playing dumb in a sense”, and demonstrating *respect*, *openness* and *awareness* in interactions with patients and families from diverse

backgrounds. Butterly's (2009) study also obtained the finding that *asking questions* was used as a primary method of information gathering amongst CLSs. Additionally, the open-ended questioning has been considered as an effective communication tool to overcome cultural challenges in practice by the Child Life Council (Warren & Lynch, n.d.) and the Registered Nursing Association of Ontario (RNAO, 2007).

On the other hand, participants described the technique of "playing dumb" as a method to be used "in a smart way" to "open up conversations". This skill aligns with adopting a "not-knowing" position (Anderson & Goolishian, 1992). Anderson and Goolishian (1992) contend that this position encourages professionals to engage in a process of learning about others' continually evolving cultural identities. With some deliberate contradiction, Laird (1999) proposes professionals to become "informed not-knowers", by "becoming aware of our own cultural baggage and to separate ourselves from it in so far as is possible" (p. 30). As such, with a lack of "competence" as the focus, Dean (2001) proposes a different view of practicing across cultures emerges. When professionals step away from becoming "competent" at the culture of another, as proposed in the cultural competence model (Betancourt, Green, Carillo, & Ananeh-Firempong, 2003), the client becomes the expert and the clinician is in a position of seeking knowledge (Dean, 2001).

Family-centered support. Not only did participants include the element of *family* in their reasons to consider culture in practice, but also collectively associated their strategies in overcoming challenges with the importance of adopting a family-centered, strengths-based approach. Several participants stated that their focus in practice is placed on the family, by stating; "it's not about me, it's about them", or "I find that families just

need to be heard”. By focusing on the families, CLSs were able to gather important information not only about the child, but also about cultural factors that may influence their interactions. This finding is, however, not unexpected, as the professional responsibility to act as an advocate for family-centered care consists of nine elements in the child life standards of clinical practice (CLC, 2001). One of these elements pertains to honouring the racial, ethnic, cultural and socioeconomic diversity of families, by being aware of personal values, acknowledging diverse family customs, identifying family’s preferred support systems, and reinforcing culturally competent care (Thompson, 2009). In addition, it was noted that the Child Life Council (“Cultural Competence in Child Life”, 2005) considered “attuning to the cultural ideology of the family as a primary skill necessary to increase CLSs’ level of cultural ‘competence’”. Additional support for this finding from pertinent research include results obtained by Belisario (2014), which suggest that CLSs’ efforts include a family-centered care approach when faced with cultural barriers in practice. Similarly, Butterly (2009) found that the concept of culture was consistently shaped by the concept of *family*, including family roles and structures.

Institutional supports. Participants primarily drew on the services provided by the Aboriginal liaison as a means to overcome cultural challenges in practice. Only a quarter of the participants actively referred to quick, go-to guides on different cultural values and beliefs in order to help them overcome challenges. In addition, participants were not actively involved in drawing on supports provided by training and/or educational opportunities provided by the institution, or considered the use of group discussions as a helpful strategy. Surprisingly, participants considered the Language Line (telephone-based translating service) of limited value in their practice and either used it

occasionally or never. This finding is unexpected as language barriers were consistently considered as the biggest obstacle in practice, a finding also obtained by Butterly (2009). In order to overcome such obstacles, Belisario (2014) noted how 96% of CLSs actively used translator services in their practice.

On the other hand, other studies found translation services in healthcare settings to be generally underutilized (Van Dellen et al., 2007; Gulati et al., 2012; Bentancourt, Green & Carrilo, 2002). Reasons for this underutilization may stem from translation services to have been reported as inaccessible or unavailable (Flores, 2005; Ku & Flores, 2005). In this study, participants stated not to use the translating services as it was only deemed as useful when translating “medical information”. However, one can also speculate about the nature of the Language Line, being telephone-based and not in-person, to be preventing CLSs from using the service. In addition, the aforementioned challenge of balancing culture with job responsibilities, including low CLS to patient realities, may play a role in CLSs’ willingness or ability to use this service. Although Butterly (2009) noted that implementing new institutional provisions related to translation may be difficult considering such low staff to patient ratios, additional research focused on optimizing the accessibility, availability and format of translating services would be beneficial.

Future resources. Participants’ reflections on which strategies and/or services were useful in overcoming cultural challenges in practice sparked additional insight into which resources they would like to see in the future. Figure Three provides an overview of these findings by depicting the resources and services CLSs identified as being useful

for their future practice. Resources have been categorized into a pre-employment and employment phase.

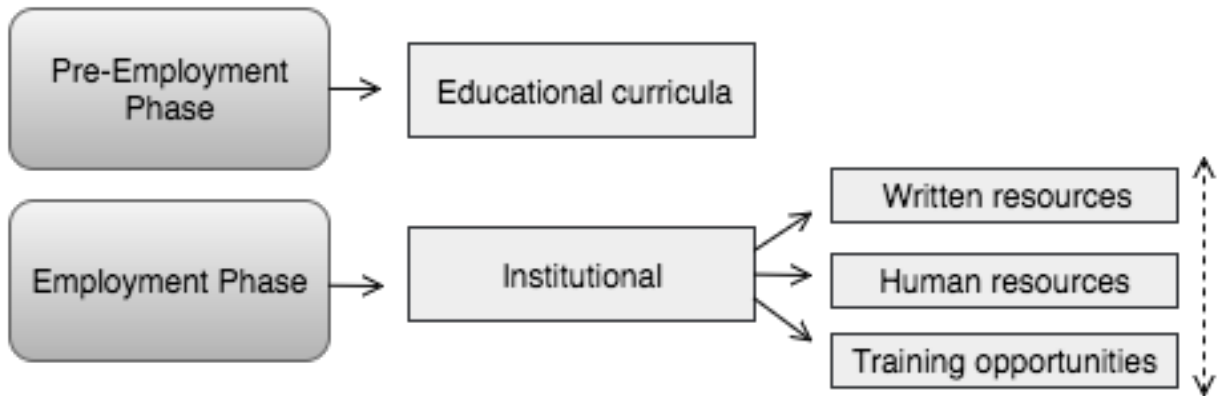


Figure Three. Overview of Future Resources.

Educational curricula. The pre-employment phase consists of placing increased focus on cultural issues, diversity, and cultural theoretical frameworks in educational curricula, such as Child and Youth Care (CYC) programs. In particular relevance to such educational curricula is the importance of bridging the gap between theory and practice by incorporating the aforementioned notion of praxis. In this study, participants referred to the importance of devoting attention to cultural factors in the mandatory undergraduate child life course, which is a prerequisite for certification as a CCLS. However, as noted by Turner and Fralic (2009), research in the area of child life curriculum content, however, remains limited. Therefore, increasing attention devoted to optimizing the content of child life educational curricula becomes warranted.

Written resources. Resources available during CLSs' employment have been categorized into written and human resources, as well as training opportunities. Written resources refer to an increased selection of applicable, "quick go-to guides" that contain

information on specific cultural beliefs and practices. Participants identified such resources as a need in order to increase their cultural knowledge on certain cultures, customs and religions. In addition, participants highlighted a need for increased pamphlets and brochures that contain information on the objectives of child life care, translated into several primary languages. Participants were, however, highly aware of the challenges inherent to including *all* cultures in such resources. As an alternative, it was suggested the information should be specific to the region in which the institution is located, giving rise to particular cultural populations that are most often encountered.

Human resources. Human resources referred to the need for a re-introduction of the services provided by a diversity coordinator, which aim to offer inclusive and patient-centred care, and help staff identify appropriate resources to ameliorate cultural challenges. In a similar manner, 21% of CLSs in Belisario's (2014) study identified the services provided by a cultural consultant as a helpful resource in their practice.

Therefore, child life services could benefit significantly from having an assigned cultural consultant, who is knowledgeable about the psychosocial nature of child life practice, available on a daily basis.

Training opportunities. Lastly, the importance of training opportunities addressing specific and applicable topics related to diversity in practice became prominent. Participants identified workshops and grand rounds to act as valuable resources, of which they would like to more of in the future. Examples of such specialized topics training pertained to a particular area of child life practice, such as death and bereavement. By specializing the topic of the training, participants felt that the material would be more applicable and useful to their practice. In a similar manner,

attention has been increasingly devoted to cross-cultural practices pertaining to death and grief in select U.S. bereavement courses geared towards child life students (Parvin & Dickinson, 2010).

Combining resources. Conclusively, several participants noted that the use of written and human resources, as well as training opportunities, should not be mutually exclusive. Rather, participants considered the value of these resources to be optimally enhanced when they are used in combination, as a participant stated; “you can read a pre-prescribed note on something but you can’t ask questions to it. So I think that is why it’s really important to have both”. It can therefore be suggested that resources such as written, applicable go-to guides, pamphlets or brochures on cultural values and beliefs, in addition to human services provided by a cultural consultant, would offer a most comprehensive opportunity for CLSs to navigate cultural issues in practice.

In order to operationalize such resources, it must be noted that the role of the child life manager becomes particularly relevant. For example, a child life manager could relay the benefits associated with combining both written and human resources (i.e. recognizing individuality and avoiding stereotyping) to the child life team. In addition, creating opportunities for workplace discussions on cultural issues, as well as organizing specialized, applicable training opportunities on cultural diversity, are responsibilities of the child life manager. Therefore, by offering constructive suggestions on helpful cultural resources in child life practice, this research aims to facilitate the ability of child life professionals to navigate the myriad of supports and resources available on cultural diversity in healthcare. In this manner, it is the ultimate aim that child life managers can

become better informed of the resources that would most benefit CLSs' practice in their specific cultural context.

Integrating Findings into the Cultural Safety Framework

Even though it has become clear that CLSs in the current study considered challenges in practice in a positive light by embracing them, the RNAO (2007) warrants attention to be devoted to distinguishing between embracing cultural diversity as an *ideology* and employing specific skills that are reflected in behaviours, in order to create an optimal, culturally-safe environment. Therefore, it can be suggested that focus should be placed on developing guidelines that offer CLSs the opportunity to develop certain skills into specific behaviours when working with cultural challenges in practice. Figure Four provides a visual representation of the incorporation of findings of the current study into the cultural safety framework, in which a clear distinction can be made between the behaviours and characteristics that the practitioner (individual) and provider (institution) can demonstrate in order to create a culturally-safe work environment.

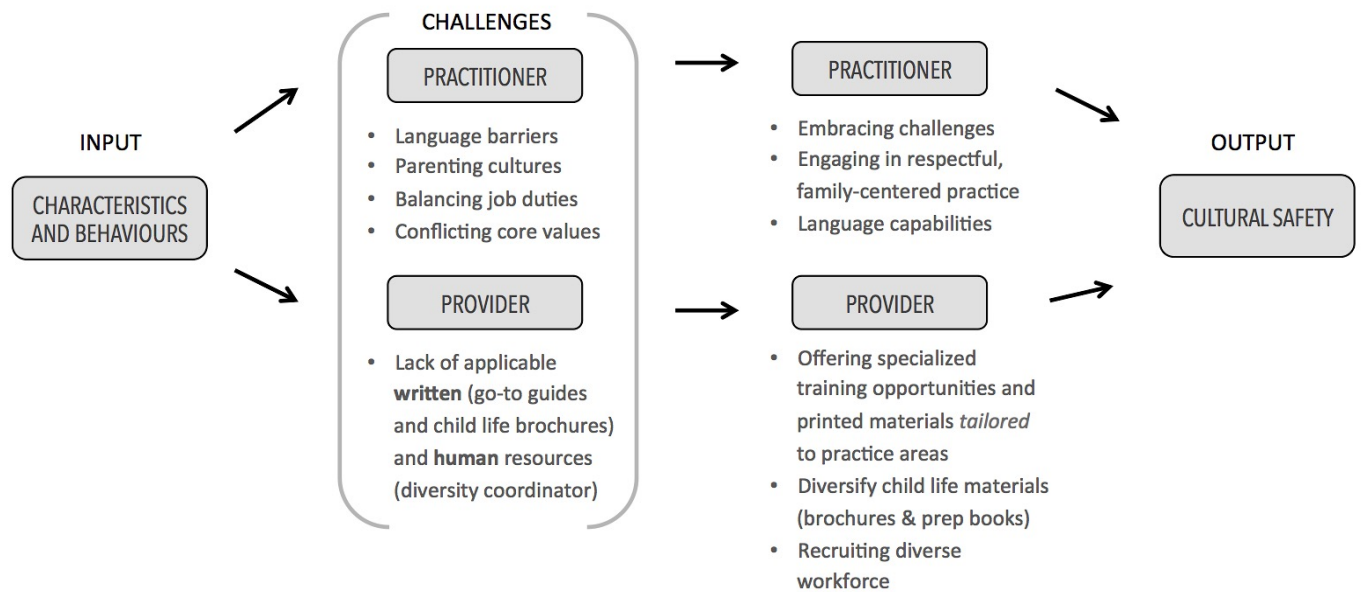


Figure Four. Integration of Findings into the Cultural Safety Framework.

Figure Four also demonstrates that the implementation of such behaviours and characteristics in practice was not straightforward, as they can be affected by a number of challenges resulting from cultural factors. However, the subsequent column depicts which types of behaviours and characteristics the participants identified as improving their ability to work with these challenges. For example, on an individual level, behaviour that reflects a respectful, family-centered approach was deemed as particularly useful in their ability to overcome challenges. In addition, one's congruency in spoken language (and physical appearance) with patients and families was identified as a useful strategy.

On a provider level, participants identified written materials and training opportunities as valuable 'behaviours' that could be implemented by the institution. Lastly, as congruencies in spoken language and/or physical appearance were identified as a helpful strategy, the recruitment of a diverse workforce acts as an institutional-level

strategy to overcome challenges. As a result, culturally-safe practice acts as an output.

By offering constructive recommendations for behaviours and characteristics that were deemed as helpful in this study, this research aims to facilitate the process of identifying starting points for achieving change in working with diversity in child life practice. In addition, by associating findings with research conducted in interdisciplinary fields, the findings of this research might offer a starting point for other healthcare professions to commence additional research on beneficial strategies and resources used in overcoming cultural challenges.

Directions for Future Research

This study offers an avenue for future research to explore the topic of culture in child life practice. Firstly, future research may benefit from employing larger and more diverse samples in order to obtain more varied experiences and perspectives of CLSs. Inherent to diversifying research samples is the inclusion of participants who have been practicing as a CLS for varying years, as the current study solely utilized the perspectives of participants who have been practicing for over 10 years. As such, valuable contributions to research could include the perspectives of new hire CLSs in addition to senior CLSs.

Diversifications of research samples could also be achieved by including CLSs from diverse ethnicities. This study consisted of a primarily a relatively homogeneous sample when considering participants' ethnic backgrounds. Therefore, diversifying this aspect could contribute to new insight into how CLSs, who identify as a member of a non-dominant (i.e. Canadian) community, experience working with diverse cultural issues in their practice. In turn, findings stemming from research utilizing such diverse

research samples could yield insight into the benefits associated with employing a diverse workforce. As suggested by the Child Life Council (2006), the employment of a diverse workforce can act as a strategy that may improve CLSs' skills in overcoming cultural challenges. In addition, it can be suggested that a diverse workforce is more likely to represent the demographics of the patients and families of the particular healthcare site.

In a reverse manner, future research may benefit from examining the perspectives of children and families, rather than that of CLSs, from diverse cultural backgrounds in healthcare settings. Few studies that have examined the perspectives of families in paediatric healthcare contexts have demonstrated that cultural factors (e.g. language) can present significant challenges. For example, challenges exist in immigrant parents' ability to obtain mental health services for their child (Guzder et al., 2013), the ability of parents to understand information related to their child's medical condition (Gulati et al., 2012), the management of a child's asthma symptoms (Van Dellen et al., 2007), and in communication with healthcare providers resulting in increased feelings of stress and anger (Davies, Contro, Larson & Widger, 2010). Such findings, obtained from interdisciplinary fields, signify that cultural issues often affect both sides of the patient-provider interaction. This area of focus therefore offers a promising avenue for future research, as it has not yet been explored in the context of child life practice, and may lead to important insights into which types of resources patients and families would consider as most useful in the context of overcoming cultural challenges.

Concluding Remarks

This study explored the way in which CLSs conceptualized the concept of culture and experienced working "with" culture in their practice. Research findings generated

insight into the types of challenges, resulting from cultural factors, CLSs experienced and which strategies they employed to overcome such challenges. Subsequently, these challenges and strategies were used as a basis to identify practice- and organizational-level suggestions for future practice. On a personal, practice level, honing specific skills such as engaging in respectful practice became highlighted, with the ultimate objective to provide optimal, family-centered child life services. On an organizational level, the importance of offering tailored and applicable training opportunities on a regular basis became prominent, as well as the diversification of child life resources, re-introduction of a cultural consultant, and the recruitment of a diverse workforce. In addition, insight into participants' conceptualizations of culture brought attention to the notion of praxis, as an attempt to incorporate (and potentially re-evaluate) theory in educational child life curricula.

An additional prominent finding pertains to participants' perceived comfort in working with often uncomfortable, challenging situations that are influenced by cultural factors. Although participants were able to identify specific challenges in practice, their confidence in their ability to overcome and embrace such challenges was clear. Participants also demonstrated a clear commitment to family-centered care throughout all stages of working with patients and families from diverse backgrounds. In addition, the majority of participants referred to the unique psychosocial nature of child life practice as being conducive to providing ample opportunity to explore cultural factors within interactions with patients and families. Considering this latter finding, the field of child life becomes an appropriate and encouraging context in which to explore cultural issues in a paediatric healthcare field, with the aim to provide optimal, culturally-safe care.

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Appendices

Appendix A. Invitation to Participate E-Mail Script

Appendix B. Research Poster

Appendix C. Participant Consent Form

Appendix D. Draft Interview Questions

Appendix A. Invitation to Participate E-Mail Script

Hello all,

I would like to share with you an invitation to participate in a research study being conducted by Amarens Matthiesen, a graduate student in the School of Child and Youth Care at the University of Victoria.

Amarens' study will explore the experiences of Child Life Specialists in working with diversity in their professional practice.

Participation in the study involves completing an individual interview with the researcher during your lunch hour, lasting up to 1 hour. Each interview will be audiotaped.

Participation in the study is completely voluntary. You may withdraw from the study at any time. Your participation or non-participation will not affect your employment status at (hidden) in any way, nor your relationship with the researcher or other Child Life staff members at (hidden).

Your anonymity will be protected before, during and after your participation in the study. In addition, your confidentiality and confidentiality of the data will be protected by not using any identifying information in the data. However, the nature of the study's topic may lead you to disclose personal information on cultural heritage, for example. This may limit the ability of the researcher to fully protect your anonymity in the final research findings. Only the researcher, Amarens Matthiesen, will have access to the data collected.

If you are interested in participating in this research study, please contact Amarens at amarensm@uvic.ca or 403 919 3854.

Thank you!

Appendix B. Research PosterRECRUITING PARTICIPANTS FOR A
RESEARCH STUDY ON:

The goal of this study is to explore how Child Life Specialists define, conceptualize and implement the concept of *culture* in their professional practice.

If you are employed as a Child Life Specialist (CLS or CCLS) at (HIDDEN), please consider participation in order to:

- o Contribute to new research in the field of Child Life
- o Help fill a gap in literature that may influence future developments on culturally-responsive Child Life services

Interested in participating?

Please contact *Amarens Matthiesen* at
amarensm@uvic.ca or 403 919 3854





**University
of Victoria**

Participant Consent Form

Working with Diversity: The Experiences of Child Life Specialists

You are invited to participate in a study entitled “Working with Diversity: The Experiences of Child Life Specialists” that is being conducted by Amarens Matthiesen.

Amarens Matthiesen is a graduate student in the Faculty of Human and Social Development’s School of Child and Youth Care at the University of Victoria and you may contact her if you have further questions at amarensm@uvic.ca or 403 919 3854.

As a graduate student student, I am required to conduct research as part of the requirements for a master’s degree in Child and Youth Care. It is being conducted under the supervision of Dr. Jessica Ball. You may contact my supervisor at jball@uvic.ca or 250 472 4128.

Purpose and Objectives

The purpose of this research project is to give you an opportunity to tell your personal experiences in working with diversity in your professional practice as a Child Life Specialist. I am particularly interested in hearing about how you define the concept of culture and your experiences with applying it to your practice. Paying close attention to how you describe your experiences will help promote, shape, understand and shed light on the way in which Child Life Specialists experience cultural diversity in their practice. This study is not designed to judge you or your experiences, but rather aims to seek an understanding of your experiences.

Importance of Research

First, this research will give Child Life Specialists a better understanding of the way in which culture plays a role in child life practice. Second, this research examines the types of challenges Child Life Specialists may experience when working with a diverse clientele. Third, by examining the sources from which Child Life Specialists gather their knowledge about cultural issues, this study may contribute to the development of new or pre-existing strategies aimed at improving culturally-responsive care on both practice (individual) level and a institutional (hospital) level.

Participant Selection

You are being asked to participate in this study because you are employed as a Child Life Specialist (CLS) or Certified Child Life Specialist (CCLS) at Alberta Children's Hospital on a casual, part-time or full-time basis. I consider your opinions and perspectives as invaluable and thus would appreciate the opportunity to gain a deeper understanding of your experiences as a Child Life Specialist. Participants will be accepted into the study on a first-come basis. A waitlist will be created once 10 participants have been recruited, reaching the maximum number for participant recruitment. These waitlisted individuals will be contacted to participate if someone withdraws from the study.

What is Involved

If you consent to voluntarily participate in this research, your participation will include taking part in an interview of approximately 1 hour with the researcher. You are welcome to shorten or lengthen that time frame if you desire so. With your permission, the interview will be audio-taped. The time of the interview would preferably take place during your lunch hour in order to minimize any disruption from your practice. The interview will take place in a vacant meeting room at Alberta Children's Hospital to provide you with optimal privacy and comfort.

Inconvenience

Should you choose to participate in this study, the time required for completing the consent forms and interview may cause you some inconvenience. The total time needed for this study will be a maximum of 1.5 hours.

Risks

There are no known risks to you by participating in this research. I, the interviewer, will try to create a safe and supportive environment. There will be no pressure to continue in the research and you can withdraw at any time. You will also be welcomed to take breaks, get up and move around at any time during the interview if you feel the need to do so. In the unlikely event that you will experience stress, emotional discomfort or fatigue during the interview, I will offer my assistance in accessing appropriate support services.

Benefits

There are potential benefits to your participation. First, by making a contribution to filling a gap in existing literature by sharing your personal experiences, your input has the potential to impact other Child Life Specialists' knowledge and understandings of culturally-responsive practices in healthcare. Such understandings may extend to informing other healthcare providers' knowledge on cultural issues in healthcare. Second, your input may help society at large better understand the challenges Child Life Specialists face in providing culturally-responsive care, and develop or tailor services that serve the needs of the target population in an optimal manner.

Voluntary Participation

Your participation in this research is completely voluntary. You may withdraw from this research at any time by contacting the researcher at amarens@uvic.ca, by calling 403 919 3854, or in person. "At any time" includes withdrawing before, during or after the interview. Refusal or withdrawal will have no negative consequences. In the event you decide to withdraw from the

research, your audios or any other documentation of your participation will be destroyed and not be used in the research.

Researcher's Relationship with Participants

It is possible that my dual role as a researcher and Child Life Specialist, as well as my role as a previous Child Life intern at Alberta Children's Hospital, could create conflicts that could affect your decision-making procedures. As my internship has ended as of April 1, 2016, I currently solely adopt the role of a researcher. To prevent this relationship from influencing your decisions to participate, your participation or non-participation will not affect your current employment status at Alberta Children's Hospital, nor your relationship with the researcher or discipline lead in Child Life and Therapeutic Arts.

Anonymity

Your anonymity will be protected before, during, and after your participation in this study. This will be achieved by removing identifying information (demographic factors and identifying direct words) from the interview transcripts. Due to the nature of this study's topic, identifying culturally sensitive information such as your cultural heritage or background may be used in the reported findings of this study. However, participants will be referred to as participant 1, 2, 3 and etc. when analyzing transcripts, and reporting findings. This will help minimize the risk that anyone will be able to associate your data (interview transcripts) with you. If you choose to not participate at any time, your anonymity will still be protected.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by not using any identifying information in the data. All electronic data (i.e. audiotapes) will be kept on the researcher's password-protected laptop. Hard copies of the transcripts and paper records will be stored in a locked cabinet at the researcher's home office. Only the researcher (Amarens Matthiesen) will have access to the locked cabinet and the password-protected laptop. However, there are limits to confidentiality due to legal requirements. Confidentiality may be breached if there is a disclosure of child abuse or a disclosure of causing harm to the participant or others (i.e. disclosure of intent to self-harm). Moreover, the fact that there is relatively small number of Child Life Specialists currently working at Alberta Children's Hospital could undermine my ability to fully protect confidentiality. Despite my use of pseudonyms and removing specific identifiers from the interview transcripts, you may be faced with a risk of being identified. If you are not comfortable with doing the interview, you can withdraw from the research at any time.

Dissemination of Results

The data provided in your interview will be used in my Master's thesis to bring me to the completion of a Master's of Arts degree in Child and Youth Care. The findings may also be published in journals and presented at workshops/scholarly meetings so that the important information found in this study can be passed along to other professionals working in a healthcare setting. A hard copy of my thesis will be given to you if you desire so.

Disposal of Data

Data from this research will be disposed of once the criteria of Master's completion have been met, anticipated to be no later than January 2017. Files on computer will be permanently deleted. Paper records will be shredded and audiotapes will be erased.

Contacts

Individuals that may be contacted regarding this study include myself, Amarens Matthiesen at 403 919 3854 or amarensm@uvic.ca, and my supervisors, Dr. Jessica Ball at jball@uvic.ca and Dr. Roy Ferguson at rferguso@uvic.ca.

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix D. Draft Interview Questions

- Are you a CLS or CCLS?
- On which unit(s) do you primarily work?
- How many years have you been working in the child life field?
- How long have you worked in your current position at Alberta Children's Hospital?
- Do you speak any languages other than English?

1. (How do child life specialists define culture?)

- Based on your understandings of the concept of culture, how do you define this concept?
- Do you believe that your own definition of culture has changed over time since becoming a Child Life Specialist?

2. (Do child life specialists consider culture in their daily practice?)

- In what ways does the concept of culture emerge in your daily practice?
- How much importance do you pay to culture within your practice?
- If a lot/not much, for what reasons do you believe it is important/not important to consider cultural issues as a Child Life Specialist?
- Do cultural considerations emerge in your engagements with all clients or only some clients?
- If all, for what reason(s)?
- If only some, for what reason(s)?

3. (How do child life specialists articulate the impact of their own culture on their interactions with diverse populations in their practice?)

- How do you define your own culture?
- Does your own culture influence your professional practice?
- If so, in what ways?

4. (What types of challenges do child life specialists experience when interacting with clients from diverse backgrounds?)

- How comfortable do you feel in assisting patients and families that are culturally 'diverse'?
- Can you describe any challenges you have faced when interacting with clients from diverse backgrounds?
- Do you draw on certain skills or knowledge that helps you overcome such challenges?

- Have you used any services provided by the hospital to help you overcome such challenges?

5. (Do child life specialists refer to practice frameworks pertaining to culture?)

- When you think about culture in your practice, is there a particular concept or framework that you use/draw from?
- If yes, where did this concept/framework come from/why have you chosen to use this concept/framework?
- Does your workplace routinely discuss issues related to culture in healthcare practice?
- Have you taken part in any training opportunities or activities related to cultural issues in healthcare?
- How beneficial have these opportunities been for your own practice?
- Would you have any suggestions on guidelines/activities that would best support child life specialists in providing culturally-responsive practices?