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Certified Child Life Specialists' Perceptions of Effective Psychosocial Interventions for Adolescents in Japanese Hospital Settings

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**CERTIFIED CHILD LIFE SPECIALISTS' PERCEPTIONS OF EFFECTIVE
PSYCHOSOCIAL INTERVENTIONS FOR ADOLESCENTS IN JAPANESE
HOSPITAL SETTINGS**

A Master's Thesis

Presented to

The Graduate College of

Missouri State University

In Partial Fulfillment

Of the Requirements for the Degree

Master of Science in Child Life Studies

By

Yukari Stickle

December 2018

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**CERTIFIED CHILD LIFE SPECIALISTS' PERCEPTIONS OF EFFECTIVE
PSYCHOSOCIAL INTERVENTIONS FOR ADOLESCENTS IN JAPANESE HOSPITAL
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Childhood Education and Family Studies

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Master of Science in Child Life Studies

Yukari Stickley

ABSTRACT

Adolescents and young adults need psychosocial support in the hospital because of their developing abstract thinking skills that occur during puberty. In addition, it is important to understand the cultural differences of effective psychosocial interventions for adolescents between the United States of America (USA) and Japan. The purpose of this study is to determine perceptions of effective psychosocial interventions for Japanese adolescents based on the experiences of Certified Child Life Specialists (n = 8), who trained in the USA and were presently working in Japan. Quantitative and qualitative data were collected from the CCLSs in Japan through a one-time online survey. Results indicated that providing educational resources, opportunities for emotional expression, and group activities were the interventions CCLSs in Japan perceived as most effective for adolescent patients. Moreover, results indicated that the biggest challenges to providing interventions for adolescent patients in Japan were the promotion of emotional expression in individual and group settings, lack of developmentally appropriate resources for adolescents, and low CCLS prioritization of adolescent patients due to the limited amount of CCLSs in Japanese hospitals. As implications for child life practice, the information discovered about the challenges Japanese CCLSs face can be further explored in future research so that solutions to the challenges can be found.

KEYWORDS: psychosocial interventions, child life specialists, child life services, adolescents, Japan

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In the interest of academic freedom and the principle of free speech, approval of this thesis indicates the format is acceptable and meets the academic criteria for the discipline as determined by the faculty that constitute the thesis committee. The content and views expressed in this thesis are those of the student-scholar and are not endorsed by Missouri State University, its Graduate College, or its employees.

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INTRODUCTION

Since the 1920s, psychologists have discussed and researched about child development (Association of Child Life Professionals [ACLP], 2018). Some of them, along with medical professionals, have focused on researching pediatric psychology for children who suffer from diseases. In addition, patients' families struggle from the patients' conditions or situations because their hospitalization influences family life. Not only physical interventions, but also psychosocial interventions, are important in hospital settings to encourage patients' and their families' quality of life.

Pediatric psychology began in 1922 when Michigan Motto Children's Hospital in the United States of America (USA) created play programs for children (ACLP, 2018). Between then and 1949, the play programs were installed in nine more hospitals in North America (ACLP, 2018). In 1955, Emma Plank, who was a leading authority of pediatric psychology, was asked by Nobel Prize winner, Dr. Fred Robbins, to make social, emotional, and educational support programs for children in the hospital (ACLP, 2018). She contributed to create these interventions in the hospitals as child life services. A Certified Child Life Specialist (CCLS) is an expert in supporting children and their families during significant challenging experiences related to healthcare and hospitalization (ACLP, 2018). Certified Child Life Specialists (CCLSs) provide psychosocial interventions for children with various injuries, illnesses, and diseases and their families to reduce their fear and anxiety in hospital settings. In 1982, the Child Life Council (CLC) was formed in the USA (ACLP, 2018). Then, in 2016, the CLC officially changed its name to the Association of Child Life Professionals (ACLP) to position the organization and its members for greater success (ACLP, 2018).

In Japan, the child life field is developing as an allied health profession. In 1999, the first CCLS started to work in a Japanese hospital (Japanese Association of Certified Child Life Specialist [JACCLS], 2018). In 2000, the Japanese Association of Certified Child Life Specialist (JACCLS) was established with relation to the Association of Child Life Professionals in the USA (JACCLS, 2018). As of April 2018, 42 Japanese CCLSs are working in 31 hospitals in Japan (JACCLS, 2018).

Rationale for the Study

Rollins, Bolig, and Mahan (2005) stated that adolescents need psychosocial support in the hospital because of their developing abstract thinking skills that occur during puberty. Carter (2014) discussed several research studies which determined psychosocial needs for adolescents in the hospital setting in the USA. Specifically, Carter (2014) revealed the importance for CCLSs to support adolescent medical non-compliance, which is defined as the failure to follow recommended medical treatment protocols.

In addition, it is important to understand the cultural differences of effective psychosocial interventions for adolescents between the USA and Japan. In contrast to the USA, there are fewer academic research studies about the psychosocial interventions for adolescents in Japan regarding child life clinical practice. Hagiwara (2015) has been one of the only researchers to explore cultural differences in patient-centered care in the pediatric unit between the USA and Japan.

Purpose of the Study

The purpose of the study is to determine CCLSs' perceptions of effective psychosocial interventions for Japanese adolescents in Japanese hospital settings, based on the experiences of CCLSs in Japan.

Research Questions. This study explored five research questions (RQ), which were two quantitative RQs and three qualitative RQs:

RQ 1: What types of psychosocial interventions do CCLSs provide for adolescent patients in Japan?

RQ 2: What do CCLSs perceive as the most effective psychosocial interventions for adolescent patients in Japan?

RQ 3: What challenges do CCLSs encounter when providing psychosocial interventions for adolescent patients in Japan?

RQ 4: What types of interventions or skills do CCLSs believe are important to know when working with adolescent patients in Japan?

RQ 5: What is the difference in providing child life interventions for adolescent patients in Japan versus adolescent patients in the United States of America (USA)?

Research Design. This study used a concurrent nested mixed-methods design. The concurrent nested mixed-methods design is a research design to include quantitative or qualitative data into answers of research questions in large qualitative or quantitative studies because sets of single data are not enough to answer the research questions (Creswell & Creswell, 2018). Data was acquired through a one-time online survey completed by CCLSs who were members of the JACCLS.

Theoretical Framework. This study used Bronfenbrenner's ecological systems theory as theoretical frameworks. Bronfenbrenner (1979) developed the ecological systems theory to explain how factors within the child, and the child's environment, influence how that child grows and develops. Bronfenbrenner's theory relates to adolescent patients in Japan because their environmental factors influence their developments. Therefore, Bronfenbrenner's ecological system theory was beneficial for a theoretical framework of this study to analyze the data.

Significance of the Study

This research study is relevant to child life practice because the results provide new information about the interventions provided for hospitalized adolescents in Japan, as well as the challenges Japanese CCLSs face when providing psychosocial interventions for hospitalized adolescents in Japan. Thus, the information discovered about the challenges Japanese CCLSs face can be further explored in future research so that solutions to the challenges can be found. This research study is especially relevant for Japanese CCLSs and child life internship supervisors who may mentor international student interns who plan to return to Japan to practice child life.

In addition, the results of this study could assist child life students in better understanding how to serve and support hospitalized adolescents in Japan. Nishimoto (2012) stated that cultural differences in child life services should be discovered more in each country in order to help the CCLSs in each country to work more effectively with children and their families in the healthcare environment.

LITERATURE REVIEW

General stressors for adolescents

Various researchers have reported that it is common for adolescents to suffer from a variety of stressors. Compared with children, adolescents are threatened by new or challenging social experiences in their lives. Zimmer-Gembeck and Skinner (2008) studied adolescents coping with stress, including normative developmental and non-normative stressors. Zimmer-Gembeck and Skinner (2008) stated that many adolescents experience stressors related to school, such as bullying by peers, academic difficulties, problems with teachers, and issues with interpersonal relationships (e.g., problems or conflicts with relatives, peers, or intimacy). Another stressor that adolescents confront is the transition to young adulthood, which begins at age 18. Adolescence is marked by various social transitions, such as leaving home, finding satisfying education or career decisions, and establishing intimate relationships (Zimmer-Gembeck & Skinner, 2008; Moksnes & Haugan, 2015). Zimmer-Gembeck and Skinner's (2008) study indicated that the majority of adolescent's struggle with their academic achievement, social relationships, and future career.

Financial situations also influence adolescent stress. Vera, Vacek, Blackmon, Coyle, Gomez, Jorgenson, Luginbuhl, Moallem, and Steele (2012) examined stressors, general stress levels, coping strategies, and subjective well-being in ethnically diverse urban adolescents and determined that the majority of stressors for adolescents were related to feelings of social isolation, family financial problems, parental arguments, injury of a family member, and the death of a family member. Vera et al. (2012) and Seiffge-Krenke, Aunola, and Nurmi (2009) also mentioned the importance of supporting adolescents through the welfare system.

In addition, gender differences were found in adolescent stress and depression in regard to interpersonal relationships. Moksnes and Haugan (2015) investigated the association among different normative stressors, sense of coherence, and life satisfaction distinguishably for gender among adolescents in Norway. Moksnes and Haugan (2015) determined that Norwegian female students felt more pressure by other people compared with the male students, especially in home life with families, school life with peers, school performance and school attendance. In addition, the female students had more stress about romantic relationships than male students (Moksnes & Haugan, 2015).

Environments influence adolescent stress. Seiffge-Krenke, Aunola, and Nurmi (2009) examined typical stressors which occur daily during the adolescent period. Seiffge-Krenke et al. (2009) found that almost all adolescents were faced with stressful situations in their everyday lives (e.g., chronic disease, violence, or parental divorce). Seiffge-Krenke et al. (2009) and Zimmer-Gembeck and Skinner (2008) clarified that negative circumstances or negative environmental surroundings tended to be detrimental to adolescent development.

In summary, adolescents typically struggle with a variety of normative stressors, such as: academic achievement, social relationships, future careers, financial issues, intimate relationships, and negative environmental surroundings (Zimmer-Gembeck & Skinner, 2008; Vera et al., 2012; Moksnes & Haugan, 2015; & Seiffge-Krenke et al., 2009).

Piaget (1950) stated that adolescents are in the formal operational stage, where they are capable of thinking logically and abstractly. According to Piaget's (1950) cognitive developmental theory, when adolescents consider or understand, they use both inductive and deductive methods: This means adolescents utilize information from societal rules or examples experienced in their lives and are able to interpret events from various perspectives (Piaget,

1950). Piaget (1950) reported that development allows adolescents to consider new methods for problem-solving, which were impossible in the earlier stages of their cognitive development. In addition, adolescents begin to think about matters that require theoretical and abstract reasoning, such as morality, philosophy, ethics, society, and politics (Piaget, 1950). Adolescents are able to differentiate, integrate self-awareness, and use self-expression based on their personality features (Piaget, 1950). Adolescents can also consider cause and effect with their experiences, and can predict the consequence of future conditions (Piaget, 1950). Eventually, adolescents start to fear their limited life span by chronic disease or death (Parvin and Dickinson, 2010; Rollins, Bolig, & Mahan, 2005). Additionally, adolescents tend to express their feelings of frustration, which can be considered differentially, abstractly and integrally (Parvin and Dickinson, 2010; Rollins, Bolig, & Mahan, 2005).

Erikson (1980) stated that adolescents are in the stage of industry versus inferiority on his theory of psychosocial development over the lifespan. Erikson (1980) discussed the importance for adolescents to achieve a sense of identity in occupation, sex roles, politics, and religion (Erikson, 1980). In other words, they must recognize that they are uniquely themselves and not anyone else. Adolescents who have a sense of self-confidence are able to establish their identity (Erikson, 1980; Rollins, Bolig, & Mahan, 2005). On the other hand, adolescents who do not have a strong sense of self-confidence and do not feel a sense of identity are in a state of identity diffusion (Erikson, 1980; Rollins, Bolig, & Mahan, 2005). During the term of identity diffusion, Erikson (1980) defined a *psychological moratorium*, which referred to adolescents who have experimented or explored their frustrations about their life. This means that they are at the age of crisis over changing identity formation (Erikson, 1980). Generally, adolescents tend to struggle with various choices or decisions in their lives. Therefore, they tend to experience a

developmental crisis, which is confusing because of their physiological changes that occur during puberty, advanced cognitive development skills, and gap between physical maturity and social immaturity.

Stress reactions and coping responses in adolescence. Zimmer-Gembeck and Skinner (2008) stated that adolescents tend to respond to stressors with positive strategies: controllability of stressors, assessing the stressors, and problem-solving, which they recognize as more influential by their efforts, such as academic difficulties. However, if adolescents evaluated the stressors as inevitable (e.g., parental conflicts or medical diagnoses), there was a chance for adolescents to develop depression, seek social support, or respond negatively in order to alleviate emotional distress (Zimmer-Gembeck & Skinner, 2008). Adolescents try to cope with stressors through social support with family or peer relationships, decision-making strategies, or distraction rather than seeking information and problem-solving (Zimmer-Gembeck & Skinner, 2008; Vera et al., 2012). If these coping strategies were not successful, the adolescents could develop a risk to being withdrawn, depressive, or cognitively impaired (Zimmer-Gembeck & Skinner, 2008; Rollins, Bolig, & Mahan, 2005).

Mirkovic, Labelle, Guilé, Belloncle, Bodeau, Knafo, Condat, Bapt-Cazalets, Marguet, Breton, Cohen, and Gérardin (2015) examined effective coping skills among adolescents who attempted suicide and found that it was effective for the adolescents to receive psycho-educational interventions which focused on positive cognitions to improve their depression. Mirkovic et al. (2015) and Rollins, Bolig, and Mahan (2005) revealed it was beneficial for adolescent coping to encourage their self-affirmation, which is how they can adapt to experiences or information which threatens their self-concept. Mirkovic et al. (2015) and Moksnes and Haugan (2015) also reported gender differences in adolescent coping skills:

adolescent females tend to think wishfully and expect more social support than adolescent males. Additionally, Jose and Kilburg III (2007) found gender differences in peer relationships related to coping and social support, and reported that adolescent female same-sex peer relationships did not help them as much as adolescent male same-sex peer relationships.

Impact of Japanese culture on Japanese adolescents

In general, cultural aspects, characteristics of nationality, traditional history, religion, and modern society effect adolescents (Nishimura, Nevgi, & Tella, 2008). Japanese adolescents are especially influenced by non-verbal and high context communication styles; collectivism, interdependence and self-confidence; and gender; age differences; socioeconomic disparities; and stress from academic careers compared to adolescents in the USA (Jose & Killburg III, 2007).

Non-verbal and high context communication style. People from foreign countries tend to communicate with native speakers in slightly different ways. Nishimura, Nevgi, and Tella (2008) studied to interpret the relationship between the communication styles and cultural features in Finland, Japan, and India. Nishimura et al. (2008) stated that Japan has some introversion features and the virtue of modesty (a preference for not being interrupted frequently and silent consideration), and mastery of how to use silence effectively during conversation. Japanese people use strong signs of reactive behavior, which means they like to follow the group's decision rather than take initiative (Nishimura et al., 2008). This shows that Japanese people do not like verbal conversations and do not show negative facial expressions directly because of their modest culture compared to people from other cultures (Nishimura et al., 2008).

During conversations, Japanese people are able to understand each other without using words about experiences, common sense, and values (Hall, 1989). The situation is influenced by high context communication, defined as a communication style in which the content, which is understood by other persons non-verbally, is richer than the content actually expressed verbally (Hall, 1989). Almost all Asian countries, especially Japan, use high context communication, whereas countries in North America, Scandinavian countries, and Germany use low context communication (Hall, 1989). Hall's (1989) high and low context communication theory revealed that Japanese people prefer euphemism and vague or indirect expression rather than direct expression. Furthermore, Japanese people do not have the immediacy of question-and-answer sessions to encourage verbal conversation progressively (Hall, 1989). Thus, the non-verbal and high context communication styles represent that Japanese people like to perceive an individual's feelings inseparably from other people's, a sort of cultural sympathy, because of their modest culture.

Collectivism, interdependence and self-confidence. Nishimura, Nevgi and Tella (2008) discussed cultural features that demonstrate why Japan is a collectivistic culture: a relatively homogeneous, listening, hierarchical society with high respect for elders and a lot of power in traditions. Therefore, Japan demonstrates collectivism by belonging or relating with others because the relationships among Japanese people are interdependent. Furthermore, Sato and Cameron (1999) examined the relationship between sides of collective self-esteem (e.g., independent or interdependent) among students in Japan and Canada. Sato and Cameron (1999) determined that Japanese people prefer harmony by suiting their values with others based on collectivistic culture.

Ueda and Shiomura (2012) stated that there are few studies which investigated Japanese forgiveness even though it was different compared with countries whose forgiveness is usually influenced by religion. Ueda and Shiomura (2012) investigated the relationship of Japanese with forgiveness, self-construal, collectivism and religious faith. The results were that “dispositional unforgiveness of self/situation was negatively related to independent self-construal and positively related to interdependent self-construal” (Ueda & Shiomura, 2013, p. 185). Dispositional unforgiveness of self or situation can encourage interdependent self-construal as collectivism and groupism. Then, the dispositional unforgiveness of self or situation may influence the cultural value of Japanese modesty, low self-confidence, and low self-esteem compared to other countries.

Additionally, historical aspects influence the cultural value of Japanese modesty, low self-confidence, and low self-esteem. Kashima, Kim, Gelfand, Yamaguchi, Sang-Chin, and Yuki (1995) examined the differences between individualism and collectivism, which were influenced by culture, gender, and self-construal. As a result, Kashima et al. (1995) stated that historical circumstances, especially World War II, might affect Japanese low self-confidence and low self-esteem. Thus, Japanese low self-confidence and self-esteem are associated with dispositional unforgiveness of self or situation, which encourage interdependent self-construal as collectivism and groupism (Ueda & Shiomura, 2013), and historical background (Kashima et al., 1995).

Japanese culture influences Japanese adolescents, especially non-verbal and high context communication styles. Moreover, Japanese people exhibit fewer facial expressions and body language, have the importance of perceiving an individual's feelings inseparably from other people's, prefer harmony with others as their interdependence of collectivism, have low self-

confidence and low self-esteem because of historical circumstances, and display cultural modesty.

Japanese adolescents. Gender and age differences relate more strongly with stress for Japanese adolescents than Western adolescents because of collectivism, in which gender and age are important concepts. Historically, Japan had lived in isolation from other people and cultures for a long time, so it is one of the most genealogically distinct and culturally homogenous populations in the world (Jose & Killburg III, 2007). Because of this, the concepts of gender and age are very significant in Japan. Jose and Killburg III (2007) used school surveys to study stress and coping skills in Japanese children and adolescents including cultural and social circumstances. Jose and Killburg III (2007) reported that female students had higher levels of stress about body image and peer relationships than male students. The female students used more isolation and problem-solving coping than externalizing coping skills compared to male students (Jose & Killburg III, 2007). The result, that Japanese female students prefer isolation, is the opposite the result of Western female students, who wish for and prefer social support (Jose & Killburg III, 2007). Jose and Killburg III (2007) also clarified different stressors between ages: young Japanese students felt more stress because of school, peers, and family, while the older students felt more stress about self-image. As a result, Jose and Killburg III's (2007) research revealed gender and age differences among stressors of Japanese adolescents, specifically, unique aspects of Japanese female students' feelings about their stress and preferred coping style.

Currently, socioeconomic disparities are a serious issue for Japanese society, and socioeconomic status has been shown to negatively impact adolescent stress in Japan (Kachi, Abe, Ando, & Kawada, 2016). Kachi et al. (2016) investigated the first evidence that socioeconomic status disparities in mental health problems exist among Japanese adolescents.

The results revealed that Japanese adolescents with low household income were less likely to display help-seeking behaviors (e.g., consulting with family members, friends or teachers) and felt more stress from interpersonal relationships with family members or peers because of financial reasons or intimate relationships (Kachi et al., 2016). However, the adolescents with high household income felt more stress about school achievement than other stressors (Kachi et al., 2016). Kachi et al. (2016) reported the reason for academic achievement stress in adolescents from high income households was that their parents expected their children to obtain high education. The parents of the high-income households tended to have a high degree of education, so the parents expected their children to acquire the same level education or higher (Kachi et al., 2016). In addition, Japan does not have diverse and abundant scholarship systems like the USA (Kachi et al., 2016). Therefore, parents in high income households with a high degree of education can pay for the children's academic tuition (Kachi et al., 2016). Kachi et al. (2016) found that different types of psychological distress exist for Japanese adolescents who are from high- or low-income households because parents' financial situation directly impacted the adolescent's academic career.

From 1980 to 2010, Japanese education policy had been *Yutori* education, which was an improved education policy by reducing hours and the content of the curriculum in primary education in order to decrease childhood academic stress (The Ministry of Education, Culture, Sports, Science and Technology in Japan, 2016). At that time, school bullying, violence, truancy, and *Hikikomori* (social withdrawal) had started to be serious issues for children in academic fields, so the Japanese government had tried to figure out these issues by reducing childhood academic stress (The Ministry of Education, Culture, Sports, Science and Technology in Japan, 2016). However, Japanese academic background is still a significant factor for being successful

in the job market (Jose & Killburg III, 2007). According to the Ministry of Education, Culture, Sports, Science and Technology in Japan (2016), the ratio of high school students who go on to the next stage of education, such as college, university, or technical school was 79.8%. This statistic indicates that Japan is still a meritocratic society. Jose and Killburg III (2007) reported that Japanese adolescents face an increasing amount of education-related stress as they age. Furthermore, Japanese youth spent more time studying academic subjects than youth in North America because most Japanese adolescents attend after-school academic sessions with their friends (Crystal, Kakinuma, DeBell, Azuma & Miyashita, 2008). The purpose of attending the academic sessions for Japanese adolescents was to pass the university entrance examinations, which called National Center Test for University Admission, and enter the next stage of their education. Crystal et al.'s (2008) research revealed Japanese adolescents felt educational stress because of the university entrance examinations and parental expectations. Thus, Japanese adolescents tend to feel academic stress (The Ministry of Education, Culture, Sports, Science and Technology in Japan, 2016; Jose & Killburg III, 2007; Crystal et al., 2008).

Triandis (1989) and Rothbaum, Pott, Azuma, Miyake, and Weisz (2000) found that Japanese youth tended to find relating to their parents important, whereas youth in North America saw relationships with peers as more significant. The reason was traditional cultural theorists (Triandis, 1989; Rothbaum et al., 2000).

Influence of hospitalization on adolescents

Stress or pain in hospitalization is occurs due to diseases, medical procedures, treatments, or examinations, and changes in living environment (Rollins, Bolig, & Mahan, 2005). Adult patients tend to have capabilities to cope with these stressors (Rollins, Bolig, & Mahan, 2005). In

contrast, it is difficult for children and adolescents, who are still growing physically and psychosocially, to cope with these stressors without support (Rollins, Bolig, & Mahan, 2005; ACLP, 2018). Therefore, physical and psychosocial stress, pain, or trauma, which can occur due to hospitalization, could also affect the healthy development or personality formation of the children and adolescents (ACLP, 2018; Rollins, Bolig, & Mahan, 2005). During hospitalization, various influences of the physical and psychosocial stress, pain, or trauma depend on age and cognitive developmental level. The following categories of specific stressors for adolescents during their hospitalization were discussed: general hospital stressors, stressors by chronic and life-threatening diseases, and unique features of Japanese pediatric hospitalization.

General hospital stressors. Rollins, Bolig, and Mahan (2005) stated that hospital issues for adolescents included dependence on adults, separation from family and peers, lack of privacy and need of more time to be alone, fear of bodily injury and pain (especially intrusive procedures in genital area), fear of loss of identity, body image and sexuality, concerns about peer group status after hospitalization, and remote medical situations. In addition, frequent and long hospitalizations resulted in loss of independence and control, which led to feelings of anger and frustration (Rollins, Bolig, & Mahan, 2005). Isolation from peers can be especially difficult during adolescence (Rollins, Bolig, & Mahan, 2005; Vera et al., 2012). Attention to privacy and confidentiality is an essential principal to facilitate adolescent trust and participation in their own medical treatment planning (Rollins, Bolig, & Mahan, 2005).

Stressors due to chronic and/or life-threatening diseases. In North America, the number of children who die from disease is decreasing because the current advancement of medicine and medical technology (Rollins, Bolig, & Mahan, 2005). However, the number of children and adolescents with chronic disease tends to be increasing (Rollins, Bolig, & Mahan, 2005; Parvin

& Dickinson, 2010). Many researchers have found that children and adolescents with chronic diseases tend to have more psychological problems and adaptive coping skills when compared with healthy children and adolescents (Rollins, Bolig, & Mahan, 2005; Parvin & Dickinson, 2010; Carter, 2014; Litt, Cuskey, & Rosenberg, 1982; Doka, 1996). Rollins, Bolig, and Mahan (2005) mentioned that potential effects of chronic illness or disabilities for adolescents have increased a sense of feeling different from peers, limited job or career opportunities, increased concerns about why they contracted this disorder, limited opportunities for heterosexual friendships, lacked abilities to master their medical self-care, and demonstrated difficulty with the transition from the pediatric unit to adult unit. Specifically, Rollins et al. (2005) and Hattori, Iwano, Sako, Honda, Okada, Akioka, Ashida, Kawasaki, Kiyomoto, Terada, Hirano, Fujieda, Fujimoto, Masaki, Maruyama, and Mastuo (2016) stated that medical self-care and transition to the adult unit were serious stressors for adolescents.

Transition from caregiver-directed care as adolescents to self-medical-management as adults is a significant process for adolescents who have chronic or life-threatening diseases (Hattori et al., 2016; Rollins et al., 2005). This transition for adolescent and young adult (AYA) patients has received attention from many pediatric departments; however, one of the issues is the lack of institutions that provide appropriate interventions for AYA patients (Hattori et al., 2016; Rollins et al., 2005). Hattori et al. (2016) used a nationwide survey in Japan to investigate the current circumstance involving the transition service for AYA patients with childhood onset chronic kidney disease (C-CKD) from pediatric to adult renal services. Hattori et al. (2016) revealed that few Japanese institutions had transition programs and/or transition coordinators for the AYA patients with C-CKD as evidenced by approximately 25% of AYA patients had ended or interrupted follow-up by renal and nephrourological services from pediatric to adult care.

Another issue for AYA patients is medical non-compliance. Litt, Cuskey, and Rosenberg (1982) studied the role of self-esteem and autonomy in medication compliance among adolescents who have Juvenile Rheumatoid Arthritis. Litt et al. (1982) determined that adolescents who have Juvenile Rheumatoid Arthritis tended to have medical non-compliance with poorly developed self-concept because of the longer duration of the disease and the more symptoms present at onset. The research by Hattori et al. (2016), Rollins et al. (2005), and Litt, Cuskey, and Rosenberg (1982) demonstrate the importance of psychosocial interventions for AYA patients to facilitate their transition to adult care while supporting their medical self-compliance.

Among pediatric chronic diseases without hematological malignancies, some of them are life-threatening diseases, such as Duchenne muscular dystrophy, Alexander disease (a progressive fatal neurodegenerative disease), and cystic fibrosis. Doka (1996) stated that pediatric patients who have life-threatening diseases and their families struggle to live with the problems of ongoing illness during the chronic phases because of the symptoms of the illness and effect of the medical treatments. Specifically, pediatric patients with chronic disease responded to strict treatment regimens with regressive and dependent reactions, aggressive nonadherence, and impaired self-esteem (Doka, 1996; Rollins et al., 2005).

Effective psychosocial interventions by child life specialists for adolescents

There are many types of psychosocial interventions that CCLSs provide adolescent patients in the pediatric hospital setting in the USA. Rollins, Bolig, and Mahan (2005) and ACLP (2018) stated that psychosocial interventions for adolescents in the hospital setting include encouragement of socialization with peers, respect for independence and privacy, provision of

developmentally appropriate therapeutic activities (e.g., emotional expression and tension-release activities), education for medical procedures/illnesses, continuation of education, and encouragement and education for the transition from pediatric to adult healthcare services. While Rollins et al. (2005) discussed these psychosocial interventions for hospitalized adolescents, there were dearth empirical literature on this topic; however, several psychosocial interventions have been studied with the hospitalized adolescent population: (a) reduction of stress with humor, (b) encouragement of medical compliance by collaborating with family and various healthcare professionals, (c) support for adolescents during the transition from pediatric to adult care, and (d) support for end-of-life care.

Reducing adolescent stress with humor. Generally, benefits of humor can maintain human mental health to reduce human stress. Vera et al. (2012) reported that humor can lessen the relationship between adolescent stress levels and negative feelings. In other words, humor can decrease the stress level for adolescents because it helps distract from their negative feelings (Vera et al., 2012). Therefore, it is important to provide psychological interventions with humor to decrease stress in the hospital settings.

Medical non-compliance. Lask (2003) investigated four psychosocial interventions for adolescents who had medical non-compliance, including the creation of a therapeutic collaboration among parents, the child, and the hospital staff; working with the child and parents to enable the parent to assist the adolescent in medical compliance; a comprehensive approach with biological, social, and psychological factors; and motivation enhancement therapies. Lask (2003) determined that the four approaches could work together synergistically; however, there were barriers for the four types of collaboration. Carter (2014) discovered there were significant factors that influenced medical compliance: creation of a therapeutic alliance with collaborations,

the comprehensive approach to adolescent medical compliance, educational interventions, and working with the child and parents to enable the parent to assist the adolescent with compliance. In short, it is important for those supporting medical compliance of adolescents to collaborate with multidisciplinary healthcare professionals, educational professionals, and families; provide comprehensive intervention including biological and psychosocial factors; and establish therapeutic relationships with the adolescents and their parents; and support their coping and encourage their motivation toward the medical-compliance (Carter, 2014).

Transition to adult care. Rollins, Bolig, and Mahan (2005) and Hattori et al. (2016) discussed the importance of supporting adolescents in the transition from pediatric care to adult care. Rollins et al. (2005) and Carter (2014) stated that effective interventions should include consideration of adolescents' understanding of the conditions, related treatments, medications, and precautions. In addition, effective interventions should inspire adolescents' abilities to verbalize healthcare concerns and needs, become compliant with medical regimens, and demonstrate their interest in the transfer to adult care (Rollins et al., 2005; Hattori et al., 2016). Thus, the effective interventions for adolescents' transition to adult care should encourage expression of adolescents' concerns, promotion of adolescents' understanding, and inspiration for adolescents' motivation of medical self-management (Rollins et al., 2005; Hattori et al., 2016).

End-of-life care. One of the essential roles for CCLSs in the hospital setting is supporting children and their families related to dying, death, and bereavement (ACLP, 2018). Parvin and Dickinson (2010) discussed the importance of interventions by CCLSs for pediatric patients and their families at end-of-life, specifically child life education programs about death and dying. Results revealed that all child life programs in the United States offer something

about the topic of death and dying (Parvin & Dickinson, 2010; ACLP, 2018). Parvin and Dickinson's (2010) research study and the ACLP (2018) indicated that CCLSs should be one of the most positive advocates for children and adolescents in hospital settings. CCLSs have a great understanding of all aspects of dying, death, and bereavement because of their education programs in the USA and are prepared with flexibility for any psychosocial crises or end-of-life events (ACLP, 2018). In short, CCLSs train to provide psychosocial interventions for adolescents at end-of-life in order to assist adolescents to accept their situation and think positively at the end-of-life stage.

The literature on effective psychosocial interventions by CCLSs for adolescents in the USA clarify the importance of (a) providing effective psychological interventions with humor for decreasing stress, (b) encouraging adolescent medical compliance with comprehensive approaches by collaborating with other healthcare professionals and educational interventions, (c) facilitating adolescent transition to adult care by promoting the adolescents' understanding and inspiring their motivations, and (d) providing end-of-life care by CCLSs with effective emotional support.

This literature provided knowledge about existing effective interventions by CCLSs in the USA for adolescents in the hospital setting. In contrast, there are few research studies about the psychosocial interventions provided by CCLSs for adolescents in Japan. Much of the existing research about the Japanese child life practice comes from only thesis research studies. Therefore, this information was used to create specific research questions about CCLSs' perception of effective psychosocial interventions adolescents in the Japanese hospital setting.

Unique features of Japanese pediatric hospitalization. Japanese pediatric hospitalizations differ from pediatric hospitalizations in the USA in several ways: length of

hospitalization, limited visitation from siblings and peers, revelation of serious diagnoses to only parents or caregivers—not children, and restricted parental/familial participation during medical procedures. In addition, psychosocial interventions provided by CCLSs are typically uncommon in Japan.

Japanese pediatric hospitalizations tend to last longer than pediatric hospitalizations in the USA. Hagiwara (2015) reported that the length of hospitalization for pediatric patients with leukemia in the USA tends to be short because they receive treatment mainly in the outpatient clinics; however, the length of hospitalization for the Japanese pediatric patients is typically more than a few years. This indicated that the average hospitalization for Japanese pediatric patients with leukemia was significantly longer than hospitalizations in the USA (Hagiwara, 2015). The reason for this difference was because the USA has an abundance of pediatric outpatient oncology/hematology services compared with Japan (Hagiwara, 2015).

Some Japanese pediatric units still have limited visitation for siblings and peers of pediatric patients. Nishimoto (2012) conveyed that the sibling support system in Japan is unknown because some Japanese hospitals do not allow sibling to play in the hospital playroom. In addition, it depends on patients' pediatric physicians to allow the sibling visitation in the hospitals (Nishimoto, 2012). The reason is that there is risk of infectious diseases from outside, especially siblings who are younger than 13 years old because of vaccinations and infection issues (Nishimoto, 2012).

Telling the truth to children is a controversial issue in Japan. Parsons (2007) reported that “96% of physicians in the USA reported always or most of the time telling the child about their cancer diagnosis, while only 38.2% of Japanese physicians reported doing so.” Furthermore, Hagiwara (2015) reported that Japanese pediatricians try to protect the children from emotional

distress by not telling them the truth about a diagnosis. Japanese pediatricians evaluate more pessimistically the effect of telling-truth to pediatric patients rather than pediatricians in the USA (Miyawaki, 2015). Both of these previous studies indicate a limitation in understanding the impact of disclosing a diagnosis to pediatric patients in Japanese.

Hagiwara (2015) stated that parental participation in medical procedures (i.e., intravenous catheter insertion, lumbar puncture, etc.) was not common in Japan. Each hospital, physician and nurse may have a different opinion about parents' involvement in the procedures. Parents' involvement is acceptable in pediatric hospital settings in the USA (Boles, 2016). Hagiwara (2015) also stated that it is important for CCLSs to advocate for parental involvement during medical procedures in Japan to the children, their parents, and medical professionals.

Psychosocial interventions by CCLSs in Japan are slowly expanding (Japanese Association of Certificated Child Life Specialists [JACCLS], 2018); however, CCLSs are still not common in pediatric hospitals in Japan for two documented reasons: (1) administrative budgeting for the cost of CCLSs and (2) medical professionals questioning of the need for the CCLS role (Hagiwara, 2015). Child life services are not eligible for medical service fees—which require hospitals to create room for CCLSs in their budget (Hagiwara, 2015; Kitagawa, 2009). In addition, culturally, it is less common to donate money to hospitals in Japan compared with the donations received at pediatric hospitals in the United States (Hagiwara, 2015; Adachi, 2015). A Japanese CCLS reported that there are toys for younger children, but not for older children (Adachi, 2010). Another reason why CCLSs are not common in Japan is medical staffing issues. Hagiwara (2015) and Matsudaira (2010) found that Japanese pediatric nurses received training to provide psychosocial interventions for pediatric patients and their families, especially diagnostic education and psychological preparation, more so than pediatric nurses in the USA. CCLSs

provide the psychosocial service for pediatric patients and their families in the USA. Therefore, Japanese CCLSs re-define the professional boundaries in collaboration with Japanese pediatric nurses. As a result, these issues influence the expansion of child life services in Japan.

Japanese CCLSs' role is different from those in the United States. This is due to the differences of length of hospitalization, limited visitations from siblings and peers, telling serious diagnosis to only parents or caregivers, restrictions on parent participation during medical procedures, and uncommon psychosocial interventions by child life service.

This literature discussed the unique features of Japanese pediatric hospitalization compared with pediatric hospitalization in North America: long length of hospitalization, limited visitations from siblings and peers, telling-truth to only parents or caregivers, restricting parents' participation during medical procedures, and uncommon psychosocial interventions by child life service.

Expand psychosocial service for pediatric patients and their families in Japan.

Different professionals, such as a CCLSs, a midwife, and a chaplain, had different opinions about child life services for families who have experienced perinatal loss in Japan (Ishizuka, 2017). Ishizuka (2017) determined that sibling support should be performed by CCLSs, who can be involved with familial support, instead of time-strapped medical staff. Moreover, Kojima, Hiramathu, and Okada (2011) stated that because there were cases where children/adolescents were hospitalized in adult wards, it is necessary to promote psychosocial activities throughout all wards in the hospital. In short, expanding psychosocial services for pediatric patients and their families to new wards in the hospital may encourage the introduction of psychosocial services to other hospital professionals, who have never known or who resist the introduction of psychosocial services.

Collaboration with other professionals. The possible goals of medical social workers in the pediatric hematology/oncology units are to support decision-making for patients/families; advocate for their opinions; support the independence of adolescents and young adults; support patients' siblings; facilitate multidisciplinary collaboration with other hospital staff; and create future long-term plans after discharge (Yokoyamam, Onda, Ishibashi, Nonomura, Katayama & Higuch, 2016). Additionally, it is important for pediatric oncologists and nurses in Japan to approach palliative care with multidisciplinary cooperation and to include the essential 12 domains into their cure/care (Nagoya, Miyashita & Shiwaku, 2017). The 12 domains are playing and learning; fulfilling wishes; spending time with family; receiving relief from physical and psychological suffering; making many wonderful memories; having a good relationship with the medical staff; having a peaceful death in the presence of family; spending time with a minimum of medical treatment; living one's life as usual; spending time in a calm hospital environment; being oneself; and having a close family (Nagoya, Miyashita & Shiwaku, 2017). These domains indicate that multidisciplinary cooperation is essential to support children and their families in hospital settings because of their unique needs, such as pain/fear management, patient- and family-centered care, and quality of life (QOL) care. Currently, psychosocial services are becoming increasingly involved in multidisciplinary cooperation because health care professionals have started to recognize the unique needs of the pediatric patient and their families.

Theoretical Framework

This study used Bronfenbrenner's (1979) ecological system theory as theoretical frameworks. Bronfenbrenner (1979) developed the ecological systems theory to explain how

factors within the child, and the child's environment, influence how that child grows and develops. There are several ways the ecological systems theory applies to the hospital setting. The microsystem, which includes the individuals who directly interact with the child (e.g., family and peer groups), influences how the child grows and develops (Bronfenbrenner, 1979). The outer layer from the microsystem is the mesosystem, which states the relationship between the microsystem, such as the child's family and the immediate community or school teachers (Bronfenbrenner, 1979). For example, in the hospital, the mesosystem would be the relationship between the child's parents and hospital staff. The next layer, the exosystem, refers to the larger social system that indirectly influences the child, such as the institutional community (Bronfenbrenner, 1979). For instance, the child's mother had a bad day at her work place, and then she came to the hospital afterward. The mother's mood influences her child in the hospital even though her child did not directly interact with that work place directly. The macrosystem makes up the cultural or religious influence, such as political, social structure, culture, or religion (Bronfenbrenner, 1979). For example, in the hospital, under medical decision-making for children in collective cultures, the mother may request for hospital staff to wait until the older or male member in her family is present in the hospital. Jose and Killburg III (2007) stated that there is different importance about gender and age between Japanese and Western people because of collectivism. Therefore, these decisions all influence the children's conditions because of the cultural rules. The outside layer is chronosystem, which is made up of environmental factors, such as death and dying of family members, natural disasters, and historic events (Bronfenbrenner, 1979). For example, while the child is hospitalized, someone in their family may have died; however, the child cannot attend the funeral because of their medical treatment in the hospital. In short, Bronfenbrenner's (1979) ecological systems theory helps to

explain how Japanese environmental factors in the hospital settings may influence adolescents in Japan.

METHODOLOGY

Introduction

Child life services are developing internationally because of the beneficial effects of psychosocial interventions for children and their families in the hospital setting (ACLCP, 2018). Certified Child Life Specialists (CCLSs) have provided psychosocial interventions to adolescents in the USA (Carter, 2014). The purpose of this study is to determine CCLSs' perception of effective psychosocial interventions for Japanese adolescents based on experiences of CCLSs in Japan.

Research Design

This research study used a concurrent nested mixed-methods. The concurrent nested mixed-methods design is a research design to include quantitative or qualitative data into answers of research questions in large qualitative or quantitative studies because sets of single data are not enough to answer the research questions (Creswell & Creswell, 2018). The concurrent nested mixed-methods design is appropriate for this research study because researchers do not have adequate time or resources to commit to large quantitative and qualitative data; for graduate students, this design may be more manageable because one method requires less data than another; and this design may be appeal to agencies because the primary focus of this design is traditionally quantitative (Creswell & Clark, 2007). For the present study, data was acquired through a one-time online survey, completed by CCLSs who were professional members of the Japanese Association of Certified Child Life Specialists (JACCLS).

Site of the Study. Participants completed the survey online. Participants include CCLSs who are a part of the JACCLS.

Participants. Participants consisted of eight Japanese CCLSs who presently worked in Japan and were clinically trained in North America. Overall response rate for the survey was 19% ($n= 8$). Approximately 12.5% ($n= 1$) of participants was male and approximately 87.5% ($n= 7$) of participants was female. The average age of participants was 30.5 years old. 50% ($n= 4$) of participants was never married, and 50% ($n= 4$) of participants was married/domestic partners as their marital statuses. Approximately 34% ($n= 2$) of participants had earned a bachelor's degree and 66% ($n= 5$) of participants had earned a master's degree.

Approximately 66% ($n= 5$) of participants had worked as CCLSs for 6-10 years, 17% ($n= 1$) had worked for 3-5 years, and 17% ($n= 1$) of them had worked for 0-2 years. Approximately 66% ($n= 5$) of participants worked as full-time employees, 17% ($n= 1$) as part-time employees, and 17% ($n= 1$) PRN employees. Most participants worked a day shift (75%, $n= 6$), with 25% ($n= 1$) of participants working either a night shift or a shift other than day shift. Hospital units or departments where participants worked are listed in Table 1. Approximately 66% ($n= 5$) of the participants reported spending 25% of their time with the adolescent population, whereas 34% ($n= 2$) reported spending 75% or 100% of their time with the adolescent population.

About 87.5% ($n= 5$) of the participants worked at Japanese national hospitals and 12.5% ($n= 1$) worked at Japanese private hospitals. Sixty-seven percent ($n= 5$) of participants reported the existence of psychosocial teams within their hospital, whereas 33% ($n= 2$) reported no existence of a psychosocial team within their hospital. The 67% ($n= 5$) who reported working within a psychosocial team choose all that apply. 20% ($n= 3$) answered that their psychosocial teams included CCLSs; 20% ($n= 3$) answered that their psychosocial teams included child health

nursing/pediatric emergency nursing; 20% ($n= 3$) answered that their psychosocial teams included social workers; 13% ($n= 2$) answered that their psychosocial teams included clinical psychologists; 13% ($n= 2$) answered that their psychosocial teams included psychiatrists; 6% ($n= 1$) answered that their psychosocial teams included child care workers; and 6% ($n= 1$) answered that their psychosocial teams included school teachers.

Procedure. The researcher emailed the study invitation and survey link to the JACCLS forum. CCLSs who were members of JACCLS received the study invitation and survey link via the JACCLS forum email. CCLSs who received the email could choose to click on the link. The survey data was collected using Qualtrics, which is an online survey management system. Informed consent was obtained on the first page of the electronic survey. Participants chose to “Agree” or “Disagree” with participation in the research study. The online survey took approximately 20 minutes to complete. Once participants completed the online survey, they had the opportunity to click on a Google Forms link to enter their contact information in order to receive a ¥1,000 (\$10 U.S. equivalent) gift card to Amazon.co.jp (funded by Missouri State University’s College of Education).

Measures

A Survey of Japanese Child Life Specialists’ Perspectives about Effective Psychosocial Interventions for Japanese Adolescents. The mixed-method survey was created specifically for this study and contained 24 items (See Appendix A). This survey was divided into three sections. The first section included demographic questions, such as age, marital status, work history, and current work. The second section included questions about experience with adolescents as a CCLS in Japan. The final section included questions about personal opinions of

culture and child life practices with adolescents in Japan and North America. Questions for this survey were developed based on relevant literature and adapted from previous surveys: Question numbers 8, 13, 14, and 18 were adapted from Kirchenbauer's (2013) survey. Question numbers 15, 16, 17, and 22 were adapted from Carter's (2014) survey.

Survey Questions (Kirchenbauer, 2013). This survey included questions on the role of the CCLS in supporting adolescents coping with chronic pain, and Kirchenbauer was a graduate student in a Master of Art in Education Emphasis in Child Life. Kirchenbauer (2013) based the survey off the questionnaire on the Bath Adolescent Pain Questionnaire by Gauntlett-Gilbet and Eccleston (2006). Moreover, Kirchenbauer (2013) stated peer-review was used to establish the reliability. The questions demonstrate content validity.

Survey Questions for Professional's working with Adolescents (Carter, 2014). This survey included questions on the importance of supporting adolescent medical non-compliance by CCLSs. The survey included questions and was derived from Carter's (2014) graduate work. Carter (2014) based the survey off of three surveys: Bregnballe, Schiøtz, Boisen, Pressler and Thastum (2011), Kirchenbauer (2013), and Logan, Zelikovsky, Labay and Spergel (2003). Then, the data and analysis were reviewed by multiple peers and faculty as the validity (Carter, 2014). There is no empirical validity or reliability, but there is only content validity.

Additional questions were included in this survey that were not be used for this thesis research study.

Data Analysis

Descriptive statistics, including frequency analyses, were used to answer RQ 1 and RQ 2. The analytic plan for RQ 3, RQ 4, and RQ 5 was to complete a qualitative thematic analysis derived;

however, due to the low sample size ($n = 8$) and the lack of saturation found in the qualitative data, a rigorous qualitative thematic analysis was unable to be completed. Instead, all participant transcripts were translated from Japanese to English, blind-reviewed by two researchers (graduate student and faculty member), and coded for themes. The codes were formed based on the emergent themes. The final themes were decided by the two researchers who reviewed the participant transcripts.

RESULTS

Research Question 1 (RQ 1) Results

Part of the purpose of this research study was to identify the types of child life interventions CCLSs were providing for their adolescent patients in Japan. Results with choosing all that apply indicated that CCLSs provided the following interventions: individual therapeutic/developmentally appropriate play activities (9.4%, $n= 5$), emotional support (9.4%, $n= 5$), family and/or sibling support (9.4%, $n= 5$), preparation for medical procedures (7.5%, $n= 4$), distraction/coping support during medical procedures, educational resources (7.5%, $n= 4$), intervention for changes of their body image (7.5%, $n= 4$), encouragements for their academic career with school teachers (7.5%, $n= 4$), bereavement support (7.5%, $n= 4$), effective therapeutic/developmentally appropriate play activities (5.6%, $n= 3$), pain management (5.6%, $n= 3$), and encouragements for their medical compliance (5.6%, $n= 3$), encouragements for their transition to adult units (3.8%, $n= 2$), and opportunities to encourage their peer relationships (3.8%, $n= 2$). The types of child life interventions CCLSs were providing for their adolescent patients in Japan are listed in Table 2.

Include explanation about difference between individual therapeutic and effective therapeutic here and provide example for each. Discuss the translation/cultural understanding for Japanese language.

Research Question 2 (RQ 2) Results

Results indicated that CCLSs perceived the most effective psychosocial intervention for adolescent patients was providing educational resources (13.3%, rank: No.1), followed by the

psychosocial interventions of providing emotional support (12%, the second place) and group effective therapeutic/developmentally appropriate play (10.6%, the third place) for adolescent patients in Japan. (See Figure 1). Intervention for changes of their body image (9.3%, the fourth place), preparation for medical procedures (8.0%, the fifth place), and pain management (8.0%, the fifth place) were also perceived as effective psychosocial interventions for adolescent patients. Individual effective therapeutic/developmentally appropriate play activities (6.7%, the sixth place), distraction/coping support during medical procedures (6.7%, the sixth place), providing opportunities to encourage their peer relationships (6.7%, the sixth place), encouraging their transition to adult unit and family and/or sibling support (5.3%, the seventh place), family and/or sibling support (5.3%, the seventh place), bereavement support (4.0%, the eighth place), encouraging their academic career with school teachers (2.7%, the ninth place) were also perceived as effective psychosocial interventions for adolescent patients. No participants selected the encouragement of adolescent medical compliance as an effective intervention.

Research Question 3 (RQ 3) Results

Results indicated that CCLSs perceived the biggest challenges to providing interventions for adolescent patients in Japan were the (a) promotion of emotional expression in individual and group settings (e.g., “感情表出を促すこと。” [Prompting emotional expression]), (b) lack of developmentally appropriate resources for adolescents (e.g., “資源や環境の違い。アメリカはおもちゃの寄付などがたくさんあったが日本はない。また、プレイルームはあるが、ティーンルームなどの環境は整っておらず、部屋を確保することが難しい。” [Differences in resources and environments. America has a lot of donated toys, but Japan does not. Also, although there is a play room, there is not a teen room.]), including protecting their privacy, and

(c) low CCLS prioritization of adolescent patients due to the limited amount of CCLSs in Japanese hospitals (e.g., “CLSの人数が少ないため、外来での思春期、AYA世代への処置、検査サポートの優先順位が低くなってしまうこと” [Because of the small number of CCLSs, the priority of support for adolescents at outpatient clinics and AYA generation during treatments and examinations is lower]).

Research Question 4 (RQ 4) Results

Results indicated that CCLSs perceived the specific interventions, techniques, or skills that are helpful for child life specialists to know when working with adolescents were the (a) skill to assess individual personality, characteristics, and developmental stage correctly; (b) skill to protect adolescent privacy, and respect adolescents as people of the AYA generation; (c) ability as CCLSs to coordinate with multiple occupations and families; (d) ability to collect diverse information, such as the environment, timing, and level of understanding; (e) skill to communicate appropriately with adolescents; and (f) skill to assess with child life techniques.

Research Question 5 (RQ 5) Results

Results indicated that CCLSs perceived the differences in child life interventions for adolescents in Japan and adolescents in North America were (a) perceptions of the individual referred to as "I", (b) not providing so much because Japanese adolescents tend not to be good at self-expressions, (c) no differences between both countries, and (d) lack of offers or limited opportunities for intervention in the adolescence and AYA generation in Japan rather than in the USA.

DISCUSSION

Types of Child Life Interventions for Adolescent Patients in Japan

Similar to literature on child life interventions for adolescent patients in North America, results from this study found that developmentally appropriate therapeutic activities, including emotional support (Rollins, Bolig, & Mahan, 2005); education for medical procedures/illnesses (Rollins, Bolig, & Mahan, 2005); intervention for changes of their body image (Rollins, Bolig, & Mahan, 2005); bereavement support (Rollins, Bolig, & Mahan, 2005; Parvin & Dickinson, 2010); support for medical non-compliance (Lask, 2003; Carter, 2014); encouragements for their transition to adult units (Rollins, Bolig, & Mahan, 2005); and encouragement of their peer relationships (Rollins, Bolig, & Mahan, 2005) were also provided for adolescent patients in Japan.

However, psychosocial interventions in the USA for adolescents in the hospital setting included *the category respect for independence and privacy*, but Japan did not. The challenge for CCLSs in Japan might be to respect adolescent independence and privacy, evidenced by one of increased needs for the CCLSs in Japan (RQ4). The one of increased needs was to offer "skill to protect adolescent privacy and respect them as people of the AYA generation."

Additionally, there might be another aspect of why the one of increased needs (RQ4) was to offer "skill to protect adolescent privacy and respect them as people of the AYA generation." As a theoretical framework, this study used Bronfenbrenner's ecological system theory to explain how factors within the child and in the child's environment influences how that child grows and develops (Bronfenbrenner, 1979). Based on the Exosystem (Bronfenbrenner, 1979), resource systems and the amount of CCLSs in Japan show evidence of influencing adolescent patients.

One of the challenges reported by CCLSs (RQ3) was that low CCLS prioritization of adolescent patients was due to the limited amount of CCLSs. The CCLSs prioritized other age populations instead of adolescents. The prioritization between other age populations and the limited amount of CCLSs would influence adolescents because of the Exosystem. Therefore, there is an increased need for CCLSs in Japan to offer “skill to protect their privacy and respect them as people of the AYA generation (RQ4).”

Psychosocial interventions in Japan for adolescents in the hospital setting included these specific categories: family and/or sibling support; distraction/coping support during medical procedures and pain management; providing group effective therapeutic/developmentally appropriate play, such as peer support (two or three adolescents meeting and talking together) or peer group (large group sharing) sessions; and encouragement for their academic career with school teachers.

Family and/or Sibling Support. Triandis (1989) and Rothbaum, Pott, Azuma, Miyake, and Weisz (2000) found that Japanese youth tended to find relating to their parents important, whereas youth in North America saw relationships with peers as more significant. Therefore, participants’ selection of *family and/or sibling support* by Japanese CCLSs matched Triandis’s (1989) and Rothbaum et al.’s (2000) findings.

Based on the Microsystem (Bronfenbrenner, 1979), families show evidence of influencing adolescent patients. One of the RQ1 results was that adolescents had a strong need for “family and/or sibling support”, which also was stated by the Microsystem. As Japan limits parents’ interaction with adolescents (Hagiwara, 2015), there is an increased need for CCLSs to offer “distraction/coping support during medical procedures (RQ4).”

Distraction/Coping Support during Medical Procedures and Pain Management.

Psychosocial interventions in Japan for adolescents in the hospital setting included the categories to provide distraction/coping support during medical procedures and pain management, but these categories were not specifically addressed in research on psychosocial interventions for adolescents in the USA. There are three possible reasons why these interventions were stated by Japanese CCLSs. The first reason is the difference in emotional expression in Japanese culture because Japanese CCLSs reported struggling to help adolescents express their emotions during their hospitalizations. (See Results section for RQ 3). Japanese people prefer euphemism, vague or indirect expression (Hall, 1989), non-verbal communication styles and modest culture (Nishimura, Nevgi, & Tella, 2008). Therefore, these preferences and cultural aspects may make Japanese adolescents tend not to express their pain level clearly, so that is why Japanese CCLSs try to provide distraction/coping support during medical procedure and pain management. The second reason is CCLSs could be filling the family/peer role because of restricted visitation in Japan. In Japan, there are restrictions on parent participation during medical procedures (Hagiwara, 2015) and limited visitations from siblings and peers (Nishimoto, 2012). Therefore, because of restrictions/limitations on parents/peers in the hospital and during medical procedures, Japanese CCLSs could try to support the adolescent in a parental or peer role by providing distraction/coping support during medical procedures and pain management. The final reason why Japanese CCLSs may have listed support during medical procedures and pain management as a common intervention for Japanese adolescents is because there may not be as many distraction resources for adolescents in Japanese hospitals when compared to hospitals in the USA. In Japan, there is a lack of developmentally appropriate resources for adolescents because of the limited budget for child life services (Hagiwara, 2015; Kitagawa, 2009) and

uncommon donation system (Hagiwara, 2015). Therefore, these situations may encourage Japanese CCLSs to provide distraction/coping support during medical procedures and pain management instead of just letting the adolescents use the resources by themselves.

Providing Group Effective Therapeutic/Developmentally Appropriate Play. Japan demonstrates collectivism by belonging to or relating with others (Nishimura, Nevgi & Tella, 2008). Sato and Cameron (1999) examined the relationship between sides of collective self-esteem (e.g., independent or interdependent) among students in Japan, and determined that Japanese people prefer harmony by suiting their values with others based on collectivistic culture. Therefore, it was expected that participants would select *providing group effective therapeutic/developmentally appropriate play* due to the importance of interdependent relationships among Japanese people based on the collectivistic culture.

Based on the Macrosystem (Bronfenbrenner, 1979), which was the theoretical framework of this study, Japanese culture shows evidence of influencing adolescent patients. Therefore, there are cultural reasons (Hall, 1989; Nishimura, Nevgi, & Tella, 2008) based on not only previous literature, but also the Macrosystem.

Encouragement for Adolescents' Academic Career with School Teachers. Jose and Killburg III (2007) reported that Japanese adolescents faced an increasing amount of stress as they age, specifically education-related stress. Crystal et al.'s (2008) research also revealed that Japanese adolescents felt educational stress because of the university entrance examinations. Therefore, it was expected that participants would select *encouragement for adolescents' academic career with school teachers*.

Based on the Chronosystem (Bronfenbrenner, 1979), which was as the theoretical framework of this study, an event that is unique to Japanese high school students, preparing for

and taking the difficult “National Center Test for University Admission”, shows evidence of influencing adolescent patients. RQ1 asked CCLSs in Japan what types of psychosocial interventions were used with adolescents. One of the results was that “encouragement for their academic career with school teachers.” The reason could be that their university entrance examinations when they become age 17 or 18 (Crystal et al., 2008). Therefore, there is an increased need for CCLSs to offer “skill to collaborate with multiple disciplinary (RQ4)”, especially school/academic teachers.

CCLSs’ Perceptions of Effective Child Life Interventions for Adolescent Patients in Japan

The top three child life interventions that CCLSs perceived as the most effective for adolescent patients in Japan were providing education resources (13.2%, rank: No.1), emotional support (12.0%, the second place), and group effective therapeutic/developmentally appropriate play (10.6%, the third place). Two of these interventions aligned with the literature review: providing educational resources and emotional support (Rollins, Bolig, & Mahan, 2005; ACLP, 2018). Piaget (1950) stated that adolescents are in the formal operational stage, where they are capable of thinking logically and abstractly, and development allows adolescents to consider new methods for problem-solving, which were impossible in the earlier stages of their cognitive development. Therefore, providing educational resources was the most effective psychosocial intervention for adolescent patients in Japan because of their cognitive development.

In addition, adolescents can consider cause and effect with from their experiences, and can predict the consequence of future conditions (Piaget, 1950; Rollins, Bolig, & Mahan, 2005). During the term of identity diffusion, Erikson (1980) defined a psychological moratorium, which referred to adolescents who have experimented or explored their frustrations about life. This

means that they are at the age of crisis over changing identity formation (Erikson, 1980). Providing emotional support is helpful for adolescents' identity development because of the possible crisis over their changing identity formation (Erikson, 1980). This explains why providing emotional support was the second most effective psychosocial intervention by Japanese CCLSs in this study.

However, the third CCLS perceived effective intervention did not align with the literature review (Rollins, Bolig, & Mahan, 2005; ACLP, 2018): providing group effective therapeutic/developmentally appropriate play for adolescent patients. In this study, providing group effective therapeutic/developmentally appropriate play was the third most effective psychosocial intervention by Japanese CCLSs. This can be explained by the importance of Japanese collectivism, referred that Japanese people prefer harmony by suiting their values with others from discussion about providing group effective therapeutic/developmentally appropriate play.

The low percentages for top three CCLS perceived effective psychosocial interventions in Japan showed that there was a wide range of psychosocial interventions provided by Japanese CCLSs for their adolescent patients. This may be because of the wide array of hospital area/units that Japanese CCLSs cover. (See Table 1).

Based on the Macrosystem (Bronfenbrenner, 1979), which was as the theoretical framework of this study, Japanese culture show evidence of influencing adolescent patients. RQ1 asked CCLSs in Japan what types of psychosocial interventions were used with adolescents, and RQ2 asked CCLSs about the effective psychosocial interventions. The same results on both RQ1 and RQ2 were “distraction/coping support during medical procedures” and “providing group effective therapeutic/developmentally appropriate play”. For the same results, there could be

cultural reasons (Hall, 1989; Nishimura, Nevgi, & Tella, 2008) because of the Macrosystem.

Therefore, there is an increased need for CCLSs to offer “skill to collect diverse information and asses as a CCLS (RQ4).”

Challenges to Providing Psychosocial Interventions for Adolescent Patients in Japan

Results indicated that the biggest challenges to providing interventions for adolescent patients in Japan were the (a) promotion of emotional expression in individual and group settings, (b) lack of developmentally appropriate resources for adolescents, and (c) low CCLS prioritization of adolescent patients due to the limited amount of CCLSs in Japanese hospitals.

Promotion of Emotional Expression in Individual and Group Settings. On the literature review, Hall's (1989) high and low context communication theory revealed that Japanese people prefer euphemism and vague or indirect expression rather than direct expression. Moreover, the non-verbal and high context communication styles represent that Japanese people like to perceive an individual's feelings inseparably from other people's, a sort of cultural sympathy, because of their modest culture (Nishimura, Nevgi, & Tella, 2008). Therefore, it was expected that it would be challenging for Japanese CCLSs to promote emotional expression in individual and group settings due to Japanese cultural background.

Using non-verbal communicative tools may be beneficial to encourage their self-expression. For instance, these tools are a pain chart, a feelings chart, a facial scale, expressive art and so on because, in pediatric hospitals in the USA, an information board in each room tends to include the facial scale.

Lack of Developmentally Appropriate Resources for Adolescents, Including Protecting Their Privacy. Child life services are not eligible for medical service fees—which require hospitals to create room for CCLSs in their budget (Hagiwara, 2015; Kitagawa, 2009). In

addition, culturally, it is less common to donate money to hospitals in Japan compared with the donations received at pediatric hospitals in the USA (Hagiwara, 2015). The lack of developmentally appropriate resources for adolescents is caused by budget issues in the child life field. For instance, even though adolescents' privacy is important, there is a lack of teen rooms in the pediatric unit. This is a problem since adolescents may not always have the complete privacy that they need. Therefore, lack of resources/budget could also cause not to protect their privacy.

Based on the Exosystem (Bronfenbrenner, 1979), which was as the theoretical framework of this study, resource systems and the amount of CCLSs in Japan show evidence of influencing adolescent patients. One of the RQ3 results was that “lack of developmentally appropriate resources, including protecting their privacy.” Adolescents do not directly use the resource system. However, CCLSs use the developmentally appropriate resources for adolescents during their distraction/coping support, so the lack of a resource system would influence adolescents because of the Exosystem. Therefore, there is a need for CCLSs to offer “distraction/coping support during medical procedures (RQ1).”

Negotiating with hospital staff about more child life service fees may be beneficial for the lack of budget in the child life field. For instance, a part of hospital fees, such as a psychosocial fee on the nursing diagnoses or a fee on a regional medical liaison office, may have a more possibility to encourage the child life service fee.

Low CCLS Prioritization of Adolescent Patients due to the Limited Amount of CCLSs. The Japanese child life field's budget is very challenging, which is also the cause of the limited number of CCLSs. Additionally, the other possible reason for the lack of CCLSs is that medical professionals often question the need for the CCLS role (Hagiwara, 2015). Hagiwara (2015) and Matsudaira (2010) stated that Japanese pediatric nurses had received training to

provide psychosocial interventions for pediatric patients and their families, especially diagnostic education and psychological preparation, more so than pediatric nurses in the USA. Therefore, this situation may influence the expansion of child life services with amount of hired CCLSs in Japan.

Based on the Mesosystem (Bronfenbrenner, 1979), which was as the theoretical framework of this study, relationships between parents and CCLSs show evidence of influencing adolescent patients. One of the RQ3 results was that “limited number of CCLSs”, which could be caused by a lack of budget in the child life field in Japan (Hagiwara, 2015; Kitagawa, 2009). The limited number of CCLSs cannot be enough to help relationships between parents and CCLSs on the Mesosystem for adolescents. Therefore, there is an increased need for CCLSs to offer “ability as CCLSs to communicate appropriately with adolescents and families (RQ4).”

Encouraging hospital staff's recognitions of CCLS roles and psychosocial knowledge may be beneficial for the low CCLS prioritization of adolescent patients due to the limited amount of CCLSs. For example, it may encourage the staff's recognitions to do a presentation about CCLSs in orientations for new hospital employees, create a poster or business card to explain when they should call CCLSs, held study workshops about child-friendly words or positioning during medical procedures, and so on. Additionally, CCLSs may gather information about existing psychosocial care by Japanese nurses through observing, asking them or looking their clinical records or unit nursing manuals. Then, distinguishing roles to provide psychosocial interventions between Japanese pediatric nurses and CCLSs may be beneficial to the expansion of child life services with increasing the number of hired CCLSs in Japan.

CCLSs' Perceptions of Interventions or Skills Do CCLSs Believe are Important to Know When Working with Adolescent Patients in Japan

Four skills were found to be helpful for CCLSs to know when working with Japanese adolescents in the hospital: (a) skill to collect unique information and assess as a CCLS; (b) skill to protect their privacy and respect them as people of the AYA generation; (c) ability as CCLSs to communicate appropriately with adolescents and families; and (d) skill to collaborate with multiple disciplinary.

Skill to Collect Unique Information and Assess as a CCLS. According to the previous section, a reason that it is challenging to promote emotional expression in individual and group settings was due primarily to Japanese cultural background among adolescents. Therefore, because of the difficulty to promote emotional expression, there was an increased need for CCLSs to obtain “the skill to collect diverse information and assess as a CCLS.”

Skill to Protect Their Privacy and Respect Them as People of the AYA Generation. According to previous section, a reason that it is challenging to protect adolescents' privacy is lack of budget and donation for adolescents. Therefore, because of the difficulty, there is an increased need for CCLSs to offer “the skill to protect their privacy.” Moreover, Kojima et al. (2011) stated that because there were cases where children/adolescents were hospitalized in adult wards, it is necessary to promote psychosocial activities throughout all wards in the hospital. Therefore, as adolescents should be pediatric patients, it is important for CCLSs to respect them as people of AYA generation, not adults.

Ability as CCLSs to Communicate Appropriately with Adolescents and Families. Specific interventions, techniques, or skills that are helpful for CCLSs to know when working with adolescents in Japan included the category of an ability as CCLSs to communicate

appropriately with adolescents and families, but the USA did not specifically. One reason why this intervention was stated by Japanese CCLSs is cultural preference, which is a sort of cultural sympathy (Hall, 1984). The cultural sympathy may make avoiding professional relationships between patients/families and CCLSs. Therefore, there is an increased need for CCLSs to offer “the ability as CCLSs to communicate appropriately with adolescents and families.”

Skill to Collaborate with Multiple Disciplinary Healthcare Staff. Multidisciplinary cooperation is essential to support children and their families in hospital settings because of their various needs, such as pain/fear management, patient and family centered care, and respecting Quality of Life (QOL) care (Nagoya, Miyashita & Shiwaku, 2017). Therefore, because of the necessary multidisciplinary cooperation for patients’/families’ various needs, there is an increased need for CCLSs to offer “the skill to collaborate with multiple disciplinary.”

CCLSs’ Perceptions of Difference in Providing Child Life Interventions for Adolescent Patients in Japan versus Adolescent Patients in North America

CCLSs perceived the differences in child life interventions for adolescents in Japan and adolescents in North America were (a) perceptions of the individual referred to as "I", (b) not providing so much because Japanese adolescents tend not to be good at self-expressions, (c) lack of offers or limited opportunities for intervention in the adolescence and AYA generation in Japan rather than in the USA, and (d) no differences between both countries.

Perceptions of the Individual Referred to as "I". According to previous section, Japanese people prefer harmony by suiting their values with others based on collectivistic culture (Sato & Cameron, 1999). Therefore, Japanese adolescents tend to prefer suiting their values with

others instead of own value. That is why there is a difference in perceptions of the individual referred to as "I" between adolescents in Japan and in the USA.

Not Providing so much Because Japanese Adolescents Tend Not to Be Good at Self-expressions. Japanese people have non-verbal communication styles and modest culture (Nishimura, Nevgi, & Tella, 2008). Therefore, Japanese adolescents tend not to be good at self-expressions in the public, and then it could tend to cause low prioritization to compare other younger populations. In addition, according to RQ 3 results, one of the biggest challenges to providing interventions for adolescent patients in Japan was low CCLS prioritization of adolescent patients due to the limited amount of CCLSs. Therefore, lack of amount of CCLSs could cause few providing interventions for adolescents to compare other younger populations.

Lack of Offers or Limited Opportunities for Intervention in the Adolescence and AYA generation in Japan. It is less common to donate money to hospitals in Japan compared with the donations received at pediatric hospitals in the USA (Hagiwara, 2015; Adachi, 2015). A Japanese CCLS reported that there are toys for younger children, but not for older children (Adachi, 2010). Additionally, Piaget (1950) reported that development allows adolescents to consider new methods for problem-solving, which were impossible in the earlier stages of their cognitive development. Therefore, these literatures indicate that younger children are prioritized rather than adolescents because of their upper developmental level than younger children, so it could cause of lack of offers or limited opportunities for intervention in the adolescence in Japan.

No differences between both countries. ACLP (2018) stated that one of the core values of CCLSs is "Demonstrated by an organizational culture reflective of our professional community's respect for the value of different cultures, experiences, and points of view." Additionally, the Child Life Clinical Internship Curriculum (ACLP, 2018) required skills in

eliciting information from children and families using approaches that demonstrate sensitivity to cultural needs. Therefore, these ACLP's statements indicated that CCLSs should have skills for various cultural needs because of CCLSs' missions as a professional, so as to eliminate the differences between the two countries.

Limitations

The small number of participants limited the generalization of the results because participants were approximately 19% ($n= 8$) among Japanese Child Life Specialists, who have registered Japanese Association of Certified Child Life Specialist.

Another limitation of this study was that this study focused on adolescents generally, so it did not include other specific aspects for them, for example, those who have oncology disease or special needs, even though they should be important to consider for Japanese adolescents.

Future continued research is also necessary to provide a more detailed information for Japanese CCLSs, especially about the biggest challenges for providing interventions to adolescent patients in Japan.

Implications for Practice

This research study is relevant to child life practice because the results give new information about the interventions that are provided for hospitalized adolescents in Japan, as well as the challenges that Japanese CCLSs face when providing psychosocial interventions for hospitalized adolescents in Japan. Thus, the information discovered about the challenges that Japanese CCLSs face can be further explored in future research so that solutions to the challenges can be found. This research study is especially relevant for Japanese CCLSs and child life

internship supervisors who may mentor international student interns who plan to return to Japan to practice child life.

In addition, the results of this study could assist child life students in better understanding how to serve and support hospitalized adolescents in Japan. Nishimoto (2012) stated that cultural differences in child life services should be discovered more in each country in order to help the CCLSs to work more effectively with children and their families in the healthcare environment.

Summary

This study determined CCLSs' perception of effective psychosocial interventions for hospitalized adolescents in Japan. Quantitative and qualitative data were collected from CCLSs ($n=8$) in Japan through a one-time online survey. Results indicated that providing educational resources, opportunities for emotional expression, and group effective therapeutic/developmentally appropriate play were the interventions that CCLSs in Japan perceived as most effective for adolescent patients. Results indicated that promotion of emotional expression, lack of developmentally appropriate resources, and low CCLS prioritization is because of the limited amount of CCLSs that perceived interventions by CCLSs in Japan for adolescent patients as the biggest challenge. Results indicated that skill to collect diverse information and assess as a CCLS, skill to protect adolescents' privacy and respect them as people of the AYA Generation, ability as CCLSs to communicate appropriately with adolescents and families, and skill to collaborate with multiple disciplinary were the interventions CCLSs perceived the specific interventions, techniques, or skills that are helpful for child life specialists to know when working with adolescents. Results indicated that perceptions of the individual referred to as "I", not providing so much because Japanese adolescents tend not

to be good at self-expressions, lack of offers or limited opportunities for intervention in the adolescence and AYA generation in Japan rather than in the USA, and no differences between both countries were the interventions that CCLSs perceived the differences in child life interventions for adolescents in Japan and adolescents in North America. Results indicated that lack of recognitions about roles of CCLSs due to its history and numbers, appropriate developmental stages, and beneficial psychosocial improvements by CCLSs for adolescents were the interventions that CCLSs perceived the differences in healthcare workers' understanding of the child life specialist role and job duties in Japan and North America.

Therefore, referring literature review, there are possible reasons of these results: adolescent cognitive development; Japanese collectivism; primarily Japanese culture; budget system for Japanese child life field; re-defining professional boundaries of Japanese CCLSs in collaboration, especially with Japanese pediatric nurses, collaboration with multiple disciplinary. Furthermore, the background of Bronfenbrenner's ecological system theory (Bronfenbrenner, 1979) was behind the results of this study and literature review basically.

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APPENDIX A

A Survey of Japanese Child Life Specialists' Perspectives about Effective Psychosocial Interventions for Japanese Adolescents

In this survey, the term “adolescent” is used to define the following populations:

- Children who are 12- to 18-years-old
- Young adults who are 18- to 25-years-old and have continued receiving pediatric treatment or have transitioned from pediatric to adult treatment

I. *The following section is about you, your work history, and your current work.*

1. Gender:

Male

Female

Other (please specify): __

2. Age: __

3. Marital Status:

Never married

Now married/domestic partner

Divorced

Separated

Widowed

4. Education Level:

High school graduate (includes equivalency)

Some college, no degree

Associate's or technical school degree

Bachelor's degree

Graduate or professional degree

Current Work

5. What shift do you primarily work?

Day Shift

Night Shift

Weekend Shift

Other: __

6. How many hours do you typically work each week?

Less than 12 hours

12-23 hours

24-35 hours

36-44 hours

45+hours

7. What is your employment status?

- Full-time
- Part-time
- Substitute/PRN

8. How long have you worked as a child life specialist (any child life work after a child life internship), including work in North America?

- 0-2 years
- 3-5 years
- 6-10 years
- 11-20 years
- 21+years

9. How long have you worked as a child life specialist **in Japan**?

- 0-2 years
- 3-5 years
- 6-10 years
- 11-20 years
- 21+years

10. In which department(s)/unit(s) do you currently work? (Choose all that apply).

- General Pediatric
- Medical/Surgery
- Hematology/Oncology
- Pulmonary
- Neurology/Psychiatry
- Intermediate Care
- PICU
- NICU
- Imaging/Radiology
- Surgery
- Emergency Room
- Outpatient Clinics
- Special Events
- Other (please specify): __

11. What type of hospital does your hospital belong?

- National
- Private
- Other (please specify): __

*II. The following section is about your experience with adolescents as a child life specialist **in Japan**.*

In this survey, the term “adolescent” is used to define the following populations:

- **Children who are 12- to 18-years-old**
- **Young adults who are 18- to 25-years-old and have continued receiving pediatric treatment or have transitioned from pediatric to adult treatment**

12. Do you have a psychosocial support team?

(In this survey, a psychosocial support team is defined by a team that provides psychosocial support, such as CCLS, social workers, music therapists, and/or chaplains/spiritual supports.)

Yes

No

If “Yes,” who is a part of your psychosocial support team? (Choose all that apply).

Child Life Specialist

Child Care Worker

Hospital Play Specialist

Child Care Specialist

Clinical Psychologist

Psychological Physician

Child Health Nursing/ Pediatric Emergency Nursing

Social Care Worker

Music Therapist

Hospital Pastoral Service

School Teachers

Hospital Dog therapy

Hospital Clown Service

Other (please specify): ___

13. On a typical workday, what percent of your time is spent working with the adolescent population in Japan?

0% of your time

25% of your time

50% of your time

75% of your time

100% of your time

14. What kind of child life interventions do you provide for adolescents in Japan? (Choose all that apply).

Individual effective therapeutic/developmentally appropriate play activities

Group effective therapeutic/developmentally appropriate play activities

Preparation for medical procedures

Distraction/coping support during medical procedures

Emotional support

Providing educational resources

Providing opportunities to encourage their peer relationships

Intervention for changes of their body image

Encouraging their medical compliance

Encouraging their transition to adult unit
Encouraging their academic career with school teachers
Bereavement support
Pain management
Family and/or sibling support
Other

15. In your opinion, which child life interventions were the most effective for adolescents in Japan? Please rank the top five interventions in level of effectiveness: 1-5. One being the most effective and 5 being the least effective.

Individual effective therapeutic/developmentally appropriate play activities
Group effective therapeutic/developmentally appropriate play activities
Preparation for medical procedures
Distraction/coping support during medical procedures
Emotional support
Providing educational resources
Providing opportunities to encourage their peer relationships
Intervention for changes of their body image
Encouraging their medical compliance
Encouraging their transition to adult unit
Encouraging their academic career with school teachers
Bereavement support
Pain management
Family and/or sibling support
Other

16. In your opinion, which child life interventions might not be necessary for the adolescents in Japan? (Choose all that apply).

Individual effective therapeutic/developmentally appropriate play activities
Group effective therapeutic/developmentally appropriate play activities
Preparation for medical procedures
Distraction/coping support during medical procedures
Emotional support
Providing educational resources
Providing opportunities to encourage their peer relationships
Intervention for changes of their body image
Encouraging their medical compliance
Encouraging their transition to adult unit
Encouraging their academic career with school teachers
Bereavement support
Pain management
Family and/or sibling support
Other
None

17. (Short answer) What is the most challenging about providing child life interventions for adolescents in Japan?

18. (Short answer) From your experience, what are specific interventions, techniques, or skills that are helpful for child life specialists to know when working with adolescents in Japan?

III. *The following section is about your opinions of culture and child life practices with adolescents in Japan and North America.*

In this survey, the term “adolescent” is used to define the following populations:

- **Children who are 12- to 18-years-old**
- **Young adults who are 18- to 25-years-old and have continued receiving pediatric treatment or have transitioned from pediatric to adult treatment**

19. In your opinion, what are the differences in child life interventions for adolescents in Japan and adolescents in North America?

20. In your opinion, what are the differences in healthcare workers’ understanding of the child life specialist role and job duties in Japan and North America?

21. What recommendation(s) would you give for Japanese child life students in North America to provide effective psychosocial interventions for Japanese adolescents in the future?

22. Please include any additional information that may be beneficial for this research study.

--

Two additional links will be included upon completion of the survey. The links will be connected to Google Forms so that participants’ data for the online survey will remain anonymous.

23. Would you be interested in completing a follow-up interview via video (e.g., Skype or Zoom) or phone call?

Yes <https://goo.gl/forms/NVAhd3KS14qjZ5kJ3>

No

If “Yes,” please click on this link to include your email address and/or contact information so that you can be contacted by the researcher for the follow-up interview. (A separate link is provided for you to enter your contact information so it is not associated with your online survey responses).

24. Would you like to receive a ¥1,000 (\$10 U.S. equivalent) gift card to Amazon.co.jp for participating in this study?

Yes <https://goo.gl/forms/odDdZec92366nvs13>

No

If “Yes,” please click on this link to include your email address that you would like to receive the gift card. (A separate link is provided for you to enter your contact information so it is not associated with your online survey responses).

Thank you for completing this survey!

日本における思春期の子ども達やAYA世代への効果的な介入に関するチャイルドライフ スペシャリストへの意識調査

このアンケートでは“思春期の子ども達やAYA世代”を、下記の研究対象群と定めます。

- 12歳から18歳の子ども達
- 小児期と成人期の間にあたる若年期の青年（18歳から25歳前後）で、かつ、継続して小児科治療を受けているか、又は、小児科治療から成人治療への移行期にある青年

I. あなたの性別、年齢、婚姻状況、現在の職業についてお答えください。

1. 性別:

男性

女性

その他（詳細）：__

2. 年齢：__

3. 婚姻状況:

未婚

既婚/内縁関係

離婚

別居

未亡人

4. 最終学歴:

高校（若しくは同等レベル）

大学卒業見込み（中退）

短大、又は、専門学校

学士

修士、又は、博士

現在の職業

5. 勤務状況に関してお答えください。
日勤
夜勤
土日・祝日勤務
その他
6. 1週間の勤務時間をお答えください。
12-23 時間
24-35 時間
36-44 時間
45+時間
7. 雇用形態をお答えください。
正社員
パートタイム
育児休暇などの代替勤務
8. どのくらいの間、チャイルドライフスペシャリストとして働かれていますか？（北米でのインターンシップ後の総合勤務年数をお答え下さい。北米での職歴がある場合は、それも含めてお答えください。）
0-2 年
3-5年
6-10年
11-20年
21+年
9. **日本で**、どのくらいの間チャイルドライフスペシャリストとして働かれていますか？
0-2 年
3-5年
6-10年
11-20年
21+年
10. 現在どちらの小児科/分野で働かれていますか？
（該当項目を全て選択して下さい）
一般・総合科
日帰り手術病棟
血液/腫瘍科
呼吸器科

神経/精神科
内科
小児集中治療室
新生児集中治療室
放射線科
救急治療室
外来診療
特別なイベント
その他（詳細を教えてください）：__

11. 貴方の病院は、下記のどれに所属されますか？

国立・公立・市立・独立行政法人
私立
その他（詳細を教えてください）：__

II. 思春期の子ども達やAYA世代との関わりにおいて、日本での貴方のチャイルドライフスペシャリストとしての経験についてお答えください。

このアンケートでは“思春期の子ども達やAYA世代”を、下記の研究対象群と定めます。

・12歳から18歳の子ども達

小児期と成人期の間にあたる若年期の青年（18歳から25歳前後）で、かつ、継続して小児科治療を受けているか、又は、小児科治療から成人治療への移行期にある青年

12. 貴方の病院には、心理社会的チームがありますか？

（ここでは、心理社会的チームは、CCLS、ソーシャルワーカー、音楽療法士、チャプレンなどのpsychosocial supportを提供するチームの事とします。）

はい
いいえ

“はい”とのお答えいただいた方に質問です。どのような職種がそのチームメンバーに含まれるか教えてください。

チャイルドライフスペシャリスト
病棟保育士、又は、医療保育士
ホスピタルプレイスペシャリスト
子ども療育支援士
臨床心理士
精神科医

小児看護専門看護師、又は、小児救急看護認定看護師
社会福祉士

音楽療法士

病院チャプレン（スピリチュアルケアの専門家）

教師

ドッグセラピー

ホスピタルクラウン

その他（詳細を教えてください）：__

13. 貴方の日々の通常勤務の中で、思春期の子ども達やAYA世代向けのチャイルドライフサービスは、全体の何%ぐらいを占めますか？

0%

25%

50%

75%

100%

14. 日本で、どのようなチャイルドライフの介入を思春期の子ども達やAYA世代に提供されていますか？

（該当項目を全て選択して下さい）

個人向けの効果的な治癒的・発達段階的な遊びやアクティビティ

集団向けの効果的な治癒的・発達段階的な遊びやアクティビティ

処置・検査などのためのプレパレーション

処置・検査中などの精神的サポート（Distractionsも含む）

入院中の精神的サポート

医療に関する教育的リソースの提供

友人関係を促進するための機会提供

ボディイメージの変化に対する介入

医療コンプライアンスを促す介入

成人病棟（ケア）に移行する為の介入

学校教師とともに学術的キャリアの奨励

グリーンケア

精神的苦痛緩和ケア

家族、きょうだいへのサポート

その他（詳細を教えてください）：__

15. 日本で、どのチャイルドライフの介入が思春期の子ども達やAYA世代にとって最も効果的だと考えられていますか？重要な上位5つの介入を順位付けしてください。

（「1」が最も効果的で、「5」が5番目に効果的な数値です）

個人向けの効果的な治癒的・発達段階的な遊びやアクティビティ

集団向けの効果的な治癒的・発達段階的な遊びやアクティビティ
処置・検査などのためのプレパレーション
処置・検査中などの精神的サポート (Distractions含む)
入院中の精神的サポート
医療に関する教育的リソースの提供
友人関係を促進するための機会提供
ボディイメージの変化に対する介入
医療コンプライアンスを促す介入
成人病棟 (ケア) に移行する為の介入
学校教師とともに学術的キャリアの奨励
グリーフケア
精神的苦痛緩和ケア
家族、きょうだいへのサポート
その他 (詳細を教えてください) : __

16. 貴方の見解で、日本では下記のどのチャイルドライフの介入が、思春期の子ども達やAYA世代にとって**必要ではない**と思われましたか？

(該当項目を全て選択して下さい)

個人向けの効果的な治癒的・発達段階的な遊びやアクティビティ
集団向けの効果的な治癒的・発達段階的な遊びやアクティビティ
処置・検査などのためのプレパレーション
処置・検査中などの精神的サポート (Distractions含む)
入院中の精神的サポート
医療に関する教育的リソースの提供
友人関係を促進するための機会提供
ボディイメージの変化に対する介入
医療コンプライアンスを促す介入
成人病棟 (ケア) に移行する為の介入
学校教師とともに学術的キャリアの奨励
グリーフケア
精神的苦痛緩和ケア
家族、きょうだいへのサポート
その他 (詳細を教えてください) : __
該当なし

17. 日本で、思春期の子ども達やAYA世代へのチャイルドライフサービスの提供において、最も難しい事はなんですか？

18. 貴方の経験上、日本で思春期の子ども達やAYA世代にサービスを提供する上で、どのようなチャイルドライフの介入・テクニック・能力が必要だと考えられていますか？

III. 日本とアメリカにおける、思春期の子ども達やAYA世代へのチャイルドライフサービスの提供・文化的相違について、貴方のご意見を教えてください。

このアンケートでは“思春期の子ども達やAYA世代”を、下記の研究対象群と定めます。

- ・ 12歳から18歳の子ども達

・
小児期と成人期の間にあたる若年期の青年（18歳から25歳前後）で、かつ、継続して小児科治療を受けているか、又は、小児科治療から成人治療への移行期にある青年

19. 貴方の見解で、日本とアメリカの思春期の子ども達やAYA世代へのチャイルドライフサービスに違いがありますか？また、その違いを具体的に教えてください。
20. 貴方の見解では、日本と北米の医療従事者間に、チャイルドライフスペシャリストの役割や職務の認識、理解について違いがあると思いますか？また、その違いを具体的に教えてください。
21. 北米のチャイルドライフ専攻の日本人学生に向けて、日本で将来思春期の子ども達やAYA世代へ効果的なケアを提供するために、何かアドバイスはありますか？
22. 今回のトピックに関して、もし他に情報、コメント、ご助言があれば教えてください。
- 下記のアンケートは、2つの追加リンクを含んでいます。
この2つのリンクはGoogle
Formに接続され、このアンケートの参加者データの匿名性を保持します。
23. 思春期の子ども達やAYA世代への効果的な介入を経験された方の中で、ご回答いただいたアンケートについて、より深くお話を伺うためSkypeやZoom、お電話を

介してフォローアップインタビュー（30～60分程度）へご協力いただけますか？

はい: <https://goo.gl/forms/NVAhd3KS14qjZ5kJ3>

いいえ

“はい”とお答えいただいた方は、下記のリンクをクリックして、Eメールアドレスやご連絡先をフォローアップインタビューの為に教えて下さい。（連絡先情報を入力するため、別リンク（Google Form）を用意しております。（匿名性保持の為）オンラインアンケート上には、連絡先情報を入力する項目が含まれていません。）

24. (すべての) このアンケートへご参加頂いた方々対象に、Amazon.co.jpにて1,000円（米国10ドル相当）のギフトカードを受け取ることができます。ギフトカードを受け取って頂けますか？

はい: <https://goo.gl/forms/odDdZec92366nvs13>

いいえ

“はい”とお答えいただいた方は、下記のリンクをクリックして、ギフトカードを受け取る為メールアドレスを入力してください。（連絡先情報を入力するため、別リンク（Google Form）を用意しております。（匿名性保持の為）オンラインアンケート上には、連絡先情報を入力する項目が含まれていません。）

アンケートにご協力頂き、本当にありがとうございました。

LIST OF TABLES

Table 1

Hospital Units or Departments Where Participants Worked

<u>Hospital units or departments</u>	<u>%</u>
Intermediate Care	12.9
Outpatient Clinics	12.9
Imaging/Radiology	10.8
Emergency Room	10.8
General Pediatric	7.5
Hematology/Oncology	7.5
PICU	7.5
NICU	7.5
Medical/Surgery	5.4
Pulmonary	5.4
Neurology/Psychiatry	5.4
Other	4.2
Special Events	2.1

Table 2

Types of Child Life Interventions CCLSs were Providing for Their Adolescent Patients in Japan

<u>Types of child life interventions</u>	<u>%</u>
Individual effective therapeutic/developmentally appropriate play activities	9.4
Emotional support	9.4
Family and/or sibling support	9.4
Preparation for medical procedures	7.5
Distraction/coping support during medical procedures	7.5
Providing educational resources	7.5
Intervention for changes of their body image	7.5
Encouraging their academic career with school teachers	7.5
Bereavement support	7.5
Group effective therapeutic/developmentally appropriate play activities	5.7
Pain management	5.7
Encouraging their medical compliance	5.7
Encouraging their transition to adult unit	3.8
Providing opportunities to encourage their peer relationships	3.8
Other	1.9

LIST OF FIGURES

Figure 1

