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Child Life Specialists' Knowledge and Perception of White Privilege

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**CHILD LIFE SPECIALISTS' KNOWLEDGE AND
PERCEPTION OF WHITE PRIVILEGE**

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, Child Life Studies

By

Renee Elise Jamar Lee

July 2021

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CHILD LIFE SPECIALISTS' KNOWLEDGE AND PERCEPTION OF WHITE PRIVILEGE

Childhood Education and Family Studies

Missouri State University, July 2021

Master of Science

Renee Elise Jamar Lee

ABSTRACT

This study's goal was to understand child life specialists' knowledge and perception of White privilege. The purpose of this study was to examine child life specialists' understanding of White privilege and to obtain their perspectives on the impact White privilege has on patient- and family-centered care within the hospital setting. Through qualitative interviews, participants defined "White privilege," shared their perception of "White privilege" and the impact it has on patient- and family-centered care, as well their personal experience with diversity and inclusion training. Additionally, participants created their own personal lists of unearned advantages as an exercise of awareness and acknowledgement of their White privilege. These results provide insight into child life specialists' knowledge and perception of White privilege. Furthermore, these results call for action within the child life community in order to improve diversity, equity and inclusion for students, professionals, and the patients and families served.

KEYWORDS: white privilege, child life specialist, patient- and family-centered care, hospital setting, racial discrimination, racism, health disparities, diversity and inclusion training, normalization

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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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OVERVIEW OF THE STUDY

White privilege, or the set of unearned institutional benefits that are granted to persons belonging to the White racial group, has been an increasing topic of discussion in the community setting (Kendall, 2002). There are an increasingly number of articles, discussions, and even documentaries being presented on the topic of White privilege, including Chelsey Handler's 2019 documentary *Hello, Privilege. It's me, Chelsea*. However, there is a gap in the knowledge regarding the impact White privilege has on patient and family-centered care in the hospital setting. In the introduction chapter, the statement of the problem, purpose of the study, research questions, research design, significance of the study, assumptions, limitations and key terms will be presented.

Child life specialists work to address psychosocial concerns that accompany hospitalization and healthcare experiences through normalization, therapeutic play, expressive modalities, and psychological preparation (American Academy of Pediatrics, 2014). In order to provide normalization, play and preparation, child life specialists utilize a variety of resources (i.e., books, dolls, toys, images, etc.). However, through personal observations and experience working in hospital settings with diverse populations, there is a lack of resources that are representative of the population served. There is also a lack of diversity and inclusion trainings, which could be argued as important for a field that is primarily White females (Nguyen, 2014; Suzuki, 2017). The lack of these resources shows the impact White privilege has on the child life community and patient- and family-centered care, “an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care professionals, patients and families” (Institute for Patient- and Family-Centered Care, n.d.).

However, more research needs to be conducted to determine if others share the observations and what, should any, changes need to occur to improve diversity and inclusion.

White privilege is a set of unearned institutional benefits that are granted to persons belonging to the White racial group (Kendall, 2002). The purpose of this study was to examine child life specialists' understanding of White privilege and to obtain their perspectives on the impact White privilege has on patient- and family-centered care within the hospital setting. This study sought out child life specialists' definition of White privilege. This study sought to understand what areas child life specialists perceive White privilege in the hospital impacting patient and family-centered care. This study sought to determine if additional education, training and reform is needed among the child life profession and within hospital settings. The following research questions guided the study:

1. How is White privilege defined among child life specialists in the hospital setting?
2. In what area(s) do child life specialists perceive White privilege in the hospital impacting patient- and family-centered care?
3. What training, if any, do child life specialists receive with regards to diversity and inclusion either through schooling or employment opportunities?

As this study holds a transformative worldview, qualitative interviews of child life specialists across the United States were utilized to gather data (Creswell & Creswell, 2018). Child life specialists were asked to share their knowledge of White privilege and their perception of how White privilege impacts patient- and family-centered care in a hospital setting. Interviews were conducted and data analyzed to determine repeated themes.

The information gained through this study will make child life specialists more aware of White privilege and the impact White privilege has on patient- and family-centered care.

Through expanded knowledge and awareness, child life specialists may then take action to analyze if the current resources being provided are appropriate for the community being served. For example, analysis of playroom toys, books, education materials and hygiene materials may further be analyzed to ensure they include diverse representation of skin color, family dynamics, religion, body shape, etc. Additional analysis may be made to determine if additional diversity and inclusion training should be part of the education or training of child life specialists.

REVIEW OF RELATED LITERATURE

In 2015, George Yancy wrote a *New York Times* blog titled, “Dear White America.” At the conclusion of his blog post he wrote these words, “If you have young children, before you fall off to sleep tonight, I want you to hold your child. Touch your child’s face. Smell your child’s hair. Count the fingers on your child’s hand. See the miracle that is your child. And then, with as much vision as you can muster, I want you to imagine that your child is Black” (para. 27). According to research, a Black child is more likely to face hardship and disadvantages than that of a White child (Hobbs, 2018; McIntosh, 1990). As Yancy (2015) suggested, throughout this literature review, self-reflect on what it means for a child to be Black.

McIntosh (1990) wrote on the advantages of White privilege, and thus the disadvantages of not being White, in her essay “White Privilege: Unpacking the Invisible Knapsack.”. The 26 statements shine a bright light on the impact White privilege has on individuals, whether it is intentional or unrealized (McIntosh, 1990). The following are some of the statements:

1. I am never asked to speak for all the people of my racial group.
2. I am pretty sure that if I ask to talk to ‘the person in charge,’ I will be facing a person of my race.
3. I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children’s magazines featuring people of my race.
4. I can be sure that if I need legal or medical help, my race will not work against me.
5. I can choose blemish cover or bandages in ‘flesh’ color and have them more less match my skin. (McIntosh, 1990, p. 2)

Today, the United States’ population is estimated at a little over 327 million people (U.S. Census Bureau, n.d.). In the United States, 13.4% of the population is considered to be Black or African American alone (U.S. Census Bureau, n.d.). 76.5% of the population is considered to be

White (U.S. Census Bureau, n.d.). The impact of continued racial discrimination and racism in the United States is shown in the 2008-2010 American National Election Panel Survey (ANES). Survey results show 16% of White people believe racial discrimination to still be a relevant issue in the United States, whereas 56% of Black people and 26% of Latinos believe there is a lot of discrimination in the United States today (Byrd & Mirken, 2011). With regards to income, the survey results shows that 67% of Black people and 52% of Latinos believe Black people make less money than White people, whereas only 37% of White people believe Black people make less money than White people (Byrd & Mirken, 2011). Finally, with regards to perception of how the federal government treatment, 56% of Black people and 30% of Latinos believe the federal government treats White people better than it treats Black people, whereas only 9% of White people feel the federal government treats White people better than Black people (Byrd & Mirken, 2011). In fact, according to Byrd and Mirken (2011), one in four White people believe the U.S. government treats Black people better than White people.

Going back centuries, White people have been afforded unearned privileges due continued institutional and systemic racism. The disproportionate treatment between different races is not an effect of race, but an effect of racism. As Romano (2018) states, “racism is a system of both racial disadvantage as well as reciprocal racial advantage” (p.262). This institutional and systemic racism has led to continued advantages, or privileges, for White people and continued disadvantages for non-White people. These privileges, today known as White privilege, have mass effects. This literature review will discuss what White privilege is; the effects of White privilege, more importantly health disparities and the effect in the child life community; and finally, potential solutions that can be made to improve the effects of White privilege.

Definition of White Privilege

White privilege is a set of unearned institutional benefits or privileges granted to persons belonging to those in the White racial group (Alexis et. al.; Bonds & Inwood, 2016; Combs, 2019; Hobbs, 2018; McIntosh, 1990).

Physical Appearance. Those receiving the benefits of White privilege may not just be from European descent. According to a study conducted by MacIntosh, Desai, Lewis, Jones and Nunez-Smith (2013), those who appear White by others receive similar benefits to those who are White. Other studies have concluded that those with darker pigmentation are more likely to have lower education, occupation status, income, and increased adverse health effects (Byrd & Mirken, 2011; MacIntosh et al., 2013).

Economics. Throughout history White people have been afforded economic privileges due to an economic system founded in racial discrimination (McIntosh, Moss, Nunn & Shambaugh, 2020). As McIntosh, Moss, Nunn and Shambaugh (2020) state, Black Americans' efforts to build wealth was impacted by years of slavery, followed by Congressional mismanagement of the Freedman's Savings Bank and the Black Wall Street massacre. Discriminatory policies throughout the history, such as the Jim Crow Era's "Black Codes," the GI bill, the New Deal's Fair Labor Standard's Act's exemption of domestic agricultural and service occupations, and redlining, only continued to increase the economic disparities (McIntosh, Moss, Nunn & Shambaugh, 2020).

Continued institutional and systemic racism has led to a significant divide in the economic disparities among White and Black people. According to McIntosh, Moss, Nunn, and Shambaugh (2020), the net worth of a typical White family is \$171,000 nearly ten times greater than \$17,150, the net worth of a typical Black family in 2016. The U.S. Bureau of Labor

Statistics (2020b) states that as of the final quarter of 2019, the median White worker made 28% more, \$967 weekly, than the typical Black worker, \$756 weekly. As of September 2020, the unemployment rate for White people in the United States is 7%, whereas the unemployment rate for Black people in the United States is 12.1% (U.S. Bureau of Labor Statistics, 2020a). As of 2020, there are only five Fortune 500 CEOs who are Black, less than 1% of the total Fortune 500 CEOs, despite African Americans representing 13.4% of the U.S. population (Wahba, 2020; U.S. Census Bureau, n.d.). According to Wahba (2020), there have been only 18 Black CEOs on the Fortune 500 list since 1999, with the peak being six in 2012. The significant discrepancies among wealth, employment rate, and leadership opportunities among Fortune 500 companies are only a few of the examples showcasing the accumulated inequality, discrimination and racism Black people in the United States face, further enforcing the idea of White privilege and the unearned advantages White people receive.

Treatment. Studies have shown that Black people are more likely to be imprisoned due to drug use and more likely to receive harsher and lengthier sentences versus White people (Human Rights Watch, 2009; Rattan, Levine, Dweck & Eberhardt, 2012). Other studies have shown that teachers are more likely to respond to White students, Black children are seen as older and less innocent than White children, and the lighter the skin color of a Black person the more likely they will receive the White privilege benefits (Milkman, Akinola, & Chugh, 2014; Goff, Jackson, Di Leone, Culotta, & DiTomasso, 2014; Eberhardt, Davies, Purdie-Vaughns, & Johnson, 2006; Ben-Zeev, Dennehy, Goodrich, Kolarik, & Geisler, 2014). As Bonds and Inwood (2016) discussed, it is important to understand the concept of White privilege and the taken-for-granted benefits and protections afforded to White people based on skin color.

Examples of Unearned Privilege Due to Skin Color. Romano (2018) defined racism as, “a system of structuring opportunity and assigning value based on appearance that unfairly disadvantages some individuals and unfairly advantages other individuals” (p. 262). Inspired by Peggy McIntosh’s (1990) own list of defined White privilege tasks available to her, Dr. Romano created his own list describing his unearned privilege in medical training as a consequence to his White skin color (Romano, 2018). See Appendix A for a partial list of examples. Others have also included their own similar lists of how White privilege benefits their role in a given field. For example, Bruce (2015) provided a similarly formatted list on how White privilege affected her as a White librarian and reader. See Appendix A for a partial list of examples. While there is not a specific list created for or by child life specialists regarding White privilege, a goal of this study was to create one based off of similarly created lists and reflection on personal experiences that have been influenced or benefitted from being White.

Effects of White Privilege

Healthcare. White privilege has implications on patients and families in the healthcare setting. According to numerous studies, White people tend to have better healthcare opportunities and outcomes than Black people. Romano (2018) discussed how non-White infants die at higher rates, non-White children get less needed care, and adults of color receive poorer quality of care than their White counterparts. Unfair and unequal medical treatment among races is a product of a system of racism. Racism is defined as “a system of structuring opportunity and assigning value based on appearance that unfairly disadvantages some individuals and unfairly advantages other individuals” (Romano, 2018, p. 262). White people have been afforded an unfair advantage, while non-White people face unfair disadvantages, purely because of the color

of their skin. The infant mortality rate for Black women is 2.4 times higher than it is for White women (Byrd & Mirken, 2011). The asthma rate among Black children is double that of White children (Byrd & Mirken, 2011). Williams and Rucker (2000) conducted a review of studies conducted in the 1990s regarding the difference in care between White and non-White patients. Studies showed that Black people have higher rates of morbidity and mortality than White people (Luquis, Perez & Young, 2006; Williams & Rucker, 2000). According to data collected, Black persons had a mortality rate that 1.6 times higher than White persons in 1995, an identical rate to the Black/White mortality ratio in 1950 (Williams & Rucker, 2000). Naim et al. (2019) found that Black children are about half as likely to receive emergency bystander CPR following an out-of-hospital cardiac arrest than White children in disadvantaged or more prosperous neighborhoods. The disproportionate care is not an effect of race, but because of the effect of racism and the unearned privileges and disadvantages people have been assigned simply because of their skin color.

Health Insurance. White privilege also affects employment and representation in good-paying jobs that provide health insurance. Due to these factors, Black people tend to have less access to medical care and less likely to have insurance coverage (Beal, 2004; Williams & Rucker, 2000). This lack of healthcare access means Black people may not receive healthcare services until they are sicker than a White person who does have healthcare services available (Beal, 2004). Research also shows that lack of insurance coverage means Black people are more likely to live in poverty due to healthcare debts than White people (Alexis et al., 2019).

Medical Care. Other research indicates that Black people receive less pain medication and less empathy for pain than non-Black people due to implicit racist biases (Forgiarini, Gallucci & Maravita, 2011; Johnson et al., 2013; Williams & Rucker, 2000). Research also

found that Black children were more likely to have a prolonged length of stay than White children (Johnson et al., 2013). Williams and Rucker (2000) found White privilege and institutional racism affects education provided in the community, impacting the potential knowledge and familiarity with medical procedures or diagnoses within the medical setting. Studies on healthcare discrimination have also shown delays in care, including delays in ordering tests, treatment, and not filling prescriptions (MacIntosh et al., 2013). Findings in research have also found that unconscious influences on decision making may impact implicit bias for decision making on behalf of patients (MacIntosh et al., 2013). Alexis et al. (2019) found there to be a consensus that White privilege impacts therapeutic relationships with patients, patient communication with physician, patient trust of physician, trust with coworkers, fear of punishment, and hiring diverse staff.

Employment Diversity. White privilege and continued institutional racism also impact the diversity of staff in the healthcare setting. Romano (2018) stated that a lack of effort or banning of affirmation action programs has led to a decline in Black males entering medical schools from 1978 to 2014. According to the Association of American Medical Colleges, in 1978, 1,410 Black men applied to U.S. medical schools (Gallegos, 2016). In 2014, only 1,337 Black men applied to U.S. medical schools (Gallegos, 2016). Despite 40 years, this number has remained consistently stagnant (Gallegos, 2016). Studies suggest that affirmative action is responsible for 40% of all U.S. trained physicians from underrepresented minority backgrounds (Williams & Rucker, 2000). While approximately 13% of the U.S. population is Black, only 2% of male full-time faculty at MD-granting institutions are Black (U.S. Census Bureau, n.d.; Romano, 2018). According to the Association of American Medical Colleges, in 1978, there

were 542 Black males enrolled at MD-granting institutions, however, this number has since reduced to 515 in 2014 (Gallegos, 2016).

Diversity within the Hospital Setting. Alexis et al. (2019) conducted a qualitative study on people's reactions to White privilege and the essay by Peggy McIntosh (1990). Through interviews with others, respondents highlighted the lack of diversity or representation in the hospital setting. According to the respondents, the hierarchy of employment and positions of power at the hospital is clearly White men holding most of the high-paying jobs with the highest responsibilities, followed by mostly White female service providers, and at the bottom of the hierarchy is the environmental service employees who tend to be all Black or non-White people (Alexis et al., 2019).

Diversity within the Child Life Community. White privilege affects diversity in the child life community of professionals as well. Suziki presented a thesis at the 2017 Association of Child Life Professionals yearly conference exploring diversity and the perspectives of underrepresented individuals practicing within the child life field. As Suziki (2017) pointed out, there is a lack of diversity in the child life field, with the majority of child life specialists being White females. As is a similar issue with increasing diversity in other medical fields, there are potential barriers to increasing the diversity in the field of child life. Suziki (2017) discussed three potential barriers: learning about the field later in their academic career, challenges of the academic work, and difficulty getting a child life position. However, these barriers can be expanded to include: the limited number of universities with child life specific degrees and the diversity of these schools; lack of familiarity with the child life field outside of the White community; and cost of requirements for certification such as practicums and internships as these include potential fees such as application materials and interviewing costs (Suzuki, 2017).

Actions and Solutions Towards White Privilege

Institutional Change and Effort. White privilege will not be changed by one simple task or by one person, and actions meant to alter White privilege should not be aimed at one person or task. To make an impact, it will require an institutional change and effort (Romano, 2018). First, there must be an acknowledgement that White privilege is an issue (Bruce, 2015; Romano, 2018). Secondly, feelings felt and caused by discussing White privilege should be acknowledged and reflected on (Bruce, 2015). Once the issue of White privilege is recognized, there should be an expansion on studies conducted to shine light on the implicit bias or unaware actions caused by White privilege, such as inventorying supplies in child life departments (Suzuki, 2017). Finally, efforts should be made to minimize actions based on White privilege, both personally and within the institution, such as additional diversity and inclusion trainings. The solution to the effects of White privilege requires a relational approach with more conversation full of active listening and respect (Helsel, 2019).

Education and Diversity Training. One way in which an institutional change can be made in the healthcare setting is through education on what White privilege is and the impact White privilege has. Education on White privilege is important in working to eliminate the healthcare utilization and provider bias occurring in healthcare (MacIntosh et al., 2013). Diversity training can also work to improve patient satisfaction and increased coping and emotional connection with physicians and strive to reverse other effects caused by White privilege (Nguyen, 2014). Diversity training, however, must be directly tailored to the specific needs and culture of each organization (Nguyen, 2014). Nguyen (2014) shares five steps to managing diversity efforts and improving outcomes: (1) build senior leadership commitment and accountability; (2) conduct thorough needs assessment; (3) develop individual well-defined

strategy linked to business results; (4) emphasize team building and group process training; and finally, (5) establish effectiveness of diversity initiatives (Nguyen, 2014).

Analysis of Resources. Analysis of resources available and provided to patients and family within the healthcare setting is one way in which the effectiveness of diversity initiatives could be measured. For example, an examination of the hygiene products for different ethnicities' hair; books with different colored characters; educational preparation dolls and resources representing different races; toys from different races, ethnicities and cultures represented could all be assessed and analyzed at the child life department level throughout hospitals in the United States to determine if the resources available is appropriate for the population served at the hospital (Beal, 2004; McIntosh, 1990). Further research should be conducted to determine if the right materials and resources are commercially available for the patients and families.

Summary

White privilege is a set of unearned institutional benefits or privileges granted to persons belonging to those in the White racial group (Alexis et al., 2019; Bonds & Inwood, 2016; Combs, 2019; Hobbs, 2018; McIntosh, 1990). White privilege has implications on patients and families in the healthcare setting, effecting healthcare outcomes and diversity within the hospital setting. In the context of this study, White privilege has impacted the child life community. This study sought to examine child life specialists' understanding of White privilege and to obtain their perspectives on the impact White privilege has on patient- and family-centered care within the hospital setting. This study also sought to determine what, if any, additional education, training and reform is needed among the child life profession and within hospital settings. As

research shows, in order to improve the effects of White privilege, education and diversity trainings should be created and attended; resources should be analyzed and changed if needed; and barriers should be minimized (Luquis et al., 2006; MacIntosh et al., 2013; Suziki, 2017).

METHODOLOGY

While interviewing participants, the researcher sought to examine each child life specialists' understanding of White privilege and to obtain their perspectives on the impact White privilege has on patient- and family-centered care within the hospital setting. This chapter will discuss the research design, site of the study, participants, ethical considerations, data collection procedures, instrumentation, role of researcher, and data analysis that was conducted while the researcher sought to understand what areas child life specialists perceive White privilege in the hospital impacting patient and family-centered care, and what, if any, additional education, training and reform is needed among the child life profession and within hospital settings.

As this study holds a transformative worldview, qualitative interviews of child life specialists across the United States were utilized to gather data (Creswell & Creswell, 2018). According to Creswell and Creswell (2018), a transformative worldview “holds that research inquiry needs to be intertwined with politics and a political change agenda to confront social oppression at whatever level it occurs” (p. 9). The purpose of this study was to further the understanding White privilege has on patient and family-centered care within the hospital setting, a politically charged topic meant to bring attention to the social oppression and improvement actions that need to occur within the hospital setting (Creswell & Creswell, 2018).

Participants

This study was open to participants across the United States through online formatting. This allowed opinions and experiences to be shared from various child life specialists, no matter

the urban or rural setting. The interview was available through the online web conferencing company Zoom, as this company is HIPAA compliant. Participants were encouraged to choose a private setting of their choice for the interview. The interviewer is based in Houston, Texas and was available to respond to participants no matter the time zone or region across the United States.

Participants included seven Certified Child Life Specialists who are members of the Association of Child Life Professionals. All participants were White females, ages ranging from 32 to 58 years of age, with 5 to 25 years of experience in the child life field. Participants work in academics, hospice, private practice, and hospital clinical settings. The Association of Child Life Professionals recognizes four different regional child life groups: East Coast, Midwest, Western, and Southeast. Of the seven participants, five participants were from the East Coast and two were from the West Coast. Specifically, participants were from New York, Pennsylvania, Delaware, Washington and California. Despite recruitment attempts, there were no interested participants in the Midwest or Southeast regions.

Participants were initially sought through the Association of Child Life Professionals professional forum online, referred to as ACLP Connect. Recruitment of participants was expanded to all regional child life association groups, approximately twenty groups in total, via their general membership email or regional group President. Through this recruitment process, 18 interested participants completed the screening survey. 11 interested participants were eligible to complete the research, based on years of experience and location in the United States of America, and were sent a consent form and request for interview participation. Of the 11 sent consent forms and request for participation, 7 responded and completed the research study

interview. A screening survey with clarifying questions was asked of all interested participants to ensure they met all previously stated requirements.

As the child life profession is primarily White females, it is important to consider the potential cultural bias or White privilege perspective that is innately involved. Full transparency of participant demographics is included. Pseudonyms were used instead of real names in order to protect the participants. Prior to the interview, participants signed and returned a research consent form to the interviewer. These consent forms were saved in a secure location. Prior to research being conducted, an initial application for research approval was filed and approved by the Missouri State University Institutional Review Board (IRB) on November 17, 2020 with an approval number of IRB-FY2021-293. See Appendix B for the IRB approval letter. A modification to participant recruitment was filed and approved by the Missouri State University IRB on February 12, 2021 with an approval number of IRB-FY2021-293. See Appendix C for the IRB modification approval letter.

Procedures

Utilizing the Association of Child Life Professionals professional forum, referred to as ACLP Connect, a forum post seeking willing participants in a qualitative interview was posted and subsequently emailed out to child life specialists' members of the Association of Child Life Professionals. Recruitment of participants was expanded to all regional child life association groups, approximately twenty groups in total, via their general membership email or regional group President. Interested participants were instructed to complete a screening survey as an indication of their interest. See Appendix D for screening survey. Interviews were set up with interested respondents who met the selection criteria, with a total of seven interviews conducted.

Participants chosen to participate were contacted at the email of their choice and a mutual interview time was decided upon by both the participant and the interviewer. Interviews were conducted through Zoom, an online conferencing company that is considered to be HIPAA compliant. Prior to a participant's interview, the participant was emailed and asked to send back a signed copy of a research consent form. See Appendix E for research consent form. Interviews were conducted for approximately 30-60 minutes depending on length of participant responses at the convenience of the participant. Interviews were recorded with an electronic recording device. Recordings and notes obtained from interviews were stored on a password protected file on a locked computer. No more than two interviews occurred in one day. All interviews were completed within two months. Once interviews were complete, responses were coded and analyzed to determine common themes.

Measures

Interviews included 18 open-ended, semi-structured questions regarding the knowledge and perception child life specialists have of White privilege in the hospital setting, especially with regards to the impact on patient- and family-centered care. See Appendix F for interview questions. First, the participants were asked some general personal information (e.g., gender, age, self-identified race, years in the profession, geographical location, etc.). Then, the participants were asked to define White privilege and share examples of how White privilege impacts patient- and family-centered care within the hospital setting. A working definition was then provided so all participants were moving forward with the same framework. Follow-up questions were asked regarding the individuals' overall personal beliefs of White privilege impacting patient- and family-centered care within the hospital setting. Additionally, more

hospital specific questions were asked to determine if their hospital site takes into consideration White privilege when providing various resources, such as toys or hygiene products.

Prior to conducting interviews, the researcher started a reflection journal. The first entry included answers to the same questions asked of participants. Following each interview, the researcher took approximately 10 to 20 minutes to reflect and write thoughts. Reflections of the interview include ideas gained from the participant that may help improve practice for the researcher within their own hospital setting. Personal reflections began to form regarding connection of themes as more interviews were conducted. After conducting all the interviews, the researcher returned to the first entry and determined the point-of-view had remained.

Data Analysis

Interviews were transcribed using the secure electronic service Rev. Per Rev Transcription FAQ (n.d.), transcriptionists sign non-disclosure agreements (NDAs) and strict confidentiality agreements within the company. Rev transcriptionists complete their work on Rev's secure platform which includes data encryption (Transcription FAQ, n.d.). At the conclusion of this study, Rev was asked to permanently delete the files related to this study.

Following Creswell and Creswell's (2018) qualitative research design approach, these steps were taken in the data analysis process following transcription, "(1) organized and prepared the data for analysis, (2) read through all compiled data, (3) coded the data, (4) generated common themes and descriptions, (5) interrelated common themes and descriptions, (6) interpreted the meaning of themes and descriptions" (p. 193-194).

During the coding process, the researcher independently coded each interview to ensure interpretations were based on the respondents' experience and beliefs and not the preconceived

notion of the coder (Alexis et al., 2019). The researcher utilized the secure electronic service Dedoose to assist with coding needs. Dedoose utilizes a secure network and data encryption (Dedoose Version 7.0.23., 2016). At the conclusion of this study, Dedoose was asked to permanently delete the files related to this study.

RESULTS

The purpose of this research study was to examine each child life specialists' understanding of White privilege and to obtain their perspectives on the impact White privilege has on patient- and family-centered care within the hospital setting. This chapter will detail the results obtained from the seven participants interviewed. Participants were each given a pseudonym to protect their identify and maintain anonymity.

Through analysis of the data, common themes related to the following three research questions emerged:

1. How is White privilege defined among child life specialists in the hospital setting?
2. In what area(s) do child life specialists perceive White privilege in the hospital impacting patient- and family-centered care?
3. What training, if any, do child life specialists receive with regards to diversity and inclusion either through schooling or employment opportunities?

With regards to defining “White privilege,” all seven child life specialists had similar definition responses. These responses will be shared in this chapter. While analyzing areas in the hospital in which child life specialists perceive “White privilege” impacting patient- and family-centered care, common themes emerged and were coded as such: attitude and treatment of others; diversity within the field of child life; barriers to entering the field, including education, financial and position availability; and resources. Analysis of diversity and inclusion training led to data being coded in three areas: schooling, employment, and informal opportunities.

Additionally, participants were asked to create their own list of unearned privileges due to the color of their skin, similar to the lists created by McIntosh (1990) and Romano (2018). A

compilation of these lists will be shared. Participants were also asked to discuss ways in which they believe White privilege or diversity and inclusion gaps within the child life profession could be improved. Participant suggestions for improvement will be shared. Finally, participants were asked what it was like to participate and talk about White privilege. Their responses will be discussed. Results in this chapter will be organized by research question topic and the subsequent common themes related to the research question, followed by additional topics speaking to child life specialists' perception and examples of their own personal White privilege, ways to improve diversity and inclusion within the field, and their feelings toward the topic.

Definition of White Privilege

Research participants were asked to define "White privilege" before a working definition was provided by the researcher. All seven of the participants had similar definitions of White privilege. Participants defined White privilege as due to a person being White, they automatically have less or no barriers, a higher level of comfort, no judgment based on their skin color, and an ability to stay quiet in uncomfortable situations or conversations. The following are each participants' responses to being asked to define "White privilege." Kristine discussed the color of her skin not being a barrier.

I would define it as that the color of our skin is not a barrier for us. I know and I hear this in child life too, where people will say, 'Well, yeah, but it was really hard for me to get into the profession too,' or people will... A lot of times when people hear White privilege, in any context they'll say, 'Well, yeah, but I also had barriers as a child, and these are what they were.' But really when it comes down to it what White privilege means is that the color of your skin wasn't one of those barriers. I can stand up when I want to or when I feel like it's safe. I have that privilege of doing that, or to stay quiet when I want to keep myself safe. But for a Black person walking in that store, they can't take off their skin, right? So that is a privilege that I have of sort of when to step in and be an ally, and when not to. And then it's also about just there are specific challenges that people of color face,

just based on their skin color, and that isn't something as a White person that I've ever had to deal with.

Georgia discussed the level of comfort from being White.

White privilege to me means that there's a certain level of comfort that we have with being White and that it's difficult to... It's easier to explain it than try to define it. But that we are unable to truly experience what it is like to be a person of color. Even if we try and we think we're trying. It's truly impossible to have that experience in the same way that it would be difficult.

Sharon shared about the ability to navigate school, adult life and childhood as a White person.

I would define it as things are maybe a little bit more easier for us, that there's not judgment against White culture because the color of our skin, and just the history of it within the Black communities, Hispanic communities, Asian communities, and it's just less judgment...and less restrictions. I think it's horrible to say, and I'm White, that we have, I guess, an easier way to navigate through school and through adult life and childhood, and possibly other races, especially if some of those other races and cultures are mixed in with a much more White community... So, I don't know what a great statement would be, I think it was just that we do, we have a little bit more of a privilege. Which is so gross. It's so gross to say.

Melanie discussed how people who are White have the privilege of not worrying about their skin color.

I think that White privilege is often not even recognized by people who are White. When you are the majority, you don't realize what it feels like to be the minority and how alienating everything you do can be. I think White privilege is just not even knowing that that's a factor and that that is something that people pay attention to consciously every single day, most minutes of the day. So, not having to worry about that and just think that everything's hunky dory all the time is a very White privilege kind of thing, or you don't recognize what other people are even struggling with.

Samantha discussed being afforded the opportunity to sit and be quiet in uncomfortable situations.

Something I did not ever realize honestly, and I'm embarrassed to say it, in this last year, is that White privileges being afforded the opportunity to just sit and be quiet in uncomfortable conversations. And I think from not saying anything because I'm uncomfortable enables racism, it enables divide, it enables gaps. I have an opportunity that I can choose to sit out those conversations because they won't and don't affect me, but I'm learning that rather than having that privilege, using that privilege and speaking up, or interjecting if I hear someone make a comment that's inappropriate, that that is now what being a White advocate is. So, I think that the number one definition of privilege for me, it's my ability to be quiet if I wanted to be.

Gloria discussed not having to think about daily experiences, not having to question actions or change the way situations are approached.

White privilege means not having to think twice about your daily experiences, not having to question things or change the way that you approach a situation. You can just be you freely. One way I can parallel that, my husband and I have had these conversations, I lived in the city by myself for a while and I was trying to describe to him that sometimes when I would walk home at night, I would get scared, I would need to look at my surroundings, I would need to be alert and aware and pop into a place if I felt like someone was following me. And that was such a foreign thing to him, he's like, 'I've never felt that way.' That to me is how I imagine it feels like to be a person of color that I have never even put the hat on to think about the way that they're navigating their daily interactions, whether it's professional, whether it's personal.

Marie discussed how White people are afforded certain opportunities automatically because of the color of their skin. She shared research and examples in regard to maternal and infant morbidity, as well as pain perception and ability to obtain medication.

White privilege is just that inherent ... I'm trying to think of another word besides privilege. It's the inherent designation that you get because the color of your skin is White, that you are afforded automatically certain things, certain opportunities. Again, whether you ask for it or not, whether you try to suppress it or not, it's there. One example that always stands out for me is the maternal care of Black women example. When we look at the statistics of maternal morbidity and infant morbidity for women of color in New York State, it's like 12 times that of White women. None of the other factors are relevant. Education, wealth, geography, rural versus urban, access to healthcare, all of that is not part of the equation. The only part of the equation that separates those two groups is race. If you have women that are all educated and have money and live in an environment where healthcare is accessible, it's still 12 times more likely that a Black woman will die of childbirth than a White woman. So that is inherent White privilege. That I am believed more readily by a physician when I go to them with a complaint or a symptom or an issue than a Black woman is. Same thing for pain medication. My pain is believed more than that of a Black person. So, I more readily can get a hold of narcotics than, say, a Black friend of mine who has everything else the same. Education, income, all of that, she's going to have a harder time getting narcotics that I am.

Impact of White Privilege on Patient- and Family-Centered Care

The researcher asked participants if diversity and inclusion and White privilege affected the following areas: child life services, resources, training, and diversity within the field. While asking if White privilege had any impact on any of these areas Marie stated, “Obviously. Even before you say any of the list, I’m going to say yes. It affects all the categories you’re going to list. It affects everything in life.” All seven of the participants believed White privilege impacted these areas and had some effect on patient- and family-centered care within the hospital setting. Four themes became apparent in participant responses to how patient- and family-centered care was affected, including attitude and treatment of others, diversity within the field of child life, barriers to entering the field of child life, and resources.

Attitude and Treatment of Others. All seven of the participants spoke on the impact White privilege and diversity and inclusion has on how people are treated, alluding to microaggressions, implicit biases, and racism. Samantha discussed diversity and inclusion and

the unconscious bias people have stating, “Diversity and inclusion is not Black and White, literally and figuratively, that diversity and inclusion is having unconscious bias about culture, about people's appearances, about the way people speak, about people's actions and body language.”

Research Awareness. Two participants were aware of prior research on biases within healthcare and the negative implications for patients and families. Kristine stated, “there's so much research out there about bias in healthcare and the negative implications for patients and families and just in terms of their comfort level with providers, the way that they interpret body language and communication, and the way that we approach them.” Kristine was also aware of research on discrepancies in pain management.

I know that there's a lot of issues within terms of how we take seriously the pain of people of color compared to White people, where a lot of White providers are much less likely to give them pain meds when they're in pain, they often think they're exaggerating their pain. There's actually research that suggests that a lot of White people, and even some people of color believe that Black people don't even experience pain at the same level as White people, like their skin is thicker, they have fewer pain receptors. And so, just in terms of managing symptoms, such as extreme pain, I mean, that's not being done equitably between White patients and Black patients.

When defining White privilege, Marie presented research statistics on the maternal and infant morbidity for women of color in New York stating, “When we look at the statistics of maternal morbidity and infant morbidity for women of color in New York State, it’s like 12 times that of White women.”

Racism in the Workplace. Kristine discussed racism from other healthcare professionals that in the past has not been addressed. Kristine shared an example of a Black doctor in her city who quit his practice due to blatant racism.

He just quit his job recently because he felt like he had to do something because there has been so much racism within the hospital that he's experienced as a doctor, and that his patients have experienced. And he's said that he's been bringing it to leadership for years and years and years, and it's just been swept under the rug, and nothing's changed. And he had to leave in order to... He's like, 'I can't keep working in this situation, and allowing my patients to be treated like this.' And he's published a few articles about this, saying that people of color who work there, even a very well-respected doctor, I mean, he said that there were people that would call him the N word at work. And so, it was so blatant racism was impacting his ability to do his job and to feel safe at work. And then, of course, that if you have medical providers who are overtly or covertly racist, that's not just affecting people who work there, that's obviously directly affecting the patients and families too. And they're not getting the same level of care.

Language. Georgia, Melanie and Gloria spoke on challenges related to language use.

Georgia provided an example of healthcare professionals treating families differently for anesthesia induction because of a language barrier or difference in socioeconomic status.

I used to work in surgery where we had a parental presence for induction program, PPI. The parents could go back with the child while they went to sleep. And time after time, it was child life advocated, but it was really in the end up to anesthesia to decide who was going to go back. Time after time, I could see their discomfort with people that were of a different culture than them because of their level of comfort. So, say you had someone who was Spanish speaking, and they wouldn't be like, 'We can't have...' Or any other language, how are they going to go back? How am I going to explain to the parent that it's time to leave? That their child is asleep and it's time to leave? I'm like, 'Well, you get an interpreter. Of course. How would you describe anything to them?' Or it was like people who were different from them social economically in any way, I definitely noticed a disparity in the opportunities for parents to go into for induction.

Samantha shared her own awareness of how speaking a different language than someone has impacted the time she has had available or spent with families.

The example this morning is that I provided heavy education and preparation all morning with multiple patients and families. Most of those families spoke English and were White. And this family, I spent less time with and invested less time in because there

were multiple people using the interpretation services and needing to convey to the parents the planned procedures, getting consent for sedation, reviewing the medications; there was less time for me to really emotionally prepare that child and family for the experience. And it wasn't by myself or my team really advocated aggressively enough for more time allotted to spend with this child. It was stick to the plan, stick to the schedule, we have an hour, everyone get the work done in an hour. And I think that consistently for me, I've really come to see language as something that can be a race issue or an inclusion issue and not valuing and embracing diversity because that family is here and deserving, that's within our ethical code, deserving of the same services of all the other families that I met today. But did I provide them with the same services? No, I let that language sort of be a barrier. And it doesn't need to be, there's somebody that's there on the computer that can talk for us and interpret our languages.

Gloria discussed colleagues not using an interpreter.

One of my colleagues on her unit, the nurses do not call an interpreter. First of all, don't even bother to get an in-person interpreter, which we do have, we also have a video interpreter system. They'll be like, the family understands, they shook their head yes and the child life specialist is the one being like, 'No, that's not how this works, here is my [phone], I am calling an interpreter.' I think it's not possible to provide family-centered care when you're not respecting and meeting the family in their diversity and where they're coming from.

Georgia also discussed language use from the perspective of using English differently based on a person's culture.

Even some of the language that we use. There's a lot of other minorities that don't use English the same way that White people typically do. So, understanding what some of those differences are and making sure that how we have written things, even if it's correct according to the White people version, maybe it's not culturally correct for other minorities. So, making sure that we have versions that are not particularly insensitive. Maybe there's phrases that we can avoid using and still describe things accurately for everyone without being just inappropriate or insensitive.

Navigating the Healthcare System. Two participants spoke on the difficulties of navigating the healthcare system. Sharon discussed families being treated differently and having a more difficult time navigating the healthcare system.

As far as the healthcare experiences goes for families, I have witnessed families of color or different backgrounds not getting the best treatment or being provided the best care. There's also some more judgement from medical team members or other people I've worked with. Because I think that with White privilege, and the majority of the people within the healthcare system are White, I feel like patients who are White may be able to navigate the system a little bit easier. There might be more accessible resources and services available, without judgement. There's a lot of judgement for other cultures.

Samantha discussed difficulties navigating the healthcare system due to language and access to online systems.

I've also learned over the course of this past year how segregated sometimes populations who do not speak English can feel and are isolated within the hospital setting alone, and that those are biases and racism in ways... I have to imagine everything from being able to have someone who's a literate adult and can read the signage and the consent forms and the paperwork needed to get your child an appointment. There's a lot that's done electronically now because of COVID. And whether that's being able to create an online chart for your child where you communicate with your providers, and or some providers are only doing telehealth appointments, does everyone have access to WIFI, computers, and or computers with a camera?

Financial Barriers. Financial barriers for families can also impact their ability to be at their appointments or the hospital. Samantha spoke on healthcare professionals needing to be aware of transportation and financial barriers for families.

I think that we work in an urban area where we have a lot of families who arrive late to appointments, but they took public transportation to get here and don't have the ability to

get in a car and leave at their own leisure and get here at their own leisure. I often think about families and how much it costs to not only buy yourself a meal, if you're spending the day at the hospital, but your maybe children or other children. And then it's been really, really disheartening to see the amount of families who have become no shows, quote unquote, to appointments because there is a lack of support for some families in other childcare. So, limiting the amount of caregivers that can be present now at appointments and no sibling visits has really, I think, put a divide in the types of families who are able to be here and be present at the hospital.

Trusting the System. Four participants spoke on the impact White privilege has on trusting the healthcare system and providers. Kristine spoke on the cycle of distrusting the healthcare system because of prior experiences and the defensiveness of healthcare professionals which results in unfair treatment.

I think about what the experiences when you hear about how many inequities there are, and how much racism that people experience in healthcare settings, I think about as a parent sitting in a room waiting for a provider to come in, and how if that's been your experience over and over again, you would be on edge and maybe feel defensive, wondering, 'Is this going to be yet another one of those people that's going to treat me differently, or whose not going to listen to what I'm saying, or not going to believe my child?' And then as a White provider to walk into a room like that, often we take that personally, like they're giving us attitude, or they're not even giving me a chance or like trying to connect with me, and kind of like it hurts our feelings. And so, I think that that just starts this nasty cycle or continues I guess, the nasty cycle, where then we feel defensive. And so then, right there, there's a disconnect between them.

Melanie believes trust occurs when patients and families have providers who they can identify similarities with.

In terms of trying to provide the most comprehensive services to patients and families, it helps when family sees similarities to themselves in the providers that they're working with at the hospital. So, if I have staff who look like the families that they're treating, they're going to feel more at ease and more comfortable. If I don't have that, they're not getting that experience. As White people, we can't understand the struggles that a lot of

our families are going through and many, like sickle cell disease for example, are predominantly African American families. So, for them to feel that they don't have someone that they can connect to and really open up and trust can really jeopardize the opportunity for having a really positive healthcare experience.

Gloria spoke on how White privilege can impact a family's comfortability and the healthcare providers trust of the patient.

I think White privilege can really impact a family's comfortability first of all. I think it can impact the lens in which we practice. And when I say we, I don't just mean child life, I mean all healthcare providers as far as what we 'believe to be true' as far as how much pain medication we use. I volunteer at a kids...and...sickle cell week is the week that I volunteer at. Just hearing their experiences and how hard that population needs to advocate for themselves to be believed in their pain crises and needing medication is honestly mind blowing to me. So, I think that is a huge thing that a lot of practitioners come with that White privilege lens.

Marie believes trust and power should be given back to the patient's and families; it should not rely on another White healthcare provider advocating for the patient.

For child life, it's important for us to be culturally sensitive, culturally humble, and also thinking about, given that our field is all White women, 99%, many of us are working in urban environments or working in communities of color, even if they're not urban, across the nation, across North America. What is that impact on sort of the power structure experience that patients and families are having? And how many child life specialists are really considering their role in advocating for their patients? Turning over the power to the family. Instead of always being the mouthpiece for the family to the doctors and nurses, are you actually training the family on how to be their own mouthpiece so they can give them the power, instead of you having the power. That's what keeps White supremacy moving forward, is us keeping the power. We've got to give the power over to the people who deserve it.... If we're not careful, we keep the power. We take it away from families. We have to be very careful about that. We have to know what our role is, and we have to help build that power within our patients and families so that they are heard, and they are acknowledged for their strengths. I think that's probably the biggest thing. Is that we...have that privilege of being believed. We don't want to keep that power; we want the family to be believed. If a family member or a patient, I've worked

with Sickle Cell kids for so long, if they tell the doctor they're in pain, you should believe them. It shouldn't have to be me going to the doctor to say, 'Hey, I really know this kid for a long time, they wouldn't lie. They are in pain.' 'Okay, if you say so, [Marie].' No, it should be the patient themselves, or the family member.

Impact of Negative Perceptions. Kristine, Melanie and Gloria discussed healthcare providers' negative perception of families. Kristine discussed how some providers lack the knowledge and empathy to understand the barriers a family of color may face.

If there's a family of color whose maybe lower SES, maybe a single parent family, we might not see the caregiver there as much because they have other kids to take care of, they don't have as much support, they have to work, or they're going to lose their house, not be able to feed their children. And so, I do worry about sort of this negative perception that people could have about a parent like that, because they're not there to support their kids, without really considering and understanding again, the barriers that that parent is facing in order to be there, in order to be part of it. And so, I guess the way that we interpret that, and I guess, the way that we're able to provide family-centered care, I mean, if they can't be at the hospital, are we reaching out? Are we making the extra effort to call them and at least talk to them on the phone and to get their input on their child to give them support and education that way? Or are we just like, 'Well, they're not here, so I'll set them up with a volunteer, and I'll just move on to the family who's here, who's present'? But I think we have to do those extra steps of really looking at the whole picture instead of if it's not convenient for us that they're here at the time that works for me, are they still a priority in some way for me to be able to provide that family-centered care maybe in a nontraditional way?

Melanie spoke on providers having a different perception of family support because of their White Privilege.

For example, not understanding the family dynamics and families from other countries that might be very large families. Typically, we expect a family to look like a mother, a father, a couple of kids, and that is your White, nuclear family. So, when you have a family that has a lot of extended family members, aunts and uncles, grandparents and things like that, that are all really connected to each other and communicate on a daily basis, having that many people in a hospital room can seem disruptive to White people

when that's more of a cultural thing. We need to accept that that is the norm and that's something that's important to them and part of their healing process.

Gloria pondered how White privilege impacts how soon situations get escalated or when social work may get involved. Gloria stated, "I'm curious how that dynamic would affect families' ability to ask the questions that they want or admit that they're not understanding the education that we're giving them, and also how quickly social work gets involved if families are late, miss their appointments, that whole dynamic can escalate very quickly."

Diversity within the Field of Child Life. A lack of diversity in the child life profession impacts patient- and family-centered care, according to research participants. The child life profession is made up primarily of White women. As Kristine stated, "When you go to Child Life Conference and look around the room, it's predominately White women in this career." Sharon stated, "The majority of our field is female, and it's White, and come from a more privileged class...I would be able to recognize everyone at the hotel who's attending the same child life conferences as me because they're all White girls who look like me. It's easy. Even at the airport, you can be like, 'You're going to the child life conference, right?' We all look the same." Samantha stated, "I do not believe that my department here at my institution is diverse in race at all. Marie stated, "Given that our field is all White women, 99%."

Sharing Similarities with Patients and Families Served. Participants believe that it is important for patients and families to see child life specialists, and other healthcare providers, who look like them and who come from similar cultures and backgrounds as them. Kristine stated, "I think that one of the problems...is that the diversity of the patients and families that we see is not being represented in our profession. So, patients of color are not seeing...They're not seeing people who look like them in these types of professions. I think that's an issue." Georgia

stated, "If people felt that they were represented, it'd just make the whole profession so much more rich. But I see the same thing among our physical therapy, occupational, speech therapy staff. It's not much different." Sharon had similar insight.

The fact that the majority of us are White and that's primarily our profession. That's all we see. We don't see a lot of diversity. And I think that it impacts us in a lot of different ways. I feel like working with families of other color, race, culture, if you come from a place of empathy and openness, you can connect with them and work with them, but I also think it's really important for families to see other staff members, especially in the medical field, aren't just White. So that they kind of are represented as well.

Awareness and Recruitment. Kristine discussed the importance of being aware of the lack of diversity and systemic racism stating, "One of the big problems is just a lack of awareness of maybe what is the negative impact of not having diversity on our staff, because we're not even really hearing or exposing ourselves to other perspectives of what it's like to be in a system that is, and has been shown repeatedly, packed with systemic racism." Kristine further explains recruitment barriers current child life professionals put in place for prospective student as a result of White privilege, and how this impacts diversity within the field.

I think because we're such a homogenous group of White women in this field, and that we don't maybe realize the barriers that we're setting up for students because we've never had to deal with that, right? And so, I think that sometimes even when we mean well and we want to make change, we don't always necessarily know what needs to happen. Like how far back do we need to go, and how many changes do we need to make in order to make it so that that is not a barrier for students? Clearly it is, because if it wasn't a barrier, we would see more people of color in the profession, right? I mean, it's just it seems pretty obvious to me when we look around that it is a barrier. I think White privilege and child life allows us to sort of let this continue to be a problem. And we keep talking about it, but there's no visible changes happening. Sometimes I'll hear child life specialists say things like, 'That student just has that It Factor.' And we need to think about that as a professional, 'What is the It Factor for child life?' Because when I look around the conference, I'm worried that the It Factor has something to do with being a middle-class

White girl, and that's really concerning. So, I think even reflecting on that, like are we, we're just trained to hire people that are people we'd be friends with, or are we really trying to get a diverse group of people that can help promote the profession and help us to move to a really different level in terms of providing equitable care? And then how are we even recruiting young people in the beginning and encouraging them and mentoring them in order to just pull them in? And then we have to support them to be able to go all the way through without feeling like they have to give up because they're going to go into debt, or they just can't make it work logistically because they can't feed themselves during an internship.

Barriers to Entering the Field of Child Life. Participants noted barriers that impact diversifying the child life profession, as well as barriers that impact students attempting to enter the field of child life. Prospective students and future child life professionals face education, financial, and position availability barriers as a result of White privilege, according to research participants.

Education Barriers. Two participants, Kristine and Samantha, discussed the education barrier for students. With regards to obtaining education in child life, Samantha stated, “Well, you have to have completed at least some form of higher education or have access to a university or college to complete college level coursework. Which I can't generalize, but I am making the assumption that for White women my age who grew up with a similar background is very easily obtainable.” Kristine, as an academic instructor, spoke further on the education barriers student face prior to starting college level coursework.

A lot of these students that are coming from poor and rural communities that the level of public education they had was so different from the level of public education that people had in higher economic status communities. And so, I see from just the beginning how much catchup they have to do to learn how to write a good paper in college, those types of things. It sometimes takes a few years for them to kind of learn some of the basics that a lot of these other students learned in high school. And so, then that impacts their GPA. And the GPA requirement that we have for students, we get applications for interns and we have 50 people with 4.0 GPAs. And so, we're not even looking at the people that have

3.0 GPAs because we have to weed them out that way. But I think we're weeding people out who they didn't get those GPAs because they didn't care or they didn't work hard, they did that because they came in, they didn't know, they didn't even really know how to write a basic paper. And so, I think the inequity starts before they even come to college, and that really sets them up on having to work 10 times harder than other people to try to get to where they kind of started out from.

Financial Barriers. Five participants discussed the financial barrier for students. Kristine spoke on White privilege and financial discrimination impacting diversity within the field.

The cost to get into child life is prohibitive. And I think that the students of mine that I see succeed, this isn't always the case, but a lot of them have parents who can just afford to fly them to interviews, to pay for them to go to their unpaid internships for three to four months in another state. And that's not something a lot of my first-generation students have; they don't have that. Their families don't have that money to do that. So yeah, I mean, the cost of even just applying for internships is sometimes hundreds of dollars between the transcripts and mailing them out, and just everything that they're having to do...A lot of them, they can't move across the country and pay for an apartment and everything, cost of living, making no money for three to four months. Yesterday I saw a quote from Chris Rock comedy special, where he was saying that hotels aren't allowed to say like, no Blacks allowed anymore like they used to, but instead they charge like \$4,000 a night. And that's basically their underlying way of saying no Blacks allowed. And it sort of it kind of made me think about our conversation today because I think we have to think about that, like what we say we want to be promoting diversity, but if we aren't changing what we're asking them to do in terms of the financial commitment that they have to make when they have nothing, we're basically saying, 'No, this is just for middle class White people,' and that's a huge problem.

Samantha discussed the impact of opportunities available just from being a middle-class White woman. She discusses how she has benefitted from this White privilege.

I do think that the child life profession continues to be dominated by White women who...are coming from middle class, upper class families who had the opportunity to go to college, who come from dual income families and maybe have a dual income family themselves. I see a very similar stencil cut out of child life specialists... financial

wellbeing or an upbringing that allowed or afforded you an opportunity to higher education, is really...where I've seen the most of what I've gained from White privilege.

Georgia discussed the costs associated with becoming a child life specialist.

In that if you are a person of color, this is only my knowledge base that I'm speaking from, but you may have a lower social economic status. And if you do, are you able to go to another city? Not have a job so you can do a practicum or internship? Those are really, really tough choices that people have to make sometimes. And can you go to conference? Do you have enough money to go to conference? Do you have enough money that maybe you're contributing to your family's household income and you're not able to spend the money to have these really rich, wonderful opportunities that perhaps other people have?

Marie discussed the financial barriers that keep the field of child life from being diversified.

I think that just like with everything in our country, there are financial barriers that keep certain groups of people out. So, you're really narrowing down the pool, when you look at the financial requirement to become certified in child life, get your degree and all that, that's going to narrow the pool. We know that there is going to be a larger pool of White Americans that can afford that than Black Americans or Spanish Americans. We've got to figure that out.

Samantha and Gloria shared their recognition of White privilege and the financial opportunities they had because of their privilege. Samantha recognizes how not having these opportunities may impact the diversity within the field.

I believe, what I've really come to understand and have a much better awareness of now, is because of my race, because of my skin color, I have been afforded very effortlessly opportunities to go to tertiary, secondary schooling, onto high school, and then on to earn a bachelor's degree, and was supported by a working-class family and just naturally had opportunities, reaped benefits of that and came across this field. And recognizing that there are such disparities with race and ability to pay for schooling, to go to college, to

have those opportunities, I think could be a huge reason why we don't see more diversity within this profession. I have the ability and am very easily able to gain access to loan and credit. I also grew up with a background that I'm sure is very common and similar to colleagues in the profession where I was not a sole caretaker of my siblings or other family members, nor was my family dependent upon an income that I needed to bring to the family. So, I was able to complete my clinical internship without also needing to work and support a family or my own family. And I think that those are huge and instrumental in getting into the field.

Gloria recognized her privilege on being able to rely on her parents for financial support.

I can only speak to my experience becoming a child life specialist and I leaned on my parents heavily. I didn't find out about child life until after I graduated college and I had to go back and take more courses, so I lived at home for a period of time. And then my parents 100% supported me financially during my internship. So, if you do not have that it's a huge barrier to entering the field. So, because of that, I think it's a huge impact. I think you have to have a level of privilege to become a child life specialist.

Samantha discussed the certification test required for child life professionals. She explained that the exam was previously not offered online, only offered at certain times of the year, and in different locations that people had to travel to. This impacted the current diversity of child life professionals. Samantha stated, "When I took the certification exam back in 2008, that at the time it was not offered online and it was only offered at different times of the year, I think quarterly, and in different locations. So, I had to travel to Boston to take my exam, and I have to imagine that not everyone has access to being able to travel, to stay overnight in a hotel for the exam that's the next day." Samantha also discussed the prior requirement of a master's degree stating, "And then for the period of time where child life was requiring a master's degree, I can see how that would have eliminated and excluded a large percentage of our country's population

baseline because of the exorbitant cost of going to higher level of education, universities, colleges.”

Position Availability and Marketing Barrier. Two participants, Sharon and Marie, discussed the barrier of available positions and diverse marketing within the child life profession. Lack of positions and non-diverse marketing strategies does not allow for an increase in diverse staff members, according to participants. Sharon stated, “Our field is so saturated with students and they're already having such a hard time getting placements within hospital settings. There's not enough jobs opened up for child life specialists. There needs to be some changes made in those areas.” Marie discussed the Association of Child Life Professional’s (ACLP) previous recruitment and marketing process.

I don't know how long you've been in the field, but it's only this year that the ACLP website has a picture on its opening page of a diverse representation of children. For many, many years, the picture that was on that home page was pictures of me and all the other women at the conference, a sea of White women faces. Well, why would anybody want to come into that field if they weren't White? They'd be thinking, ‘I don't fit in there. I don't see anybody that looks like me there.’

Marie discussed recruiting efforts and lack of available candidates from a diverse background for her own program.

We need to start looking at more direct recruitment efforts, and I'm calling myself out on this. Because I've been saying for years, I don't understand why I never get any applicants of color. I work in the Bronx. Where are people that want to work in the Bronx? They're not here. Now, I recognize, I'm going to have to be more direct. I'm going to have to go to schools that I know have a higher population of people of color and direct recruit from them. Because I'm not getting any submissions for my applications. That's really frustrating to me. We need to work on that. I think as a field, we've got to figure out how to bring people in.

Resources. Participants were asked how White privilege impacts resources provided to patients and families. The word “resources” was left to be interpreted by the participant. All seven participants were able to identify areas in White privilege impacts resources for patients and families. Kristine discussed how because of biases and microaggressions, people may be more likely to limit the resources that are available to be provided. Kristine stated, “If we have biases against certain people based on their race or socioeconomic status, we might be more hesitant to give them certain resources, like maybe leave an iPad with them overnight. Maybe there's a bias that we have about whether or not they'll return it or steal it, and that type of thing.”

Time. Time was discussed as a resource that is sometimes withheld due to implicit biases. Kristine discussed the unintentional preferential treatment to those similarities are shared with.

The allocation of our time. And I think that it's probably across the board unintentional, I don't think anybody would set out or be aware of the fact that they would be giving preferential treatment to one race versus another, or people who look like them versus people who don't. But there's a comfort level thing, right? There's certain families that you sort of click with really easily, and there's various reasons for that. But one of the factors that could be part of why we maybe don't feel as comfortable or that instant connection then, or just sort of that easy conversation that we would feel with people who just are sort of like the people that we have in our lives all the time, that maybe the interactions don't last as long or maybe we are, because we're not as comfortable, we don't spend as much time building rapport, because it feels harder. I think that there could be a lot of issues with that. Of course, as I said, unknowingly and unintentionally, but leading to then some patients and families of color potentially not getting even that same action and allocation of time as maybe a patient who looks like us or acts like us. It's an example of a microaggression, right?

Availability of Resources. Availability of resources, such as band aids, books, and dolls, and microaggressions were discussed. Kristine discussed availability of resources and microaggressions.

It's an example of a microaggression, right? When we can only offer products that are designed for White people...And I think in children's hospitals our band aids tend to be designed, but if they're not, are they Caucasian skin colored band aids versus... That's giving them a message, right? And I think that what we're giving them, and in terms of our playrooms, do we have books that reflect the population that we're serving? Are your Black patients walking into the playroom and seeing books that are full of all White kids or White families? Or are the dolls all White? So, I think that there's so many different places that we can really look in terms of those resources, and are they showing, are they reflecting that we've put the thought in, that we want those families to feel welcome, and accepted and appreciated? I talk with my students when I talk about environment I'm always like, 'If you walk into a children's hospital versus an adult hospital, and it's such a different feeling, right?' Because there's been so much work done, because we want to be giving messaging through the environment. We want to give the message like, 'Oh, this is a place for me, everything was on my level, and everything's bright and colorful, and this is a place for kids.' And we have to take that a step further and make it where yes, and then also, does the artwork on the wall, do the books that we have, do the dolls that... I mean, down to the products that we use or the band aids that we use, is it giving them the message, 'You're welcome and wanted here. You're important. We want you to feel that White's not the default. That there's no preference for one skin color versus another'?

Georgia discussed trying to have diverse representation in dolls stating, "We always try to have dolls of color and books that express different cultures. Most of our toys are White centric...So it does impact us in that there's a really low availability of more diverse options for us to use."

Sharon believes while there are some resources there needs to be more available stating, "I think that there are some resources. I think that there needs to be more." Gloria discussed the availability of dolls and resources at her hospital.

As far as dolls and resources, we have no problem having different colors dolls, Barbies, baby dolls, all that stuff I would say is totally fine. Books, I would say probably the majority of our playroom books, even outpatient, we have a closet of library books that we hand to families so that they don't have to buy them on their own. They're not all kid based, some are animal-based, but of the ones that are kid based, probably the majority are White characters, White families in the book.

Diversity and Inclusion within the Toy Market. Two participants discussed diverse and inclusive items within the toy market. Sharon discussed the impact of White privilege on the toy market stating, “Everything we have is based on Whiteness. You go to the store to pick up toys and it's always the White babies, the White Barbies...I think that's just how it's been for so long.” Marie discussed awareness in defining diversity, the availability of diverse resources based on the toy market, and a department's ability to purchase and clean said items.

What's the availability of diverse? When we say diverse, diverse toys and books and things. What is even, just in the general marketplace, what is the availability? It's not great. Especially when you're put down the limits of what can child life specialists buy? What is able to be used in the hospital setting that can be sanitized and all that? We have our own restrictions. Then within that small group of toys, can we find things that are diverse? Diverse by race, diverse by gender, diverse by orientation, diverse by ability level. When we think about toys and puzzles and all that kind of stuff, and books, are we showing all of those different diversities? Sometimes diversity, for some people, and we're talking about this a lot on the racially conscious collaboration group. Diversity for some people is a synonym for African American or Black. It's like, people hear diversity and they're like, ‘That means you need more Black dolls. That means you need more stories with Black people in them.’ But that's not really what diversity is. It's got to be that prospect of everything. That's the first thing, that it's challenging to find those resources.

Reevaluation of Department Resources. Two participants discussed their departments' goal in reevaluating resources being provided. Melanie's child life department has a goal to reevaluate the resources being provided to patients and families. Melanie stated, “A goal for our team this year is to look at the resources we're giving to patients and families and see which ones represent the diversity of our community and which ones need to be updated to make sure that it's not all a bunch of White kids on the cover of any resource.” Samantha discussed resources impacted by White privilege and her department's recent interest in addressing this issue.

White privilege affects hygiene products, books, dolls, toys. And sadly, wasn't really anything that our institution I think cared enough about or paid enough attention to until this past year. And now that is a part of the diversity and inclusion committee, replacing 'normal' hair products or standardized hair products with an assortment of haircare and skincare products, as well as creating more diverse character library books, so within the playrooms and the waiting areas, having more characters that we've said look like our patient populations, or have characters, the main role of the book is a diverse character. White privilege affects all of those areas, even food.

Creating Diverse and Inclusive Resources. Two participants discussed making their own diverse and inclusive resources. Gloria discussed having some diverse child life preparation materials, but that her department is focused on creating more diverse materials, which is not always successful.

We specifically try to make diverse preparation materials. I would say it's not always successful. I'm not a part of that committee to know who's making those decisions. I know that the majority of our preparation books are based on White little girls, but we do have some that are more diverse. That being said, I had a super uncomfortable conversation with a family, this was probably two years ago. [We] a cartoon surgery preparation video that's meant for kids with autism, it's more like storyboard style and I'm not joking, there is not one White character, they are all very dark skinned. And I have had Black families say to me, 'Did you send this video because you knew I was Black, because you think that that's all my kids see?' And it was so uncomfortable. So [they] try, but I would not say it's always successful.

Marie discussed needing awareness of the resources being made stating, "When we're making our own resources, which we all know we do that so much, we have to be mindful. We have to be mindful that we're utilizing diverse representations in social stories that we're making, and all of that. Marie also shared about an article discussing the availability of diverse and inclusive characters in children's literature.

I read an interesting article recently that was talking about ...I think this probably happened from a good place, which is often the case. But it's just an interesting thing. That someone was doing a children's literary search and they noticed that there are more children's books on the market where the main characters are animals, than when the main characters are Black and Brown. Sort of the conclusion that came from that, in an effort for people to not center White people in their stories, they started using animals, because they don't have a race and they don't have to worry about it. That is really true. When I think about so many books that I know, the animals are the main characters. Why is it that we're afraid to show true representations of children and people in our books?

Monetary Resources. Two participants discussed monetary resources available. Samantha discussed her hospital's privilege of monetary opportunities compared to those who have less funding and the impact this has on patients and families.

I come from a large institution within an urban setting, we're a huge campus that's afforded many opportunities monetary-wise, and I think about local community partners and smaller child life programs who maybe are not afforded those same monetary donations. So, less access to the same type of simply donations that we receive, that fund what we do and who we are. Whether it's prizes, whether it's birthday gifts, whether it's gift cards to purchase more light spinners. I think that there absolutely is a gap probably with location and population from institution to institution.

Marie also discussed monetary resources available stating, "On the book side, you're looking at your funding and how can you acquire funding? Marie focused on the tie between funding and marketing.

That all gets tied into marketing, and what does your marketing look like? Child life often works very closely with those two departments, development and marketing. You have to figure out, is your development strategy and your marketing strategy representative of your population? Is that going to be attracting donors to you in a way that you're going to get the money you need for those resources? That can be a tricky thing, to walk that fine line of what do we need to do to engage people to give us money without exploiting a certain population? That harkens back to showing a lot of pictures of poor, starving babies in Africa to get money. Are you exploiting those babies? Or is all that money

actually going there? How is that working out? How are we showing good representations here?

Training and Education

The researcher explored participants' formal training, both through school or employment, as well as any informal experiences that have impacted their knowledge of diversity and inclusion. One participant, Gloria, believes White privilege is to blame for lack of diversity and inclusion training in the field of child life.

I think White privilege is the reason that not much training exists. And I think as child life specialists, we are accommodating, and wanting to soothe, and wanting to help, and wanting to fix. And because of that, sometimes hard conversations can be harder to have. And I don't mean hard in like death, we can do that easier than we can do race. So, I think that it's a topic that we are scared to approach head-on because we don't want to offend anybody.

Kristine also discussed her rationale for limited progression in increasing diversity and inclusion training within the child life profession, alluding to child life professionals being our own barrier.

I think it's harder for people who have been in the profession for a long time to acknowledge that maybe we haven't been doing as well as we should have been... It's interesting because I've come across some interesting writings about how White women in particular can be, can kind of derail the progress for inclusive feminism, and working with Black women to try to make things better. And part of that is just how a lot of us have been socialized to be, to think like, 'No, we're really nice, good people.' And if anyone says anything that doesn't like up with that, it feels very uncomfortable, and we feel really resistant to that. And of course, in child life we're a bunch of really nice people drawn to this career. So, I can see, I think that for a lot of us when we first realize it, it can be hard to acknowledge that, and that's a barrier that you have to overcome, and to just be like, 'I have to commit to doing this or nothing's ever going to change.' ...I think there's a lot of resistance to accepting that about ourselves.

Three participants, Kristine, Georgia and Marie, gave credit to the Association of Child Life Professionals (ACLP) and their recent focus on diversity, equity and inclusion education.

Kristine stated, “I guess I’m hopeful in terms of what I’m seeing from ACLP, and there’s more and more out there that I hope means that there’s going to be a domino effect where this is going to be incorporated more into training programs.” Georgia shared similar sentiments stating, “ACLP is really banging the drum about this issue and really trying to make people more aware.” Marie shared her pride in the ACLP stating, “I’m really proud of ACLP for taking the bull by the horns this past year and doing this racially conscious collaboration work group with Leaders for Change.” The following section divides the participant responses related to training and education in to three sections: schooling, employment, and informal experiences or opportunities.

Schooling. All participants discussed their diversity and education training or education opportunities through schooling. Four participants: Kristine, Georgia, Samantha, and Gloria all stated they did not have any type of education or coursework discussing diversity or inclusion. Samantha stated, “I have a bachelor’s and went to a four-year undergraduate program. I can’t say confidently that I had any type of education or coursework that introduced diversity or inclusion or embracing race.” Gloria stated, “Truthfully none in my academic path towards child life.” Two participants, Sharon and Melanie, alluded to minimal diversity and inclusion education provided in their undergraduate degree. Melanie mentioned participating in a “cultural diversity class in college.” Sharon stated, “Through school, a little bit in my undergrad.... with more of a diversity with special needs, mental illness, a little bit of culture and diversity and race.” Sharon went on to describe her graduate program.

More so...we had a whole course in grad school for child life. The grad school I went to is very much inclusive and open-minded and wants diversity and wants to include everybody and wants to train their students to be able to go into the community, whether it's child life or schools or museums or wherever they're working, to be more representative on having an open mind. So, I feel like I got a lot from grad school.

Marie also discussed graduate coursework stating, "As part of my master's program, way back in the 90s, they had some cultural competency work. I don't know that I would put it in the DEI (diversity, equity and inclusion) category, but there's coursework on cultural competency." One participant, Kristine, works in academics and discussed the diversity and inclusion training she provides to her students.

It's something that I bring up and I address in all my classes...I have certain classes where we really dive deeper into it. So, I mean, I'm changing not just my curriculum, but I teach a general child life or child development class for a 200-level class. And I'm currently working on completely revamping that curriculum with a book that is written with a social justice lens, because I think it has to start right from when we're starting the conversation about child development and family dynamics, and then that needs to continue on up into when we're training, specifically training people to be working in this profession. And that needs to be more specifically about what are the disparities that we see in healthcare? How does that impact our job as child life specialists? How can you really be really mindful of that is an issue and then the actions that we need to take in terms of like, I have a paper that they have to write where they're reflecting on their own biases. They have to take the Harvard bias test, and they have to reflect on that. And so, I think that...I'm hoping that kind of these, the next generation of child life specialists are being exposed to that in the various academic programs, so that it's something that is just, that they can't ignore, I guess.

Employment. Diversity and inclusion training and education through employment opportunities was discussed by six of the seven participants. Note: one of the participants is in private practice and does not have an employer. Kristine was unable to recall any education provided when in a previous clinical role stating, "Not that I remember. So, it's been in my role

as a professor that I've gotten that instead." Georgia verbalized education through "annual mandatories.... but other than that, none." Georgia also alluded to availability of trainings and education provided stating, "It depends on whether your people that are in the supervisory role or people who are in the role of providing educational opportunities...you have what they give you, that's what you have available. So, there's that dynamic." Melanie discussed not having any formal training in any previous jobs but having "a lot of diversity education" at her current place of employment. Melanie stated, "We have an Office of Health, Equity and Inclusion, and they lead a lot of different classes and stuff. So, I'm always the first person to sign up for those. I think I took like 18 classes last year." With regards to Melanie's department, Melanie stated, "We offer a lot of diversity, equity and inclusion trainings for our team. I think that's really important to make sure that they are able to identify things that are important to other families that they're working with." Two participants, Samantha and Gloria, both shared that their hospitals increased their diversity and inclusion education and training opportunities since 2020. Samantha discussed previously available resources now being more publicized.

I would say pre 2020 there was probably resources available. However, they were not at the forefront of the institution or being promoted or publicized to the extent that they have been over this past year now. So, there is now a working group, the hospital wide committee, that is the diversity and inclusion committee. And I'm now offered more opportunities to participate, to be an advocate, and to take coursework through our leadership academy and leadership institute training, if you want to.

Gloria stated there were no opportunities prior to 2020, however, these have greatly increased within the last year.

I would say none up until this past year.... maybe in the orientation there was something about work diversity, but it's just a segment of a whole hospital-wide organization and it was never really touched on until this past year. And now our department has been really actually super proactive. In the past year they started these, first of all, one of our department committees is diversity and inclusion. We are doing monthly discussions where anyone can come in and just talk about the news, what's bothering them but related to diversity. We also do a weekly email that just has general updates and there's standing agenda items. It's like, people's birthday, they've added a diversity and inclusion aspect to that and its resources, whether it's a movie or podcast, something that people can engage. And then some of my Black colleagues did some presentations during Black History Month of just like... We haven't gotten Black History Month discussion since we were in high school, what does it look like as an adult? Let's revisit it. So, there's been a lot in this last year.

Marie is in a leadership position and did not explicitly say what education she has received through employment opportunities. Instead, she focused on the challenges she has faced in providing diversity and inclusion training to her staff.

I think just for training within our programs, I've seen this, especially this year, a lot of challenges. Because everybody's starting at a different place. Depending on where you grew up, or what you've done in your background, or where you went to school, you have different levels of what your starting point is. It can be very hard, especially with White people, to talk to them about this topic without a lot of defensiveness. If they haven't built the foundation of understanding that racism is pervasive and persistent, no matter what you do, you are likely racist at some point in your life. Without them understanding that Whiteness is elevated by our culture, whether you want it to be or not, whether you want that to be your privilege or not, it is. Then understanding this, we call it interest conversion. It's like, 'What is your interest in working on this? Are you gaining something from it? Is there some reason why it's a good idea for you to be involved in it?' Getting those three things aligned for staff, and that takes a long time to do even those three things. To get them to a point where they feel like, 'Okay, I am going to state, yes, racism is pervasive and persistent. I am going to acknowledge that my Whiteness elevates me above other people in our culture.' Until people get to that point, you can't really even start the work. That's really challenging.

Informal Experiences or Opportunities. Participants were asked to share what, if any, informal experiences have impacted their knowledge of diversity and inclusion. The phrase

“informal experience” was left to be interpreted by the participant. All seven participants discussed informal experiences. Participants discussed conducting their own research on the topics of diversity and inclusion, as well as the impact of White privilege. Kristine discussed conducting her own readings and research stating, “I’ve done a lot of reading and research on my own to try to just better educate myself, for my personal and professional life...so I can teach my students better.” Two participants, Georgia and Melanie, discussed listening to podcasts. Georgia has expanded her knowledge by listening to Ted Talk podcasts stating, “The ones I attended were on race and culture in our community.” Melanie discussed listening to the podcasts *How to be an Anti-Racist*, *Black History for White People, 1619*, and *Black History in Two Minutes*. Two participants, Melanie and Marie, discussed trainings or classes they have taken on their own outside of their schooling and employment opportunities. Melanie stated, “I got a lot of education in the process of adopting.... there was two really good cultural competent classes that were about raising children who don’t match your own skin color.” Marie spoke on various courses and accountability groups she has participated in, including Civil Rights Advocacy Training Institute (CRATI) training with the National Association for the Advancement of Colored People (NAACP), racially conscious collaboration training with the Association of Child Life Professionals Leaders for Change group, the Arc of White Womanhood, a 21 Day Equity Challenge with a local organization group, and a book club with other child life specialists in her area. Marie also mentioned, “I’ve basically been looking at this for the last twenty some odd, or maybe even forty some odd years.” Three participants, Sharon, Melanie, and Gloria shared about learning through experiences with friends and the communities they have been a part of. Sharon spoke about learning through informal experiences such as, “personal experience growing up and being aware of differences and injustice...and having a

very open mind to not live a way that is cruel or pushes people away.” Melanie stated, “I had grown up in Southern California in a very diverse area. Most of my friends were not Caucasian. I was only one of two White kids in my circle of friends.... I didn’t realize other people didn’t grow up like that.” Gloria discussed her first role child life role in Northern Philadelphia.

In Northern Philadelphia...the population is majority Black, I would say. And I worked in the emergency department there. So just seeing and being immersed in a different community like that for me, was really eye opening. And I think that non-traditional learning, just as far as what they come into the hospital for, or family dynamics, those things that are really big on talking about Black culture now, I was immersed, but no one ever sat down and taught me.

One participant, Samantha, mentioned social media as her largest informal experience in learning stating she has learned through *Instagram*, “I’ve seen and read some articles that have connected me or brought me to larger media sources and/or to books that I’ve read.” Samantha also mentioned informal conversations with colleagues and friends stating, “In daily informal conversation, I’ve really learned about the power of my word choice and the arrangement, I guess you could say, of word choice. And that’s been through friends of color.”

White Privilege and Unearned Advantages

Participants were asked by the researcher to create their own list of unearned advantages, similar to McIntosh (1990) and Romano (2018). The following are each participants’ response:

1. Kristine: I am taken fairly seriously when in meetings; my opinion is taken seriously. If I forgot my badge, I would not have to worry about it. I have never had people accuse me of being pushy or bossy when I speak up in meeting. I have the grace of knowing that if I mess up on something that it’ll be okay.

2. Georgia: I don't feel inferior to other people because of my race. People don't automatically find me untrustworthy. My language and accent are acceptable to most people. It's not threatening or difficult to understand for most people because people are used to hearing the English spoken language.

3. Sharon: In grad school, the majority of my cohort were of the same skin color, the same race. My professors as well. The people interviewing me, my supervisors, everybody pretty much was the same color, the same race as me. The majority children's book or dolls are all white characters or dolls that look like me. I can easily find images on Google for a presentation that represent me.

4. Melanie: I have the resources to be able to go to grad school and get a master's in child life. I would be able to recognize everyone at the hotel who's attending the same child life conference as me because they're all White girls who look like me. I assume everyone will have past medical experiences similar to mine. Because I am White and have had very little trauma, I'm going to naturally assume that everyone else has also not had traumatic medical experiences that have shaped them into who they are. I can go into a room not knowing what I'm doing and not worrying that people will judge me on the color of my skin. I think everyone will naturally assume that I speak English. They won't hesitate to try to figure out what language I speak before I speak to them. I think some things will be assumed, like that everyone has a cell phone, everyone has a computer...because that's my experience. So naturally, I'm going to assume that others have those resources at their disposal. So, everyone who comes into the hospital has what they need to be able to work remotely or log in to school and do homework.

5. Samantha: I don't have to worry about my child's skin color from birth as a new mother and worrying about him entering into the world. I don't have to worry that he's already damned, for a lack of a better word, because of the color of his skin. I don't have the same fears as a person of color when driving. If I were to get pulled over, the anxiety I would have would be about the traffic violation that I had made, and not that I would be potentially about to lose my life or need to fight for my life.

6. Gloria: There is always someone at the next level that's my race that I can learn from and feel comfortable with and help get me to where I want to go. I am not questioned when I come into the hospital. And if I say I've forgotten my badge, or this is the excuse why I am doing this weird thing, I'm always believed, and I am always helped for what I need. I'm never sent somewhere else. I'm able to think freely both in language, but also, I'm not filtering what I'm saying either to my colleagues or to families. I am able to just stream of conscious, say whatever my message is, whether it's preparation, whether its toy giving. I never need to pause to think about what I'm going to say. If someone can say your name...if a child's name is difficult to say, I ask how they say it and if I don't feel like I can say it, then I choose another word to refer to them to, because either I don't want to offend them to ask their name again, or I don't feel confident in how to say it. And no one has ever had to do that to me. My name is always my name. I can also relate to there always being resources that are affirming to me, whether it's a book or a video,

or even sometimes as a patient myself. If I go to a clinic, I see who's in there and there are people who look like me.

7. Marie: I can easily travel without any hardships getting through TSA to go to conference and trainings. When I'm going to speak to a donor, I'm usually going to be facing a person that's the same race as me. If I walk into a restaurant, I could request a certain table and probably get it. I have familiarity and understanding with child life colleagues because most of my child life colleagues are my same race. Most of my child life colleagues speak English as their first language. Most of my child life colleagues were able to obtain graduate level education. Most of my child life colleagues grew up in similar living conditions. I can speak up at a meeting with an opposing view without being labeled difficult or angry. I can live in White neighborhoods or neighborhoods of color; I have a choice. I can travel with little worry about the immigration line at airports. I can shop in any retail store without being followed. If I have car trouble or an accident, I am not afraid to call for help. I can climb through my home window when I lock myself out and not worry that I'll get shot. This happened to me once and then also to my mixed-race son a few weeks later and he was shaking with fear.

Suggestions for Improvement

The researcher asked participants to share ways in which they believe White privilege or diversity and inclusion gaps within the child life field and/or profession could be addressed. Participants had a range of suggestions on how the field could improve, including not just acknowledging the issue, but working to actively make change. Kristine stated, "We have to demand to make changes, and we have to do it. We can't just be like 'Oh yeah, we're acknowledging and validating that it's hard,' but what are we going to do try and change things?" Participants had thoughts on how to make these changes. Areas of growth or changes that should be made, according to the participants, included addressing the financial barrier, relooking at the student requirements and application process, diversifying staff, expanding recruitment practices, and provide mentorship opportunities.

Feedback. Two participants, Kristine and Georgia, discussed needing feedback from a diverse set of people, acknowledging that the child life field is predominately White females.

Kristine stated, “We can’t really adjust our practice accordingly because I don’t think we’re getting.... feedback from people who are different from us.” Georgia also focused on the need for change, the need to include other people’s perspectives in order to start the conversation and make change, and to be aware of White privilege when making these changes.

The thing is we can talk about it and we can do everything, but if we don’t put it into action, it’s not going to help the people who it’s going to help. And I think if we’re able to get their opinions, the same as we’ve had these parent panels in our hospitals, that we’ve included parents to help make decisions for things that happen to kids in the hospital, not just their own, but if we don’t include people of color in the conversation and specifically people who are affected by it, parents, children, then it’s just us asserting our White privilege to say, ‘This is what I think should be done.’ It’s not them saying what they know should be done because it’s their experience.

Addressing the Financial Barrier. Five participants discussed the financial barrier they believe students to face and suggested ways in which to address this gap. Kristine discussed finances being the number one barrier for students and needing more scholarship opportunities.

I think that we have to address the financial barrier. I mean, I think that’s one of the biggest things that we need to do. I’m working with our foundation to try to get.... a scholarship that would be for a child life student, to support them to come to our master’s program, that would also cover the expenses for practicum and internship. Everything, cost of living and everything. I think that needs to happen, both at the academic side and at the ACLP organization side.

Kristine was aware of the Association of Child Life Professionals (ACLP) diversity scholarship, but stated it is not enough. Kristine stated, “I know we have diversity scholarships.... I know it’s limited also on who can apply and what that looks like and you have to have an internship set up first, and then apply. So, I have some students that are like, ‘If I don’t get this, I don’t know what

I'm going to do.' But also, it's just not enough....it doesn't take away all of those barriers."

Sharon believes more scholarships are needed saying, "There needs to be more opportunities for scholarships." Marie stated, "I know they do diversity scholarships, and that's a great start. But I think we've got to look at some more aggressive ways to level that playing field and make it more equitable." Melanie also acknowledged ACLP's diversity scholarship, but stated it's not enough saying, "I do think that the ACLP is making efforts with their diversity scholarship. I feel like it's just one tiny pebble in a very big pond. It's helpful and I know people who have gotten those scholarships, but it's not like you just hand them some money and wash your hands of it. That's not the end." Gloria believes paid student programs are needed stating, "I think scholarship is number one...let's not say scholarship. Let's say a paid student program, whether it's practicum, specifically intern, you're working full time...Paid student time I think would be a huge way to allow even the opportunity for other people, just a more diverse application pool." Samantha highlighted child life specialists' compensation stating, "We don't get paid very much." Melanie also discussed child life specialists' compensation and the need for this to be improved in order to diversify the field stating, "We don't get paid very much. So, as a profession, if you're going to have to work really hard and get a master's degree just to make what we make as a child life specialist, that's not exactly worth the investment for some people." Marie shared her perspective on why the field is not more diverse and how this relates to child life specialists' income.

My completely subjective and non-evidence-based opinion on why we don't have more people, just looking at my own circle of African American friends, when people my age or their children are the first to go to college, which is very common for African Americans in our country, people my age or their children are the first ones to go to college. Sometimes when that's happening, because it's such an area of pride and such an area of accomplishment, they want to go for the highest. So, they're going to become a

nurse or a doctor. Or they're going to get their PhD in something, psychology and become a licensed clinical practitioner. They're not always wanting to go for a middle of the road, lower-paying job that costs a lot of money to get educated for.

Student Requirements. Two participants, Kristine and Marie, discussed the process for students, their barrier, and suggestions for change. Kristine spoke on being more aware of a student's circumstance.

We need to look at our process as well, how they apply for practicums and internships, how we are selecting students for those things, even looking at things like GPA. Are we just looking at GPA, or is there something else that we can sort of be like, 'Okay, look at GPA and something else?' Or maybe, if you have a GPA below such and such, is there an extra essay question where maybe they can address, 'Why is their GPA not a 4.0?' Were they living at home and caring for family and working three jobs in order to complete school while they were taking classes? Because that's a really different situation than somebody who didn't have to work and was living on campus, and they could devote all their time to school. So, I think we really need to be more mindful about the requirements that we're looking at for interns.

Marie spoke on previous Association of Child Life Professional requirements for a graduate degree and needing to be more inclusive on how people enter the field.

We went through this period of time where we were struggling so hard to get recognized, and there was all this talk about licensure, and we need to do this and do that. We worked on this whole thing around, we have to get a master's degree, and you need this and this and this to become a child life specialist. I think that came out of a place of fear, for us not getting the recognition that we want and deserve, not getting the compensation we deserve. That all developed out of that place. But what it actually did is it narrowed our pool again....I think, they did backpedal. They took away that master's requirement. But I think we have to be more open to various ways to come into the field...There's more than one way to do this. I think we need to be more inclusive of different ways of entering the field and promote that and engage people in that.

Recruitment and Mentoring. Six participants spoke on the need for changing how students are recruited into the field of child life and how to mentor students in order to set them up for success. Kristine mentioned needing more outreach and mentorship to high school students.

More outreach to high schools before they even come to college, so that people are... There's more diverse people that are even exposed to the profession that know it exists, and that can find programs that can support them to get into it. So, is there a way that departments can partner with high schools? Maybe high school that are in the city, right? That are in areas that maybe with lower income kids who might not be exposed to this type of thing, where they could bring them into sort of volunteering in high school even, and just get to know the hospital setting and kind of learn if this might be a good fit for them.

Sharon spoke on educating students as young as elementary school level.

When it comes to even getting into the field, it needs to start at a much lower level, like in elementary, high school, college. There needs to be more of an awareness to reach out to those communities that aren't just White and sprinkle that and, hey, there's these opportunities to work with children and families in a crisis situation. Because I think that it can't be just the White kids going that route. So, we need to start earlier before we get into it.

Melanie discussed community awareness of child life and outreach to varying communities.

There's so much more support that we can continue to provide to so many different people, and even encouraging younger kids before you even get to the point where you're applying for a diversity scholarship in child life. How are we teaching elementary school kids about what we do? How are we being present in minority communities? If all the child life specialists live in White neighborhoods, how are we becoming a part of neighborhoods where Black children and Latinx children live, to encourage them to look up to child life specialists as role models? I think there's a lot of opportunity for education.

Samantha discussed her hospital's career days and the need to expand these to high schools. She emphasized focusing on students who may not already be on the college trajectory.

A lot of the career day type events or career workshops that we offer one, cost money, but two, are really directed towards people that are already in college or in a university, navigating 'What do I major in?' And I think that a way to potentially improve the diversity within our profession is to be doing more secondary education and education within high schools.... I think that it's important to support people who are not automatically already in a college and have an opportunity to now just choose a major... I just feel like any opportunities we have to reach even younger populations of Gen Z, Gen Millennial, all those generations who are trying to find their way.

Gloria brainstormed a mentorship program.

I'm trying to think of a community-based action.... like maybe a mentor program of some sort where at least for us, we're in a super diverse area, can there be a pathway that if you are accepted as a volunteer...you then volunteer through the childhood department, you then have a mentor who if you express interest can help you with the application process. Almost that type of thing, because that's what I had. I was really lucky to have someone who's two years older than me, who I just knew through a friend of a friend who was a child life specialist. And she literally helped me go through every step. So, I wonder if something like that could be helpful too.

Marie currently offers a mentorship program and discussed the benefits of improving diversity in not just child life, but across various healthcare professions.

One of the things that I'm doing at my program is, I started two mentorship programs where I hire high school kids and college kids to do various jobs for us here. One of those jobs is playroom assistant, and I hire people ... They're not people who are on the child life track already. These are people that live in the Bronx, which by default, makes them mostly people of color. Not always but mostly. They come and work as a playroom assistant...But they make \$15 an hour and they work for me for one year. During that year, I introduce them to any kind of healthcare career they want to learn about, and I help them with their resume and their interview skills and building their professional

package and all of that. Now, some of them might decide they want to go into child life, and some of them have, which is great. That's my way of recruiting some diversity into our field. Some of them want to go into other areas of healthcare, which is great, too, because we need diversity across the board.

Marie shared words of advice on mentoring, "I challenge you to do this. Find a person of color you can mentor in any way, expose them to what you do, expose them to the work that you do, and invite them into the field. Invite them to consider this as a career." Marie also spoke on the power of career fairs at schools and speaking with various groups.

We need to be going to career fairs at schools. I just did a career fair, a virtual one the other day, spoke to about 20 different students. They've never heard of child life before. They were all students of color. Now they all know about child life. Maybe some of them will want to come into the field. I offer them all an opportunity to come into my mentorship program. Maybe some of them will. I think we have to make it our professional responsibility to be involved in that way, and not just wait for someone else to do it.... I had [a university], they contacted me that they have a virtual spring break community service thing that they do for three days... I had the most menial tasks that I needed done...It gave me an opportunity to speak to them for an hour about child life and what we do. And invite them in the future to come and be in my mentorship program. It was very strategic on my part, and that's sort of that interest convergence. I had an interest that was going to benefit me, they had an interest they needed to get their community service hours. But at the center of it was the exposure of child life to the African American student, which is good.

Feelings While Talking about White Privilege

Participants were asked at the conclusion of the interview what it was like to participate in the research study and talk about White privilege. Two participants mentioned being nervous. Kristine stated, "I always feel a little...nervous. Whenever we're talking about race, I don't ever want to be stepping in to act like I'm an expert on it...I do get nervous that I never want to come across like, 'Oh, I have this all figured out. Or I'm an expert on this topic,' because I can't be."

Two participants mentioned feeling awareness or mentioned a synonym for awareness. Gloria discussed her increase in awareness, as well as feeling both nervous, self-conscious, and happy.

I'm still learning, there are still things that I am seeing within myself that I'm like, ooh, don't love that, but it's true. So, it doesn't always feel great, but I am proud to be talking about it. And I am so interested. And to me, that's the only way that I can do... Not the only way, that is a big way that I can improve my skillset as a child life specialist and that is my goal always. So, I feel happy to be talking about it. And I feel 75% happy and 25% nervous and self-conscious.

Georgia also described feeling aware stating, "I think the word that's coming to me is awareness. Just feeling more aware and wanting to make people more aware." Georgia also stated, "It is uncomfortable. It is eye opening. It is empowering. It's energizing." Three other participants mentioned feeling uncomfortable. Sharon discussed being uncomfortable and worried about offending others.

It's very uncomfortable, but I think uncomfortable is good, because uncomfortable makes change. I think it's important. I think that the vulnerability of being mindful of where you come from and how you've been raised and what privileges, if you're White, you've had, it does make it a little uncomfortable, because that's how it is, you've been known in your life, so it's not any different. But when you're culturally shocked by, 'No, this stuff is still happening and it's happening everywhere,' and then you want to talk about it. I think the uncomfortable part for me is making sure that the things I say, I don't want to offend anybody.

Melanie stated she felt uncomfortable stating, "It's uncomfortable. I think that's kind of the whole point of it." Samantha stated she no longer felt uncomfortable, but unsettled and disturbed.

I probably would have said, before some of the reading and conversations I've had over the past year, uncomfortable, but I don't feel uncomfortable anymore. I feel unsettled, I

feel disturbed, I don't feel sad or bad for myself. I absolutely had a mentality of, 'It's not my fault that I was born White,' but really have been able to change this mentality into, 'I have been afforded to be a White woman, and how do you use your voice?' So, I think that unsettled, I'm living in this space now of being able to find my voice, how to be an advocate, how to be a good co-human with every race, but to not project any White tears or White emotion or White struggle with those thoughts.

Marie stated she felt hopefulness.

I find it a little bit hopeful, to see a young person like you invested in this topic, and to think that it is White people that need to fix this situation right now. I'm glad to know that White colleagues, and especially the next generations of them are stepping up to the plate and finding this important, an important topic to do...It gives me hope to know that this, our country, has been pushed into a position where we can't avoid it anymore, and it's not just that small group of activists who are trying to make a point. It's growing into a bigger culture shift. I feel good about that, and hopeful about that.

Marie stated she also felt frustrated and disheartened.

At the same time, feel somewhat frustrated and disheartened at how repetitive and pervasive this pattern is. In that so many people are still in denial of White privilege, and that reality...I feel like there's so many people now that still don't recognize that. They don't see the systemic infiltration of racism across every single continuum. Education, housing, justice system, healthcare, all of it. That, it's like I know that it's a slow process. And I know that it takes a lot of work, and sometimes I get frustrated when people are taking a long time to get onboard or to catch up in their work.

DISCUSSION

The goal of this study was to understand child life specialists' knowledge and perception of White privilege. The purpose of this study was to examine child life specialists' understanding of White privilege and to obtain their perspective on the impact White privilege has on patient- and family-centered care within the hospital setting. Through qualitative interviews, participants were asked to define "White privilege," share their perception of "White privilege" and the impact it may have on patient- and family-centered care, as well as their personal experience with diversity and inclusion training.

Certified Child Life Specialists, provided with pseudonyms to protect their identity and maintain anonymity, were recruited to participate through the Association of Child Life Professionals (ACLP) professional online forum, ACLP Connect, and regional child life association groups via email. All interested participants who met the research eligibility requirements were admitted to participate. A total of seven Certified Child Life Specialists participated in the research study. Participants participated in an interview consisting of 18 open-ended, semi-structured questions regarding the knowledge and perception child life specialists have of White privilege in the hospital setting, especially with regards to the impact on patient- and family-centered care.

The following is an analysis of the results obtained through the seven qualitative interviews. A consideration of research bias will be presented before discussing the overview, interpretation and implication of the results. Additionally, initial study assumptions and limitations will be shared. Finally, suggestions for improvement and future research opportunities will be discussed.

Consideration of Research Bias

The researcher for this research study is a graduate student conducting a thesis to meet graduation requirements for a Master's in Child Life Studies. The researcher is also a Certified Child Life Specialist working at a children's hospital in the Texas Medical Center in Houston, Texas and an active member of the Diversity, Equity and Inclusion Committee for the Association of Child Life Professionals. Throughout the development and implementation of this research study, steps were taken to minimize the potential for researcher bias. There was no participation selection bias as all interested participants who met the research eligibility requirements were accepted to participate. Open-ended, semi-structured interview questions were designed to not be leading and were pre-approved by the researcher's thesis committee prior to conducting the research study. During coding and analysis of data, the researcher was the only person conducting the coding and analysis. However, the researcher maintained constant communication with the research and graduate student advisor, including multiple drafts of the thesis and research study results.

Overview, Interpretation and Implication of Results

All seven participants were able to define "White privilege," discuss the impact White privilege has on patient- and family-centered care, and the limitation of diversity and inclusion training and education. Participants were also all able to create their own list of unearned advantages due to White privilege, discuss suggestions for improvement, and share their feelings when talking about White privilege. The following is an analysis of the participant responses in relation to the research previously presented in the literature review.

Definition of White Privilege. Research participants were asked to first define “White privilege” before a working definition was provided by the researcher. All seven participants were able to define White privilege appropriately and had similar definitions of White privilege. Participants defined White privilege as due to a person being White, they automatically have less or no barriers, a higher level of comfort, no judgment based on their skin color, and an ability to stay quiet in uncomfortable situations or conversations. The working definition of White privilege provided by the researcher following participant responses was stated as a set of unearned institutional benefits or privileges granted to persons belonging to those in the White racial group (Alexis et al; Bonds & Inwood, 2016; Combs, 2019; Hobbs, 2018; McIntosh, 1990). The definitions provided by participants, while all similar in nature, were less concise. Participant definitions consisted of more situational examples, or explanations and examples of unearned institutional benefits or privileges, due to a person being White.

Impact of White Privilege on Patient- and Family-Centered Care. All seven participants were able to discuss and expand on the impact White privilege has on patient- and family-centered care. Rather than solely listing areas in which White privilege impacts patient- and family-centered care, participants all provided thorough responses, which appears to be a benefit of the qualitative interview process. While two participants explicitly stated awareness of prior research on biases within healthcare and the negative implications for patients and families, the question was not asked of participants on their explicit awareness of research. Other participants may be aware of research, but this was not explored. Participant responses could be based on awareness of research or from their own personal observations and experiences.

Attitude and Treatment of Others. Kristine was aware of research on discrepancies in pain management in that Black people are less believed than White people and are less likely to

receive pain medication. Kristine was correct in her statement as research does indicate that Black people receive less pain medication and less empathy for pain than non-Black people due to implicit racist biases (Forgiarini, Gallucci & Maravita, 2011; Johnson et al., 2013; Williams & Rucker, 2000). Marie presented research statistics on the maternal and infant morbidity for women of color in New York. Studies have shown that Black people have higher rates of morbidity and mortality than White people (Luquis, Perez & Young, 2006; Williams & Rucker, 2000). While Marie stated the maternal and infant morbidity of women of color in New York state is 12 times that of White women, research appears to indicate that in New York the maternal and infant morbidity of women of color is 3 times that of White women (National Center for Health Statistics, n.d.; New York State Task Force, 2019). Participants' further awareness and observations of racism and White privilege were in alignment with research findings. Participant perspectives on treating families differently for anesthesia induction because of a language barrier or socioeconomic status, not using an interpreter, or amount of time spent with a family due to the language barrier aligns with the research. In each of these examples provided by participants, unconscious bias impacted a decision made on behalf of the patient (MacIntosh et al., 2013). Two participants, Sharon and Samantha, spoke on the difficulties of navigating the healthcare system for non-White people. This aligns with the research by Williams and Rucker (2000) in which it was found that White privilege and institutional racism affects education provided in the community, impacting the potential knowledge and familiarity with medical procedures or diagnoses within the medical setting. Samantha discussed the financial barriers for families impacting their ability to be at their appointments or the hospital. According to McIntosh et al. (2020), the net worth of a typical White family is nearly ten times greater than the net worth of a typical Black family. With this

difference in net worth, the potential financial barriers for Black families appears to be congruent with Samantha's statement. A majority of the participants spoke on the impact White privilege has on trusting the healthcare system and providers, as well as the impact White privilege has on negative perceptions of families. Their perspective aligns with the research stating White privilege impacts therapeutic relationships with patients, patient communication with physicians, and patient trust of physicians (Alexis et al., 2019).

Diversity Within the Field of Child Life. Suzuki (2017) discussed the lack of diversity in the child life field, with the majority of child life specialists being White females. All participants discussed the lack of diversity within the field of child life. Each participant alluded to the field being primarily White females, aligning with the research presented by Suzuki (2019). Participants discussed further the importance of patients and families seeing child life specialists, and other healthcare providers, who look like them and who come from similar backgrounds as them. Having diverse representation within the field of child life could improve therapeutic relationships with patients, patient communication with physicians, and patient trust of physicians (Alexis et al., 2019).

Barriers to Entering the Field of Child Life. Suzuki (2017) discussed three potential barriers to entering the field of child life: learning about the field later in their academic career, challenges of the academic work, and difficulty getting a child life position. Participants in this research study described awareness of the child life field as a barrier for recruitment as well. However, participants did not mention it as it relates to timing in their academic career. Instead, participants, such as Marie, discussed recruitment practices of academic and hospital institutions, encouraging expansion of recruitment outside of the collegiate level and an increase in diverse marketing. Participants in this research study also discussed education barriers, including

challenges of the academic work (Suzuki, 2017). Samantha acknowledged the ease in completing a higher level of education for White women her age who grew up with a similar background. Kristine further explored the idea of education barriers students face prior to starting college level coursework. This thought process aligns with Suzuki's (2017) thought that the difficulty of academic work is a barrier. Finally, Suzuki (2017) proposed the difficulty of getting a child life position as a barrier for diversity within the field. Only one participant in this research study discussed the barrier of available positions. Sharon believes the field has more students than hospital clinical placements available. In contrast, Marie discussed having available positions, but not receiving any applications from people of color. Five participants discussed a barrier that Suzuki (2017) did not consider: the financial barrier. Participants believe the cost of getting into the child life profession is prohibitive. The cost of obtaining a minimum of an undergraduate degree, application and interview process for obtaining an unpaid practicum and internship, cost of the certification exam, high chance of needing to relocate multiple times during the school and employment process, as well as a less than ideal employment salary is a barrier for prospective child life specialists and a huge indicator of White privilege.

Resources. Through personal observations and experience working in hospital settings with diverse populations, the researcher began this study with the belief that there is a lack of appropriate resources representative of the population served (Beal, 2004; McIntosh, 1990). However, with a lack of available research on the availability of resources, the researcher sought out the opinion of other child life specialists and their perspective on the impact White privilege has on resources provided. The word "resource" was left to be interpreted by the participants. All seven participants were able to identify areas in which White privilege impacts resources for patients and families. While sharing personal experiences and observations, participants

identified the following as resources impacted by White privilege: time, band aids, books, dolls, hygiene products, and money. While the tangible resources were previously thought of by the researcher, the resource of time had not been previously identified by the researcher prior to conducting this research. Similar to the two participants who discussed the limitation of diversity and inclusion within the toy market, the researcher had previously thought of toy production availability as a barrier for availability of resources within child life departments. Finally, participants discussed their departments' goal in reevaluating resources being provided and ensuring that resources created are diverse and inclusive as well. This a goal for the researcher at their place of employment, as the researcher believes there is a gap in the availability of diverse and inclusive materials and resources.

Training and Education. Education on White privilege is important in working to eliminate the healthcare utilization and provider bias occurring in healthcare (MacIntosh et al., 2013). Diversity training can also work to improve patient satisfaction and increased coping and emotional connection with physicians and stive to reverse other effects caused by White privilege (Nguyen, 2014). However, there is a lack of diversity and inclusion trainings, which could be argued as important for a field that is primarily White females (Nguyen, 2014; Suzuki, 2017). Participants were asked to share their formal training, both through schooling or employment, as well as any informal experiences that have impacted their knowledge of diversity and inclusion. Based on participant responses, it appears that participants received little to no education through schooling, some training through employment opportunities, with the majority of knowledge coming from informal experiences or participants' personal investment or research into the issue. Many of the employment trainings participants referred to were voluntary, rather than mandatory. Diversity, equity and inclusion education and training has

become more prevalent since 2020, as discussed by Gloria. The amount of training and education participants received in each of these areas could be impacted by their academic graduation date, time within the field, and their personal desire to seek out this knowledge and information.

White Privilege and Unearned Advantages. Participants were asked by the researcher to create their own list of unearned advantages, similar to McIntosh (1990) and Romano (2018). Six of the participants verbalized being unaware of McIntosh's (1990) essay and seven participants verbalized being unaware of Romano's (2018) essay prior to the interview. While answering this interview question, participants appeared to pause and reflect more. Their responses ranged from lack of judgment, acceptance, safety, maintenance of identity and ease of opportunities based on their unearned advantage of being White. The list provided by each participant is similar to that of McIntosh (1990), Romano (2018) and Bruce (2015). The participants' lists are largely representative of the White privilege held by the majority of Certified Child Life Specialists.

Suggestions for Improvement. To make an impact, it will require an institutional change and effort (Romano, 2018). According to Bruce (2015) and Romano (2018), there must be first be an acknowledgement that White privilege is an issue and then feelings regarding the issue should be acknowledged and reflected on. Once recognized as an issue, actions should be taken to impact institutional change. Kristine discussed needing to demand change and then following through with actions, not just acknowledging and validating that it is hard. Helsel (2019) stated the solution to the effects of White privilege requires a relational approach with more conversation full of active listening and respect. In order to enact institutional change, two participants discussed needing diverse representation during these conversations and when providing feedback on what should be done in enacting change. Areas of growth or changes that

should be made, according to the participants, includes addressing the financial barrier, relooking at the student requirements and application process, diversifying staff, expanding recruitment practices, and providing mentorship opportunities. These recommendations assist in addressing some of the gaps the participants previously shared when discussing the impact White privilege has on patient- and family-centered care.

Feelings While Talking About White Privilege. Feelings felt and caused by discussing White privilege should be acknowledged and reflected on (Bruce, 2015). Participants were asked to acknowledge and reflect on their feelings while discussing White privilege. Two participants described being nervous, two participants mentioned feelings of awareness, three participants mentioned feeling uncomfortable, feelings of hopefulness combined with frustrations was also expressed by a participant. The majority of participants had opposing feelings, such as hopeful but frustrated, uncomfortable but aware, happy but nervous. Despite feeling nervous or uncomfortable, all participants volunteered to participate in the research study and completed the interview in totality. Those who felt more aware or uncomfortable may have been using the research study as another opportunity to learn and reflect on their own implicit biases or White privilege. All of these feelings are valid and important to acknowledge and reflect on (Bruce, 2015). These contradicting feelings can help drive the act for change in addressing the issues of racism, White privilege, and diversity and inclusion.

Initial Study Assumptions

While conducting this research study, three assumptions were made. First, participants would be open and honest with responses to questions asked. Second, participants would be able to define White privilege. Finally, participants would be able to recognize White privilege's

impact on patient- and family-centered care within hospital settings, specifically within the child life field, including making a list of their own privileges as modeled after McIntosh's (1990) and Romano's (2018) essays. The results suggest that all three assumptions were true. Participants appeared to be forthright, honest, and open when sharing personal perspectives, experiences, and observations. All participants were able to define White privilege and provide examples of how White privilege impacts patient- and family-centered care. Finally, all participants created their own list of unearned advantages and privileges similar to that of McIntosh (1990) and Romano (2018).

Limitations

The goal of this study was to understand child life specialists' knowledge and perception of White privilege. While this goal was achieved, there were limitations to this study that should be considered, including timing of the study, participants, and participant recruitment.

Review of related literature and research began for this study in February of 2020 as the researcher noted gaps in diversity within the field of child life and inequitable resources provided to families. In May of 2020, George Floyd was murdered and cities across the United States of America increased Black Lives Matter protests. Since then, diversity, equity and inclusion has been a topic in the forefront of the news, businesses, academics, and employment entities. The timing of these research interviews, conducted from January 2021 to March 2021, is most likely impacted by the increased awareness of White privilege following the summer of 2020.

Participant recruitment was impacted in the change of format for the Association of Child Life Professionals' (ACLP) professional forum. The forum would initially send an email out to all members of the ACLP. In December of 2020, the forum changed to an online website named

ACLP Connect in which members must log in to be aware of posts and actively participate. Recruitment was then expanded to emailing the approximately 20 regional child life association groups, via their general membership email or regional group President. Lack of ease for the new ACLP Connect forum and relying on regional child life association groups to reach out to members most likely impacted recruitment of participants and the small sample size. Additionally, this recruitment process could explain why there was only representation from the East Coast and West Coast. Participant perspectives could have varied depending on other geographic locations.

Participation was voluntary. Participants who chose to participate may have chosen to participate based on their pre-existing awareness and interest in the topic of White privilege. Additionally, participants ranged from 32 to 58. The time practicing within the field of child life and length of time it has been since they were a student could impact their memory on diversity and inclusion training they received in schooling. However, as diversity, equity, and inclusion is a topic more in the forefront within the last year, their schooling may not have focused on this during their academic years. Finally, as all participants were White females, there was a lack of diversity in participation.

Suggestions for Improvement

In congruence with the research participants, areas of growth or changes that should be made include addressing the financial barrier, relooking at the student requirements and application process, diversifying staff, expanding recruitment practices, and providing mentorship opportunities.

When addressing the financial barrier, student requirements, and application process, the following should be considered. Additional education scholarship opportunities should be provided from an academic, clinical, regional child life association and group perspective, and national Association of Child Life Professionals perspective. Applications for clinical programs should not require a fee and should have the option to submit online in order to reduce the mailing costs for the numerous applications sent. Departments should continue to advocate for increase in salary for Certified Child Life Specialists and should consider offering a stipend for clinical students. Academic programs that require affiliation during clinical practicum and internships should minimize the number of credits the student is taking, as this is an additional cost for students who are typically not getting paid during this time. Scholarship opportunities for conference or reduction in conference costs, both regionally and nationally, should be available.

Diversity, equity and inclusion education and training should be increased. Diversity, equity and inclusion training should be required for all prospective Association of Child Life Professionals (ACLP) certification candidates. This means that all students, either through academics or their clinical placements, would be required to have appropriate training through their course curriculum. With that being said, these education requirements can be included in existing academic coursework as to not add an additional course cost. The ACLP should also require professional development units (PDU) in the area of diversity, equity, and inclusion. The cost of PDU opportunities should be considered, with a minimum amount offered free to members. Employers should also require education and trainings with regards to diversity, equity, and inclusion, including a department competency to ensure the resources being provided are representative of the population served.

Diverse and inclusive marketing, recruitment, and mentorship of prospective child life professionals should continue and expand. Outreach to schools, elementary through high school, should be conducted. This outreach can increase awareness of the child life profession as a whole, improve children's perspective of the hospital and healthcare system, as well as recruit diversity within the field of child life and healthcare as a whole. Additionally, more mentorship opportunities should be offered, both academically and clinically. Mentorships could be through paid opportunities, volunteering opportunities, or easily accessible education seminars.

Future Research

Additional research is needed in the field of child life as well as on the impact of White privilege on patient- and family-centered care. This study could benefit from replication and inclusion of more research participants, potentially conducted by the Association of Child Life Professionals as a whole. Research should be conducted on the appropriateness of resources provided by departments based on their population served. Additional research on diversity within the field of child life should also be conducted. An examination of recruitment processes for the field of child life, as well as the education opportunities on diversity, equity and inclusion within the field of child life should be examined further.

Summary

White privilege is a set of unearned institutional benefits or privileges granted to persons belonging to those in the White racial group (Alexis et al., 2019; Bonds & Inwood, 2016; Combs, 2019; Hobbs, 2018; McIntosh, 1990). Child life specialists are able to define White privilege and understand the impact White privilege has on patient- and family-centered care

within the hospital setting including attitude and treatment of others, diversity within the child life field, and training and education. In order to appropriately enact change, people should acknowledge their own privileges and unearned advantages, as well as explore the feelings had when acknowledging these privileges and unearned advantages. Actions within the child life community need to be made in order to improve diversity, equity and inclusion for students, professionals, and the patients and families served.

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APPENDICES

Appendix A: Examples of Unearned White Privilege

Examples of Dr. Romano's unearned privilege in medical training as a consequence of being White (Romano, 2018):

1. During college and medical school, I never struggled to find professors and academic role models who shared my race.
2. When I walk into an exam room with a person color, patients invariably assume I am the doctor in charge, even if the person of color is my attending.
3. Even if I forget my identification badge, I can walk into the hospital and know that security guards will probably not stop me because of the color of my skin.
4. I can speak my native language in my own dialect in professional settings without being viewed as uneducated or out-of-place.
5. I can attend most professional meetings confident that I will be surrounded by physicians who look like me, and that we will likely have mutual acquaintances who also share our race. (Romano, 2018, p. 262).

Examples of Bruce's unearned privilege as a White librarian and reader (Bruce, 2015):

1. I have a wide variety of books from all genres to choose from in which characters look and speak like me.
2. When I visit other libraries, the librarians I meet often look and speak like me, which makes it easier for us to form partnerships and share resources.
3. When invited to speak on panels or events, I am not asked to speak on behalf of all White people or offer the 'White perspective.'
4. When I bring up issues of racial justice, I am generally praised and lauded as an 'ally' and 'changemaker' by children's literature colleagues. I am rarely, if ever, dismissed as someone who is complaining, attention-seeking, or 'can't let go of the past.'
5. I can bring up issues of racial inequity in my work without fear of being demoted or fired. (Bruce, 2015, p. 4).

Appendix B: Human Subjects IRB Initial Approval



Missouri State.
U N I V E R S I T Y

To:

Lindsey Murphy
Childhood Ed & Fam Studies

RE: Notice of IRB Approval

Submission Type: Initial

Study #: IRB-FY2021-293

Study Title: Child Life Specialists' Knowledge and Perception of White Privilege

Decision: Approved

Approval Date: November 17, 2020

This submission has been approved by the Missouri State University Institutional Review Board (IRB). You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented. Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB.

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), 45 CFR 164 (HIPAA), 21 CFR 50 & 56 (FDA), and 40 CFR 26 (EPA), where applicable.

Researchers Associated with this Project:

PI: Lindsey Murphy

Co-PI:

Primary Contact: Renee Jamar

Other Investigators:

Appendix C: Human Subjects IRB Modification Approval



Missouri State.
U N I V E R S I T Y

To:
Lindsey Murphy
Childhood Ed & Fam Studies

RE: Notice of IRB Approval
Submission Type: Modification
Study #: IRB-FY2021-293
Study Title: Child Life Specialists' Knowledge and Perception of White Privilege
Decision: Approved

Approval Date: February 12, 2021

This submission has been approved by the Missouri State University Institutional Review Board (IRB). You are required to obtain IRB approval for any changes to any aspect of this study before they can be implemented. Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB.

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), 45 CFR 164 (HIPAA), 21 CFR 50 & 56 (FDA), and 40 CFR 26 (EPA), where applicable.

Researchers Associated with this Project:

PI: Lindsey Murphy

Co-PI:

Primary Contact: Renee Jamar

Other Investigators:

Appendix D: Participant Screening Survey

1. How many years of experience do you have in the field of child life?
2. What is your current job title?
3. In what state do you currently work in?
4. Please provide an email address that you wish to be contacted at should you be chosen to participate in this research study.

Appendix E: Research Consent Form

Consent to Participate in a Research Study Missouri State University College of Education

Child Life Specialists' Knowledge and Perception of White Privilege Renee Jamar Lee, CCLS

Introduction

You have been asked to participate in a research study that is part of the requirement for a master's degree in Child Life Studies for Renee Jamar Lee, CCLS. Before you agree to participate in this study, it is important that you read and understand the following explanation of the study and the procedures involved. The investigator will also explain the project to you in detail. If you have any questions about the study or your role in it, be sure to ask the investigator. If you have more questions later, Renee Jamar Lee, the person mainly responsible for this study, will answer them for you. You may contact the investigators at:

Renee Jamar Lee, CCLS	713-704-5821	renee.lee@memorialhermann.org
Dr. Lindsey Murphy, CCLS		LindseyMurphy@missouristate.edu

By signing this form, you indicate permission to be involved in the study. Taking part in this study is entirely your choice. If you decide to take part but later change your mind, you may stop at any time. If you decide to stop, you do not have to give a reason and there will be no negative consequences for ending your participation.

Purpose of this Study

The reason for this study is to examine child life specialists' understanding of White privilege and to obtain your perspectives on the impact White privilege has on patient- and family-centered care within the hospital setting. You have been asked to participate because you are a member of the Association of Child Life Professionals as a Certified Child Life Specialist. This study will review the understanding and perspective of White privilege from Certified Child Life Specialists working in the hospital setting.

Description of Procedures

If you agree to be part of this study, you will be asked to participate in an interview through the online conferencing format of Zoom. The interview audio will be recorded. The interview will take approximately an hour to complete. You may choose not to answer any questions and stop at any time. Any information about you will be kept confidential. To protect your privacy, you will be assigned a pseudonym and your name, or any other identifying information, will not be identifiable. The key to participants and pseudonyms will be kept separate from data and locked in a filing cabinet in a locked office.

What are the risks?

We estimate that the potential risks of this study are minimal. However, you may experience some psychological discomfort when answering questions about the topic White privilege.

What are the benefits?

You may not benefit directly from this study. Nevertheless, your participation in this research will help investigators identify areas in which patient- and family-centered care is affected by White privilege in the hospital setting. This information may be useful in addressing diversity and inclusion gaps, especially within the child life practice.

How will my privacy be protected?

The results of this study are confidential and only the investigators listed in this consent form will have access to the information which will be kept in a locked facility. Information about you will be filed under your pseudonym. Your name will not appear on the interview answer sheet. You will not be identified by name in any publications that may result from this research. All information gathered during this study will be destroyed 3 years after the completion of the project.

Consent to Participate

If you want to participate in this study, *Child Life Specialists' Knowledge and Perception of White Privilege*, you are required to sign below as an indication of your willingness to participate.

I have read and understand the information in this form. I have been encouraged to ask questions and all of my questions have been answered to be my satisfaction. By signing this form, I agree voluntarily to participate in this study. I know that I can withdraw from the study at any time. I have received a copy of this form for my own records.

Signature of Participant

Date

Printed Name of Participant

Signature of Person Obtaining Consent

Date

Appendix F: Interview Questions

1. How would you identify your gender?
2. How old are you?
3. What would you identify your race?
4. What is your current job title?
5. What hospital do you work at? What unit do you work on?
6. How many years have you been in the child life profession?
7. What formal training, if any, did you receive with regards to diversity and inclusion, either through schooling or employment opportunities? What informal experiences, if any, have impacted your knowledge of diversity and inclusion?
8. Does diversity and inclusion affect any of these areas? If so, how?
 - A. child life services
 - B. resources
 - C. training
 - D. diversity within the field
9. How would you define “White privilege?”

For the purpose of this study, moving forward, we will be using the definition of White privilege as a set of unearned institutional benefits or privileges granted to persons belonging to those in the White racial group (Alexis et al., 2019; Bonds & Inwood, 2016; Combs, 2019; Hobbs, 2018; McIntosh, 1990).

10. How does White privilege impact the child life field and/or profession?
11. How does White privilege impact the hospital setting?

12. How does “White privilege” impact patient- and family-centered care within the hospital setting? Please provide examples if possible.

13. If not already discussed, does White privilege affect any of these areas? If so, how?

A. resources (e.g., hygiene products, books, educational dolls, toys, etc.)

B. training/education on diversity and inclusion

C. diversity within the field

Peggy McIntosh (1990) wrote on the advantages of White privilege, and thus the disadvantages of not being White, in her essay “White Privilege: Unpacking the Invisible Knapsack.” McIntosh shared 26 statements identifying some of the daily effects of White privilege she has. Some of these statements include:

1. I am never asked to speak for all the people of my racial group.
2. I am pretty sure that if I ask to talk to ‘the person in charge,’ I will be facing a person of my race.
3. I can easily buy posters, postcards, picture books, greeting cards, dolls, toys, and children’s magazines featuring people of my race.
4. I can be sure that if I need legal or medical help, my race will not work against me.
5. I can choose blemish cover or bandages in ‘flesh’ color and have them more or less match my skin.

Romano (2018) was inspired to write his own list in his essay *White Privilege in a White Coat: How Racism Shaped my Medical Education*. His list focused on ways in which he accrued unearned privilege in medical training as a consequence of his White skin color. Some of his statements include:

1. During college and medical school, I never struggled to find professors and academic role models who shared my race.
 2. When I walk into an exam room with a person color, patients invariably assume I am the doctor in charge, even if the person of color is my attending.
 3. Even if I forget my identification badge, I can walk into the hospital and know that security guards will probably not stop me because of the color of my skin.
 4. I can speak my native language in my own dialect in professional settings without being viewed as uneducated or out-of-place.
 5. I can attend most professional meetings confident that I will be surrounded by physicians who look like me, and that we will likely have mutual acquaintances who also share our race.
14. If you were to create your own list of unearned advantages, similar to McIntosh and Romano, what might your list include?
15. After reviewing previous lists and creating your own list of unearned advantages, do you still maintain your position on the impact White privilege does/does not have on the following? If not, why?
- A. Child life field and/or profession
 - B. Hospital setting
 - C. Patient- and family-centered care within the hospital setting
 - a) resources
 - b) training/education on diversity and inclusion
 - c) diversity within the field
16. What is it like for you to sit here and talk about White privilege?

17. What are some ways in which you believe we can improve White privilege or diversity and inclusion gaps within the child life field and/or profession?

18. Do you have any additional comments you would like to share regarding anything discussed today?