Child Life Assessment

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Cambridge
Scholars
Publishing

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This book first published 2024

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN: 978-1-0364-1116-9
ISBN (Ebook): 978-1-0364-1117-6

TABLE OF CONTENTS

PART I:

FOUNDATIONS OF CHILD LIFE ASSESSMENT

CHAPTER 1

AN INTRODUCTION TO CHILD LIFE ASSESSMENT

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What is Child Life?

A common question asked of child life specialists is: What is child life? The child life profession is unknown to the general public due to its specific origins in children's hospitals and modern continuation as a niche specialization within children's healthcare. Yet, once people become aware of child life, whether through a personal or professional experience, they acknowledge the valuable role of child life specialists.

History of Child Life Practice

Prior to the Industrial Revolution, a majority of children in North America were raised in agrarian communities where families were responsible to produce the resources to fully care for the family on a homestead. When the Industrial Revolution began, these families left farm life to gain employment in the cities where jobs were located (Wojtasik & White, 2018). In both situations, due to the family's low socioeconomic status, children were required to work and help provide for the family. Organized hospital systems were created to care for adults and children now residing in cities.

As developmental sciences and pediatric medicine began to evolve, children were identified as having specific needs that must be met to reach their optimal development (Brown, 2014). These discoveries impacted all areas

of children's lives including standards for child labor, education, physical, cognitive, social and emotional well-being. Child life's unique role in pediatric healthcare was initiated by pioneers who understood children in healthcare had very different needs than adults in healthcare including the need for play. For more in-depth information regarding the child life profession's complete historical development please refer to *The Pips of Child Life: Early Play Programs in Hospitals* by Turner and Brown (2014) and *The Pips of Child Life: The Middle Years of Play Programs* by Turner and Brown (2016).

Scope of Practice

As play programs began emerging in children's hospitals, Emma Plank wrote the seminal book, *Working with Children in Hospitals* (1962), setting the standards for child life practice. Plank's goals for child life programming are still included in child life specialists' modern-day scope of practice. Thompson and Stanford published *Child Life in Hospitals: Theory and Practice* (1981) setting the foundations of two primary objectives for all child life programs

> 1. "to help the child cope with the stress and anxiety of the hospital experience
> 2. to promote the child's normal growth and development while in the health care setting and after returning home" (p. 7).

These authors also incorporated coping with stress and anxiety, play, preparation, parent and family support, environmental, advocacy, and developmental interventions into the child life specialist's scope of practice.

The current-day text for child life is *The Handbook of Child Life: A Guide for Pediatric Psychosocial Care* 2nd edition (Thompson, 2018). This foundational overview of the child life profession provides the most updated categories for child life's scope of practice:

- Play interventions
- Psychological preparation
- Patient- and family-centered care
- Therapeutic relationships
- Assessment techniques
- Coping strategies
- End-of-life work

The Association of Child Life Professional's (ACLP) Child Life Competencies (2016; 2024 updates pending) are the guiding knowledge and skills for child life specialists.

I. Care of Infants, Youth, and Families
II. Professional Responsibility
III. Education and Supervision
IV. Research Fundamentals
V. Administration

The Child Life Competencies (ACLP, 2016) are evaluated in the three key areas of assessment, intervention, and professional responsibilities via the Child Life Professional Certification Exam (ACLP, 2024). While the child life profession is primarily focused on the patient, the patient's parents or caregivers, siblings, and at times extended family are also included in the child life specialist's assessment and intervention.

Education and Training Requirements

The academic and clinical training requirements for child life specialists are set by the Child Life Certification Commission, the credentialing branch of the Association of Child Life Professionals member organization. See the ACLP's website, childlife.org, for the current Standards for Academic and Clinical Preparation Programs. Formal requirements to become a Certified Child Life Specialist are:

1. Earn a bachelor's degree
2. Complete specified Required and Recommended Coursework
3. Complete a 600-hour child life clinical experience

While these appear easy to obtain, the child life profession is highly competitive with many people pursuing these requirements (Wittenberg et al., 2023). Most clinical child life internship programs require a minimum number of experience hours with children who are developing typically, children in healthcare settings, and children in stressful situations. Refer to the *Certification* page on the ACLP's website, childlife.org, for more information.

Child life assessment requires knowledge and skills for effective practice and it is ethically best practice for the education and training of child life students to be taught by academic professionals who hold the Certified Child Life Specialist credential.

The Future of Child Life

It is interesting to ponder what the child life profession will become in the future. Certainly, the pioneers of early play programs would never have imagined a time when child life specialists were not engaging in play on a daily basis with each child they met. Yet times have changed and clinically focused areas of child life practice are becoming the priority. This is often necessitated by the higher acuity of care required in pediatric healthcare facilities due to increased demands by insurance companies for patients to be moved through healthcare experiences more quickly than in the past.

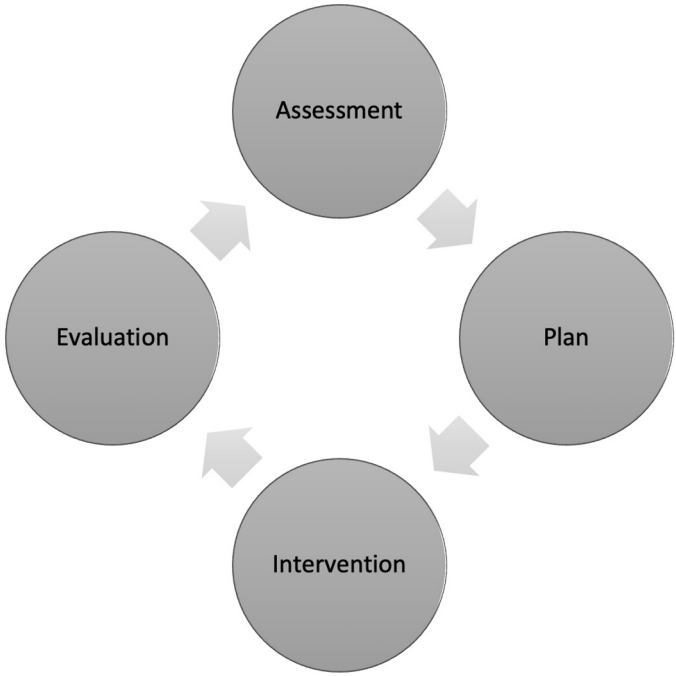
Although we cannot predict the future, we can hope the child life specialist is still dedicated to the goals Emma Plank established and the scope of practice foundations recognized today. The Child Life Competencies (2016) should remain a guide to quality child life practice thus promoting positive patient experiences.

What is Assessment?

Child life specialists are not clinicians who provide medical care to patients and families. Instead, they are developmentalists who work from a preventive stance, ensuring that children and families continue to develop healthily regardless of pediatric experiences. Despite this preventive stance, child life specialists borrow from other fields of study when providing patient- and family-centered care.

One of the ways child life specialists mirror pediatric clinicians in their provision of services is by following the clinical process of **assessment**, **plan**, **intervention**, **evaluation**, and **re-assessment** (Walsh & Petro-Yura, 1967). In this model, presented in Figure 1-1, assessment is a systematic process of collecting information about the patient and their family in order to provide specific and tailored interventions aimed at improving a part of their experience or preventing developmental decline. Pediatric hospitalization leads to significant disruption in a patient and family's coping and development (Romito et al., 2021). Assessing this disruption is one of the most essential skills of a child life specialist.

Figure 1-1 *Clinical Process*



As Thompson and Stanford (1981) described, in child life we seek to improve a patient and family's coping with the stress of the hospital experience and promote the child and family's growth and development. When we engage in the assessment step of the clinical process, we are gathering information that will help us formulate a plan, or construct interventions that specifically target coping, growth, and development. This is a complex process and one that shifts and changes with each patient and family in each healthcare setting.

Due to this scope, child life assessments collect a broad range of information from patients and families and their healthcare teams in order to paint a full picture of coping and development. Historically, child life specialists have tried to pin down the specific type or scope of their assessments by labeling them as biopsychosocial, developmental, and/or cultural. Today, it is understood that there is no one-size-fits-all approach or type of assessment

that provides a full understanding of the patient and family's coping and development; instead, we must consider each family as having unique needs and collect data that is holistic. Despite the informal nature of child life assessment, the focus of this book is to present assessment information child life specialists can use to develop their assessment skills.

What is Child Life Assessment?

Because child life assessment is scoping and abstract, a book like this one is necessary. Since the child life profession cannot place the assessment process into a singular, crisp structure that is easy to communicate across pediatric settings, we must work together to share our unique approaches to supporting patients and families. Too, as child life continues to evolve and expand its scope of practice, assessment also evolves and morphs with the profession's growth. Looking at assessment in a number of domains and settings prepares child life specialists for their own professional development and helps the profession scale up.

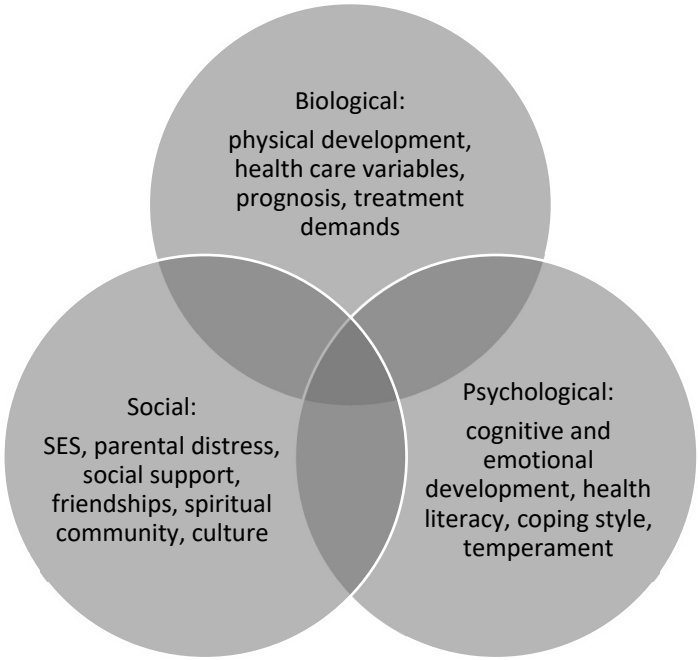
In this book, we will consider the assessment process from the traditional child life scope of practice discussed by Thompson and Stanford (1981) by looking at the long-standing tools used to collect assessment data, such as play, interviews, and measures as well as the theories that inform our approach. To meet the profession's growth, we will also be looking at assessment in emerging settings and domains that now make up our evolving scope, such as working with families who have been historically oppressed in healthcare, working with children who have disabilities, and working with children and families online, to name a few.

In this section, we will be grounding ourselves in the traditional definition of child life assessment and the types of approaches that have been historically used to inform our practice. Child life assessment is "a systematic procedure for obtaining information from observation, interviews, and collaboration used to determine the level of need for services" (Turner & Fralic, 2009, p. 39) and the goal of a child life assessment is to "determine a child's risk for negative psychological outcomes due to hospitalization and to plan appropriate interventions" (Koller, 2008, p. 61).

Traditionally, child life specialists have considered their assessments to be **biopsychosocial** in nature, meaning that they consider the impact of hospitalization on the child and family's biology, psychology, and social lives. The biopsychosocial model is widely used in healthcare and was first created by Engel in 1977. The model seeks to directly subvert the dominant

medical model often seen in pediatrics by placing emphasis not only on the patient's biology but also their social, environmental, and emotional lives. It is understood in the model that each domain impacts the others; in other words, a child's prognosis (biology) impacts their coping (psychology). Given that "the quality and intensity of a child's reaction to hospitalization can be influenced by many variables," child life specialists must consider the most significant biopsychosocial variables that might impact a child and family's world, including child variables, family variables, illness variables, and medical experiences (p. 61). In Figure 1-2, *some* examples of variables to consider from the biopsychosocial model are presented.

Figure 1-2 *The Biopsychosocial Model*



In the ACLP's evidence-based practice statement on assessment, Koller (2008) outlined the most significant variables that impact a child and family's coping with hospitalization. Child variables such as temperament, coping style, age, and gender impact coping. Too, family variables such as parental anxiety and distress, family characteristics, socioeconomic status, and parental presence and involvement also play a large role in coping.

Lastly, the quality of the illness and medical experiences inform how a patient and family will cope; these include chronic vs. acute, length of hospitalization, exposure to invasive procedures, and previous hospitalizations. You will learn more about these variables in future chapters of this book.

In addition to gathering information on biopsychosocial variables that have been shown to impact coping, child life specialists also conduct developmental assessments by gathering a broad look at a child's overall growth. By assessing the child and family's development, child life specialists prepare themselves to address the second aspect of our scope of practice, the promotion of a child's growth and development while in the health care setting and after returning home (Thompson & Stanford, 1981). The developmental domain is broad and it is impossible to capture a child and family's complete development in one assessment process. Returning to the clinical cycle (Figure 1-1) is essential when thinking about development. Many child life specialists will work with patients and families during extended periods of time and will observe changes in a child and family's development. As such, returning to the assessment process frequently in the therapeutic relationship is necessary.

To complete a developmental assessment, child life specialists zoom in on a child's physical development by looking at their gross and fine motor growth, their history of meeting physical milestones, and their history of illness and injury. They also zoom in on a child's cognitive and emotional development, especially when considering how a child might be processing the healthcare environment. They do this by asking about a child's ability to reason, problem solve, and communicate their needs. Lastly, they investigate a child's relational development by asking about their attachment style, support system, and friendships.

Child life specialists rely heavily on developmental theories to inform their approaches to these aspects of assessment. For example, Piaget's (1964) theory of cognitive development is often used when assessing a child's cognitive development whereas Erikson's (1950) theory of psychosocial development and Bowlby's (1969) theory of attachment are used to inform the collection of information related to a child's social development. You will learn more about the theories that inform developmental assessment in the theory chapter of this book.

In addition to assessing a child's biopsychosocial development, child life specialists integrate information about a child's culture, race and ethnicity, and spirituality when completing their assessments. By asking about how

the patient and family's culture views health and healthcare, learning about how the intersection of their racial identity impacts their coping with illness, and uncovering how spirituality plays a role in their family, child life specialists can further tailor their interventions to the child and family's needs. In addition, these questions provide an understanding of potential risk for disparities in care. Racial and ethnic disparities in pediatric healthcare outcomes are well documented in the literature (Trent et al., 2019). As such, integrating cultural information into the assessment process is key to painting a full picture of the patient and family.

In summary, do child life specialists conduct broad biopsychosocial, developmental, cultural assessments? Mostly. Many child life specialists seek to include these domains within their approaches but again, there is not a one-size-fits-all model, especially considering the vast differences in healthcare environments and illness experiences. As we progress through this book, consider how child life assessment is a moving construct with a definition that is alive and actively changing with the evolution of healthcare.

What Does Child Life Assessment Look Like?

While all child life specialists adhere to the clinical cycle by beginning their relationship with a patient and family with the assessment process, every child life specialist gathers information differently and relies on their own unique style. Because of this, assessment looks different across settings and populations. However, most often, child life assessment includes observation, interviews, and collaboration (Turner & Fralic, 2009). Key to these features is a strong therapeutic relationship which allows the child life specialist to observe the family in a manner that feels trusted and safe, have intimate and open interview conversations, and gather helpful information from others involved in the patient and family's care.

What are child life specialists observing? Child life specialists use **observation** to collect information on variables associated with child and family coping as well as their developmental needs. By observing how a child and family react to the healthcare environment, a child life specialist can learn about key variables such as temperament, gender presentation, parental anxiety and distress, and parental presence and involvement. By observing how a child plays in the healthcare environment, a child life specialist can learn about key variables such as coping style, cognitive development, physical abilities, and social skills. By looking closely at how a child and parent interact, a child life specialist can gather information

about attachment style, a child's ability to communicate their needs, and a parent's responsiveness.

What is included in an **interview**? Not all information can be gathered through observation. While these moments often enable a child life specialist to fill in the gaps, a majority of the information gathered during the assessment process comes from asking the patient and family direct questions. Often, when interviewing a patient and family, child life specialists will ask specific questions about variables that can be more difficult to observe such as coping style, age, family characteristics, socioeconomic status, and previous experiences with hospitalization. Information is gathered regarding the child's overall development such as their history of meeting developmental milestones, history of illness and injury, ability to reason and problem solve, understanding of their hospital experience, and the family's social support. Interviews are key for gathering information regarding the patient and family's cultural, racial, ethnic, and spiritual identities and how their family views healthcare.

How is assessment informed by **collaboration**? In addition to observations and interviews, child life specialists collaborate with other members of the medical team to gather information on variables that patients and families may not know. For example, a patient's prognosis and severity of their illness, the length of hospitalization, the likelihood a patient will encounter invasive procedures during their hospitalization, and the burdensomeness of their treatment regimen can all be gathered by collaborating with other healthcare professionals. Too, information on how a patient has previously coped with other healthcare encounters, either through the electronic medical record or through conversations with colleagues, can prepare a child life specialist for entering their room and meeting the patient and family where they are emotionally in their healthcare journey.

How is This Information Used?

All of the data gathered during the assessment process is used to inform a written assessment that accompanies a patient's electronic medical record. In these documents, key features are often included such as a summary of the patient and family's coping and development, a plan of the prioritized needs, and a final plan that includes specific recommendations.

When painting a full picture of the child and family's coping and development, child life specialists must work to organize the information in a manner that guides the reader through the complete picture. Some child

life specialists choose to break down their assessments by developmental domain (for example, physical, cognitive, psychosocial, cultural) in order to organize the information more clearly. In the plan, a child life specialist will summarize the prioritized needs of the patient and family. For example, if parental anxiety and distress were significant factors that impacted a child's coping in previous hospitalizations, a child life specialist might identify this variable as one to target with their plan. Often, a plan will only include 2–4 variables that a child life specialist will target with the understanding that no single member of the medical team can address the entirety of a child and family's coping and development.

After presenting the assessment and plan, a child life specialist will share the plan for the patient. This plan is constructed using not only the assessment information but also **evidence-based practice**. Child life specialists integrate the unique needs of the patient and family with scientific data that demonstrates which interventions are most appropriate for meeting the needs identified in the assessment. The plan should also adhere to patient- and family-centered care by promoting collaboration amongst family members and include the patient and family's wishes and hopes for their healthcare experience.

Plans often outline a handful of interventions that will be provided to the patient in future encounters. As the therapeutic relationship progresses, child life specialists will document when they complete each intervention with the patient and family, leading to the evaluation step of the clinical process whereby the child life specialist asks the family, "did this help?" and considers alternatives for future interventions. Thus, assessment not only informs the intervention step of the clinical process but also the evaluation and reassessment steps so that child life specialists are able to continually improve their care.

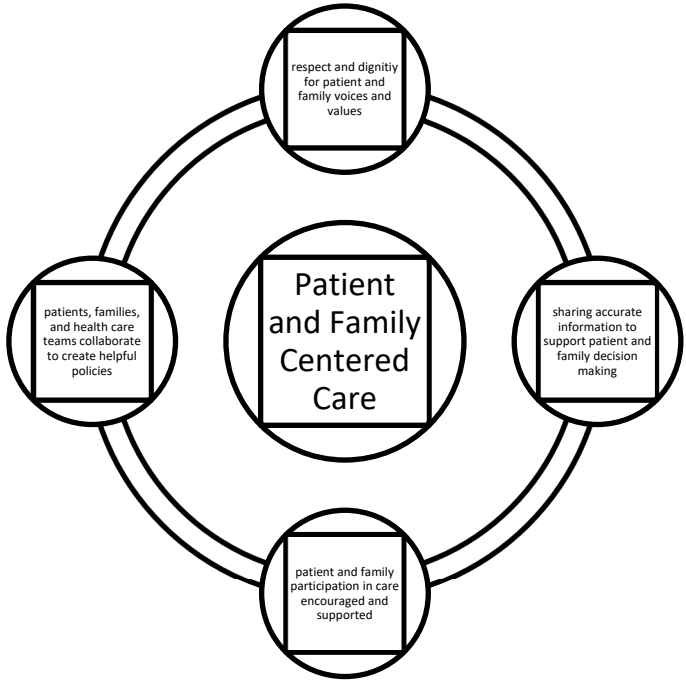
As you can see, the child life assessment process is complex and maintains a broad scope. In order to be skilled at collecting such a range of data, a child life specialist must rely on their ability to work with patients and families from diverse backgrounds with a variety of needs while simultaneously collaborating with interdisciplinary team members. The therapeutic relationship is at the heart of this process as the more a patient and family trusts their child life specialist, the more rich and helpful the data will be, leading to both tailored and therapeutic interventions.

View of the Child and Childhood in 2024 and Beyond

Both childhood and health care influence the child life specialist's assessment practice. As childhood changes with the 21st century, assessment methods are changing too. Our methods have changed with the movement in healthcare away from longer inpatient hospitalizations to shorter, more integrated outpatient visits. Today, children have complex and dynamic stressors that extend beyond their health. Gun violence, hostility between countries, pandemics, climate change, poverty, discrimination/oppression, fluid online lives, to name a few, impact their development and coping and are thus, variables that should be assessed by child life specialists.

Child life assessment is not simply done to the child; instead, the child and family are active participants in their own healthcare. Child life adheres to the service provision model of **patient- and family-centered care** which maintains four distinct pillars: **respect and dignity**, **information sharing**, **participation**, and **collaboration** (Johnson & Abraham, 2012). The respect and dignity pillar requests that health care practitioners listen to and honor the patient and the family's perspectives and choices in their care. The information sharing pillar asks that health care practitioners communicate and share complete, accurate, and unbiased information with patients and families in ways that are affirming and useful for decision-making. The participation pillar asserts that patients and families are encouraged and supported in participating in care and decision-making. And the collaboration pillar recommends that patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation, and evaluation. See Figure 1-3 for a visualization of each pillar. It is an honor to gather intimate details of a patient and family's inner world. Incorporating their expertise into the process only improves the data we are able to collect.

Figure 1-3 *Patient and Family-Centered Care*



Assessment Ethics and Rights of Children

When discussing assessment in the child life profession, we are committed to consider the ethics of assessment and the rights of the children and families who are being assessed. There is limited literature on the ethics of assessment for children, which mostly considers the ethics of educational assessment methods and the agency of the child within these methods. The field of social work and child maltreatment have considered the ethics of child abuse assessment with the conclusion that assessment should occur when it is in the best interest of the child (American Professional Society on the Abuse of Children, 1997). This is a similar starting point for the child life profession to consider regarding assessment ethics and the rights of children.

Ethical Principles

In order to apply ethical principles to child life assessment, child life specialists must be familiar with four key ethical principles: respect for autonomy, non-maleficence, beneficence, and justice (Beauchamp & Childress, 1979). Each key principle will be defined and described within the context of child life assessment.

The first ethical principle, **respect for autonomy,** means demonstrating respect for the decision-making abilities of all persons. This ethical principle can also be applied to the patient- and family-centered care principles of respect and dignity, information sharing, and partnership. As child life specialists, we recognize that this principle is not only to be applied to adults but also to children. Children represent a unique and potentially vulnerable population for this principle due to their age, developmental level, and neurodiversity. For example, a three-year-old's decision-making capacity is different from a 12-year-old's decision-making capacity. Due to their developmental level of understanding, children present a varying range of decision-making capacity when compared to adults' range of decision-making capacity. Adding the consideration of *hospitalized* children to this principle brings another level of complexity: When persons are ill or recovering from illness, injury, or trauma, their decision-making abilities may vary. For example, a child in acute pain may not be able to think clearly and make sound decisions due to the pain. Similarly, if a child is taking pain medicine or sedated, their decision-making capacity may be impaired due to the medication. When applying the respect for autonomy ethical principle to the assessment of hospitalized children, it is important to demonstrate respect for the child's autonomy, regardless of their developmental level, and to incorporate this lens into the assessment process.

The second ethical principle, **non-maleficence,** means to avoid causing harm. In the context of child life assessment, this means to avoid causing any type of harm, including psychosocial and/or emotional harm, to children and families during the assessment process. When considering the child life profession, it is easy to think that a child life specialist would never cause harm to children and families because that is the opposite of the foundation for our clinical practice; however, certain forms of assessment and the timing of when assessment takes place with hospitalized children and families may put these children and families at risk for socioemotional harm. For example, let's say there is an intubated and sedated patient in the PICU who is being tested for brain functioning after a tubing accident on a

lake. It could be emotionally harmful for the family to complete the Pediatric Emotional Safety Screener (PESS) for their child due to their medical condition. The PESS asks three questions, one of which is: "Do you think this healthcare visit will be hard or upsetting for your child for any reason?" Because of the severity of the child's injury and the possible impending death of the child, choosing this assessment tool could lead to socioemotional harm if the parent were to complete the assessment. As child life specialists, it is important to be aware of the many ways we can assess children and families, and to choose the appropriate method of assessment in order to avoid causing harm.

The third ethical principle, **beneficence**, means to be obligated to provide benefits to individuals and to balance benefits against risks. In the context of child life assessment and considering the previous ethical principle of non-maleficence, child life specialists must make sure that the assessment process provides benefits to the child and their family or appropriately considers the balancing of benefits versus risks in the child life assessment process. This principle is inherent in the child life specialists' job duties and exemplified in our professional code of ethics: In 2023, the ACLP published the third edition of the *Child Life Code of Ethics*, which outlines 12 ethical principles and 14 rules for child life professionals to follow for the "benefit and protection of children…and families" (ACLP, 2023, p. 1). Many of these principles can be applied to child life assessment ethics, which recognize the need to "[maximize] the physical and emotional health as well as the social, cognitive, and developmental abilities of children, and [minimize] the potential stress and trauma that children and their families may experience" (ACLP, 2023, p. 1). For instance, the reason patient and family assessment are a key facet of the child life specialist's job duties is because the assessment process helps to determine what child life interventions are needed to benefit the child and their family. Without the assessment process, child life specialists would not have all the information they need to plan and implement psychosocial interventions.

The fourth ethical principle, **justice**, means to demonstrate fairness and the fair distribution of benefits and risks to all persons. This ethical principle aligns with the Child Life Code of Ethics, Principle 3: "Certified Child Life Specialists have an obligation to maintain an environment that respects every variation of race, identity, ability, and community" (ACLP, 2023, p. 2). Principle 3 means that child life specialists cannot discriminate which patients and families they choose to assess, but must show fairness in providing child life assessment, and subsequently child life interventions, with any child and family. Similarly, this principle calls child life specialists

to be self-reflective and to recognize bias within themselves and within the medical team toward certain groups. This principle will be further expanded on in chapter 3: Towards Culturally Conscious Psychosocial Assessment in Child Life.

Preview of Each Chapter as a Road Map

In this book, assessment as an alive and ever-changing construct will be explored. To set the foundation for assessment practices in child life, Part I of the book will cover the history of child life assessment, presented by Sisk and Burns-Nader. Next, Ferrer and Porter will describe the cultural implications of child life assessment and how social determinants of health impact development and coping.

In Part II, we will look closely at theories and tools that inform assessment approaches. Cantrell, Harmeyer, and Wittenberg Camp present traditional and contemporary developmental theories often used to inform assessment approaches and formulate plans. Next, Staab and Wittenberg Camp break down the many measures and tools used to help structure the assessment process. And lastly, to provide a deep dive into one of the most relied upon methods for child life assessment, Turner and Hotchkiss discuss play.

After learning about methods and approaches for the practice of assessment, Part III will consider the assessment process in specific settings and populations. Staab and Chrisler look at completing assessments with children with disabilities. Boles and Thomas-Adams will consider assessment when working with children and families at end of life. Daniels and Cantrell explore the impact of the online environment on assessment as well as how to conduct assessments online. Sisk and Burns-Nader consider how to educate and train child life specialists on assessment practices. And Daniels, Boles, and Barta look closely at new emerging settings and populations as child life expands into new arenas like community health and children of adult patients.

The book concludes with considerations for the future of child life assessment and recommendations for completing patient- and family-centered assessments that support coping and development. Koller and Wheelwright discuss the future of the child life profession and how these implications impact assessment practices. Sisk, Cantrell, and Wittenberg Camp conclude the textbook and provide practical suggestions for using this information to inform quality child life practice. Throughout the text, case

examples will be used to illustrate the art of assessment. Names and details of patients and families have been changed to protect their privacy.

References

American Professional Society on the Abuse of Children. (1997). Code of ethics. www.apsac.org

Association of Child Life Professionals. (2016). Child life competencies. https://www.childlife.org/docs/default-source/the-child-life-profession/childlifecompetenciesjune2016.pdf?sfvrsn=2

Association of Child Life Professionals. (2023). Child life code of ethics (3rd ed.). https://www.childlife.org/docs/default-source/certification/child-life-code-of-ethics.pdf

Association of Child Life Professionals. (2024). Child life professional certification examination content outline. https://www.childlife.org/docs/default-source/certification/candidate-manual.pdf

Beauchamp, T. L., & Childress, J. F. (1979). Principles of biomedical ethics. Oxford: Oxford University Press.

Bowlby, J. (1969). *Attachment and loss, Vol. I: Attachment*. New York: Basic Books

Brown, T. (2014). Schools of thought the influence of theory. *The pips of child life: Early play programs in hospitals*. Kendall Hunt.

Erikson, E. H. (1993). *Childhood and society*. WW Norton & Company.

Johnson, B. H. & Abraham, M. R. (2012). Partnering with patients, residents, and families: A resource for leaders of hospitals, ambulatory care settings, and long-term care communities. Bethesda, MD: Institute for Patient- and Family-Centered Care.

Koller, D. (2008). Child Life Council evidence-based practice statement Child life assessment: Variables associated with a child's ability to cope with hospitalization. *Child Life Bulletin Focus, 26*(4), 1–6.

Piaget, J. (1964). Cognitive development in children: Development and learning. *Journal of Research in Science Teaching, 2*, 176–186.

Plank, E. (1962). *Working with children in hospitals: A guide for the professional team*. Press of Case Western Reserve.

Romito, B., Jewell, J., Jackson, M., Ernst, K., Hill, V., Hsu, B., Lam, V., Mauro-Small, M., & Vinocur, C. (2021). Child life services. *Pediatrics*, *147*(1).

Thompson, R. (2018). *The handbook of child life: A guide for pediatric psychosocial care*. Charles C. Thomas Publishing.

Thompson, R. & Stanford, G. (1981). *Child life in hospitals: Theory and practice*. Charles C. Thomas Publishing.

Trent, M., Dooley, D. & Douge, J. (2019). The impact of racism on child and adolescent health. *Pediatrics, 144*(2). https://doi.org/10.1542/peds.2019–1765

Turner, J., & Brown, C. (2012). *The pips of child life: Early play programs in hospitals*. Kendall Hunt.

Turner, J. & Brown, C. (2016). *The Pips of child life: the middle years of play programs in hospitals*. Kendall Hunt.

Turner, J. C., & Fralic, J. (2009). Making explicit the implicit: Child life specialists talk about their assessment process. *Child & Youth Care Forum, 38*(1), 39–54.

Walsh, M. & Petro-Yura, H. (1967). *The nursing process: Assessing, planning, implementing, and evaluating.* Catholic University of America Press.

Wittenberg, B., Cantrell, K. & Sisk, C. (2023). Child life internship readiness: Perspectives of child life academics. *The Journal of Child Life: Psychosocial Theory and Practice 4*(2).

Wojtasik, S., & White, C. (2018). The story of child life. In R. Thompson Editor, *The handbook of child life: A guide for pediatric psychosocial care* (pp.3–22). Charles C. Thomas Publishing.

CHAPTER 2

HISTORY OF CHILD LIFE ASSESSMENT

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Bolstered by the integration of research and clinical expertise, assessment is a paramount cornerstone of child life practice. The first step in any encounter with a child and family requires a child life specialist to use assessment knowledge and skills. Child life specialists provide quality child life services built upon accurate, ongoing assessment to identify crucial information for planning an intervention to meet the child and family's needs. Child life specialists' knowledge of assessment is essential for effective child life practice. This chapter will summarize the evolution of child life assessment practices.

Theoretical Foundations of Child Life Assessment

Knowledge of human development is a prerequisite for assessing children and adolescents, thus a timeline is presented to provide historical context (Table 2-1). As these human development theories emerged, professionals, including child life specialists, began using them as a foundation for assessing children's developmental needs.

Table 2-1 *Historical Timeline of Developmental Theories*

Date	Theory	Theorist	Contribution
1690	Empiricism- or "tabula rasa"- born with a blank slate and without preconceived ideas	John Locke	• Provided foundational knowledge of human behaviors
1762	Kindness and morality do not come naturally	Jean-Jacques Rousseau	• Provided foundational knowledge of human behaviors
1859	Theory of Evolution by Natural Selection	Charles Darwin	• Provided foundational knowledge of human behaviors
1904	Built upon Recapitulation Theory	G. Stanley Hall	• Father of developmental psychology in the United States of America, (Oxford Bibliographies, 2017) • Founder of the American Journal of Psychology (1887) First president of the American Psychologist Society (1892) • View of child development influenced by Darwin • Focused on a child's development over their lifetime as similar to the evolution of a species
1905	Psychosexual Theory	Sigmund Freud	• Introduced the stage model of psychosexual development
1925	Maturational Theory	Arnold Geselle	• Student of G. Stanley Hall • Introduced the concept of normal age ranges for developmental milestones including walking and talking
1928	Behavioral Theory	John B. Watson	• Focused on the behaviorist perspective related to child rearing and education

1950	Theory of Psychosocial Development	Erik Erikson	• Introduced the theory of psychosocial development a staged theory focused on successful resolution of crises in personality that lead to a positive virtue
1958	Behavioral Theory	B. F. Skinner	• Studied behavioral conditioning
1959	Cognitive Development Theory	Jean Piaget	• Developed the stage theory of cognitive development
1958 1960 & 1969	Attachment Theory	James Robertson John Bowlby	• Described stages of a child's response to parental separation • Viewed infants' attachment to caregivers as an evolutionary development for their protection and expanded this to include attachment theory which involves the parent-child relationship that develops during the child's early years
1962	Sociocultural Theory of Cognitive Development	Lev Vygotsky	• Saw children's cognitive development as influenced by interactions with adults in their lives
1971	Social Learning Theory	Albert Bandura	• Expanded behaviorism to include bidirectionality of development
1979	Ecological Systems Theory	Urie Bronfenbrenner	• Developed the bioecological theory of development with the child at the center as an active participant in their development among various contexts
1996	Integrated Model for the Study of Developmental Competencies in Minority Children	Cynthia Garcia Coll	• Emphasizes the importance of racism, prejudice, discrimination, oppression, and segregation on the development of minority children and families

Adapted from Lumen Lifespan Development (n.d.) and Oxford Bibliographies (2017)

Child Development & Child Life Assessment

These developmental theories, research evidence of the time, provided guidelines to inform child life specialists' assessments leading to interventions to meet the two primary objectives of child life programs (Thompson & Stanford, 1981, p. 7):

1. "to help the child cope with the stress and anxiety of the hospital experience";
2. "to promote the child's normal growth and development while in the health care setting and after returning home."

As the profession of child life integrated early play program observations with Emma Plank's goals (1962 and reprinted in 1971) and knowledge of applicable theories, the profession began to formalize a scope of practice to include: play, preparation, parent and family support, environment, advocacy, and promotion of development (Thompson & Stanford, 1981). Without these initial developmental theories, the child life profession would not have an evidence-based foundation for child life assessment of children and families.

Developmental & Psychosocial Assessment

Early pioneers in child life were not formally trained in child development so they relied on previous experiences with children in hospitals to inform their interactions and services. While the field of developmental psychology grew, child life specialists used their practical experience and new knowledge of development to understand the children they worked with in hospital settings. Anne Smith, an early advocate for play as a preventive measure and facilitator of social interactions, recognized the importance of humanism in pediatric medicine as the best means of caring for children (Turner, 2014). B.J. Seabury's work provided significant evidence of the importance for including psychosocial variables into child life specialists' assessment (Pearson, 2014). Mary Barkey championed child life specialists' psychosocial assessment connecting it to assessment of the whole child including four domains of development, as well as, assessment of children's "fears, anxieties, and concerns" (Brown, 2014, p. 61). As more developmental theories were published and child life specialists gained clinical expertise; it became evident that factors beyond child development should be considered to thoroughly assess the unique needs of children in the medical environment.

Comprehensive developmental assessments include multiple domains as outlined by Brenner and Grimm (2013):

- Cognitive development
- Problem-solving skills
- Communication skills
- Language development
- Gross motor development
- Fine motor development
- Social development
- Emotional development
- Self-care
- Adaptive behaviors
- Play behaviors
- Motivation to play
- Auditory and visual abilities

While child life specialists assess these developmental domains informally, unless trained to implement standardized developmental measures, their primary focus is on the child and adolescent's psychosocial development and coping. Rollins and Riccio (2001) documented that psychosocial assessments include the following: "affect, temperament, ability to communicate and interact, personal or family stressors, coping style, amount and type of defense mechanisms used, and self-concept and level of self-esteem" (as cited in Rollins, 2018, p. 151). Comprehensively combining developmental and psychosocial domains in child life assessment is important for learning about and understanding the children child life specialists serve.

The Emergence of Play and Assessment in Child Life

Play was emerging as a right for children post World War I with toys becoming more prevalent by the 1930s (Turner & Grissom, 2014). In *The PIPS of Child Life: Early Play Programs in Hospitals*, Turner (2014) provided an historical review of the first documented full-time hospital play program work of pioneer Anne Smith at Children's Memorial Hospital Chicago including her research and advocacy which began in 1932. Evident throughout Smith's work was her dedication to the assessment of children in her care to determine appropriate play interventions to meet their needs.