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Special Issue: Family Science Careers Through the Eyes of Theory

This manuscript is part of a special issue of Family Science Review entitled Family Science Careers Through the Eyes of Theory, edited by Raeann R. Hamon, Ph.D., CFLE. The authors of these deliberately unconventional manuscripts were asked to select and describe a career that a professional with a family science background might pursue. After outlining the professional role, authors reflected upon the family theories that most influence the way they approach their work and perform their professional duties. Authors briefly review the scholarly literature on selected family theories, provide case studies or work scenarios as illustrations of theory in action, and discuss the strengths and weaknesses of the theories in their unique professional contexts. The Special Issue articles are designed to be used individually or in combination, and feature articles about careers in early intervention, special education, family court, child life, and higher education. The introduction to the special issue is available at https://doi.org/10.26536/GMJK4953. The complete special issue is available at https://doi.org/10.26536/ZLUL3923.

Child Life in Practice: Applying Theories in the Emergency Department and on a Pediatric Unit

Karin Rourke, Department of Family and Consumer Sciences, Western Michigan University
Jou-Chen Chen, Department of Family and Consumer Sciences, Western Michigan University
Karen Blaisure, Department of Family and Consumer Sciences, Western Michigan University

ABSTRACT. Certified child life specialists (CCLS) serve as an integral component of the health care team by attending to the psychosocial concerns that arise as children and their families face stressful situations. The CCLS provides individualized care to meet the developmental needs of infants, children, teens, and young adults and assists in coping with medical-related stressors, using play as a main healing modality. As they engage, assess, and educate, CCLS use play for therapeutic purposes and provide education to children and their families regarding diagnosis, treatments, procedures or tests needed, strategies for coping and managing pain, and the medical environment. In this article, two theories and one process that help guide the work of the CCLS are applied in a scenario: Bronfenbrenner's bioecological theory of human development (Bronfenbrenner, 2005), Lazarus and Folkman's (1984) transactional theory of stress and coping, and the APIE process (Wilson et al., 2006). CCLS use theory to assess, plan, and provide appropriate interventions to promote optimal care of patients.

Keywords: Child Life Specialists, Family Science Theories, APIE process

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Direct correspondence to: Karin Rourke, 3214 North Kohrman, 1903 W. Michigan Ave., Dept. of Family and Consumer Sciences, Western Michigan University, Kalamazoo, MI 49008-5322. e-mail: karin.rourke@wmich.edu

Child Life in Practice: Applying Theories in the Emergency Department and on a Pediatric Unit

Certified child life specialist(s) (CCLS) utilize theoretical foundations to provide evidence-based care to children and families facing medical and other life challenges. In this paper, the authors employ Bronfenbrenner's (2005) ecological and bioecological models of human development and Lazarus and Folkman's (1984) transactional theory of stress and coping to examine and explain a child's development and their interactions with people inside and outside of hospital environment when facing and coping with stressful situations. The adoption of the APIE process (Wilson et al., 2006) guides CCLS to assess, plan, intervene, and evaluate care and coping plans to provide services to children and families in healthcare settings.

Career and Theory

Child Life Profession

As of December 2022, there were 6,593 CCLS (ACLP, 2022); and over 430 child life programs exist in hospitals and community settings (Romito et al., 2021). CCLS are recognized by the American Academy of Pediatrics as part of the interdisciplinary healthcare team providing care to pediatric patients and their families. Moreover, "the provision of child life services is a quality benchmark of an integrated patient- and family-centered healthcare system, a recommended component of medical education, and an indicator of excellence in pediatric care" (p. 5).

History of Child Life

The profession of child life has roots extending back approximately 100 years (Wilson et al., 2006). In a time when medical care was still cold and impersonal, the concept of children playing in a hospital setting was revolutionary. Over the decades, programs took stronger root in hospitals, until during the Association for the Care of Children's Health annual conferences in the 1970s, a small group of professionals who cared for the emotional, educational, and psychological needs of hospitalized children emerged (Gaynard et al., 1990; Wojtasik & White, 2018). They formed work groups and a task force to better identify and outline the work of child life specialists, and define and establish professional standards, accreditation, and competencies. The profession of child life was formally organized in 1982, with the founding of the Child Life Council, now the ACLP. With diligent effort, these early professionals paved the way for an improved hospital experience for all children and their families (Gaynard et al., 1990; Wojtasik & White, 2018).

The Role of Child Life Professionals

The CCLS serve as an integral component of the healthcare team by attending to the psychosocial concerns that arise as children and their families face stressful situations, primarily in hospitals and other medical settings (Romito et al., 2021). CCLS provide individualized care to meet the developmental needs of pediatric patients and their families and assist in coping with medical-related stressors. As the main healing modality for a CCLS, play is utilized to engage, assess, and educate children, and may be used for therapeutic, educational, or recreational purposes (Romito et al., 2021). CCLS educate children about their medical experiences, support children undergoing medical procedures, offer emotional support to and advocate for patients and their families, and provide bereavement support (Gaynard et al., 1990; Romito et al., 2021; Wojtasik & White, 2018).

Becoming a Certified Child Life Specialist

The career of child life attracts students who express a deep commitment to children and who can envision themselves working in a healthcare setting. Child life academic programs are often housed

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in departments of human development and family science, as knowledge of child development and family theory, and field placements are crucial to the profession. In addition, CCLS take courses designed to explore the developmental challenges and other unique needs of children facing illness, injury, or other stressful life events. To obtain certification in child life, one must earn a minimum of a bachelor's degree and complete ten specific courses (e.g., family systems, child development, and bereavement courses), complete a minimum 600-hour internship under the supervision of a qualified CCLS, and pass a certification exam. Although not required, many students acquire extra hours of work and volunteer experience with children and families prior to the clinical child life internship and/or complete an advanced degree. Some CCLS may be dually certified as Certified Family Life Educators.

Theories

Child life competencies are grouped into five areas: care of infants, children, youth, and families; professional responsibility; education and supervision; research fundamentals; and administration (ACLP, 2019). Included in the first group is knowledge of theories. Theories guide child life practice by providing a way of assessing and understanding the experiences of children and families as they face an illness, injury, or other health or developmental challenges and by pointing to possible interventions (Turner, 2018).

Multiple factors impact choice of theory, including the medical unit CCLS work in, the patients or families they serve, and the planned interventions. In the scenario below, we apply Bronfenbrenner's (2005) theories (ecological and bioecological models of human development) and the transactional theory of stress and coping (Lazarus & Folkman, 1984). We chose these theories because they address two key expectations in child life practice: account for development when providing child life services, and support patients' and families' coping with stress (ACLP, 2019). First, however, we will describe a process for guiding delivery of child life services: assessment, plan, interventions, and evaluation, or APIE (Wilson et al., 2006). We will follow the description of APIE with an overview of the theories before applying them to a scenario.

APIE Process

Child life competencies include following a process for delivering services. APIE is a process CCLS engage in throughout their workday. The "steps of assessment, plan, interventions, evaluation, and reassessment are the process for quality and professionally-accountable service delivery" (Wilson et al., 2006, p. 9). By adhering to APIE, CCLS understand that the assessment of the child and their situation comes first, then the development and implementation of a care plan. CCLS use theory when making an assessment, evaluating a child's development, considering a family's strengths and challenges, and planning interventions (Wilson et al., 2006).

In each encounter, CCLS perform ongoing assessments and reassessments, determining the efficacy of each interaction and intervention and adjusting the care plan accordingly. The APIE process may therefore happen many times in an encounter. For example, a well-developed plan for a procedural support intervention may not go as expected, so the CCLS will adjust the plan to better accommodate the immediate needs of the child.

The extent of each individual assessment is contingent on variables such as time afforded for each patient encounter. A CCLS in the Emergency Department (ED) may have limited time to assess an emergent situation. A rapid initial assessment may be based simply on the child's age and medical needs. In other situations, a CCLS may use additional time to make a more comprehensive assessment, utilizing a medical chart or information provided by medical staff.

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Ecological and Bioecological Models of Human Development

Scholars describe Bronfenbrenner's theorizing in three phases spanning from 1973 to 2006 (Rosa & Tudge, 2013). In the first phase (1973-1979), Bronfenbrenner (1979) developed an ecological model of human development to highlight the role of context in human development. The ecology, or context, of human development, was described as involving,

> "the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between these settings, and by the larger contexts within which the settings are embedded" (Bronfenbrenner, 1979, p. 21, as quoted in Rosa & Tudge, 2013, p. 246).

Visualized as an individual at the center of four levels of circles, the ecological model emphasizes development as a social process engaged by the individual, environment, and others in that ecological environment. The immediate environment, the microsystem, includes the most proximal settings in which a child interacts with others (Bronfenbrenner, 2005), often including family, school, neighborhood, and, for some children, a hospital. The mesosystem consists of relationships between two or more settings. The exosystem contains systems and policies that affect those who interact with the child, potentially affecting the child's development (e.g., working overtime decreases the time a parent spends with a child). Finally, the macrosystem includes "the institutional systems of a culture or subculture, such as the economics, social, education, legal, and political systems," which can influence the functioning of ecological settings such as families and schools (Rosa & Tudge, 2013, p. 247).

Assumptions of the ecological model include humans are "not only the product but also the producer of their own development" (Rosa & Tudge, 2013, p. 254); successful development occurs when attachments are positive, mutual, and permanent; and the child observes and engages "in activities with the assistance of people who have better understanding and skill" and who encourage the child to use skills learned in other settings (p. 248).

In the second phase of theorizing (1980-1993), Bronfenbrenner (1986) discussed how personal characteristics of individuals in a microsystem affect one another's development. Likewise, he explored how "extrafamilial conditions" affect "intrafamilial processes" (p. 723), noting, for example, how characteristics of the environment encourage development (e.g., by inviting exploration) or discourage development (e.g., through unpredictability, instability). He used the term chronosystem to account for individual development and environmental change, and the interaction of the two, across time (Rosa & Tudge, 2013, p. 250).

In the third phase (1993-2006), Bronfenbrenner (1995) featured proximal processes which are reciprocal interactions between "an active, evolving biopsychosocial human organism and the persons, objects, and symbols in its immediate external environment" (Bronfenbrenner, 2005, p. 6). He considered proximal processes to be "primary engines of development" and to grow in complexity as an individual gained abilities, knowledge, and skills (p. 6). He noted that the interactions need to occur regularly across a period of time to influence development.

Bronfenbrenner (2005) referred to this version of his theorizing as the bioecological model of human development. Beyond proximal processes, components of the bioecological model include the *person* with their characteristics; *context* (the micro-, meso-, exo-, and macrosystems); and *time* (Rosa & Tudge, 2013).

Transactional Theory of Stress and Coping

The transactional theory of stress and coping (Lazarus & Folkman, 1984) has been widely recognized and applied in settings such as healthcare (Biggs et al., 2017) by professionals like CCLS (Boles, 2018). The transactional theory of stress and coping accounts for variability in what is experienced as a potentially stressful event and means of coping with it. That is, stress is a subjective experience. Individuals make a primary appraisal about whether an environmental stimulus is stressful (i.e., perceived as a potential threat, causing damage or harm; or as a challenge that could result in growth; Biggs et al., 2017). Individuals can appraise the same stimulus differently. If the stimulus is perceived as stressful, then they engage in a secondary appraisal as they consider demands of the situation and their coping capabilities given available resources (Boles, 2018). Coping can be problem-focused (managing the stressor), emotion-focused (regulating emotion; Lazarus & Folkman, 1984), or meaning-focused (Folkman, 1997).

The transactional theory of stress and coping guides psychological preparation and procedural support interventions that address a child's primary and secondary appraisal of a situation (Boles, 2018). Research recognizes children's anxiety (as they face medical procedures, hospital settings, and physical transitions within a hospital), parental anxiety (that predicts child anxiety), and benefits of preparation for children and parents.

In the hospital setting, a child uses primary appraisal to determine if situations are a threat. A CCLS educates the child about the environment by describing the procedure or event, providing sensory information (what they may feel, hear, or see), and giving them a sequence of events and anticipated timeline for what they will experience (Boles, 2018). In the secondary appraisal stage, a child is determining strategies to best cope with a situation. A CCLS helps a child develop a plan for coping, such as blowing bubbles, reading an *I Spy* book (e.g., Marzollo & Wick, 1993), or using technology to play a familiar game.

Scenario Application

Background

In the scenario below, the setting is a hospital where the proximal processes are the interactions the patient, Chun-Chieh (pronounced: Jùn Jiéh), has with persons (e.g., medical doctors, nurses, CCLS, family members) and objects (e.g., medical equipment). Our focus is on CCLS, whose expressed role is to provide individualized psychosocial care to meet the developmental needs of hospitalized children (Romito et al., 2021), including coping with potentially stressful situations (Goldberger et al., 2018; Lazarus & Folkman, 1984). The goal of these reciprocal interactions, or proximal processes, between CCLS and Chun-Chieh is an increased ability to cope with the hospital stay, medical diagnosis, and treatment. Increased coping, or competence, is built through gaining knowledge about the injury to his leg, medical terminology, and what machines do, and practicing and applying new skills such as distracting oneself (e.g., singing, reading, watching videos), deep breathing, or walking on crutches.

Due to The Health Insurance Portability and Accountability Act of 1996 regulations, the scenario presented below is inspired by numerous cases the first author encountered during nearly two decades of working as a CCLS. Demographics (e.g., age, family positions) and scenario details (e.g., presenting injury, additional stressors, culture) have been changed, and pseudonyms are used. The scenario features two of the many locations within a hospital where CCLS are found: an emergency department (ED) and a pediatric unit.

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Application

Emergency Department (ED)

Notification. Assessment begins when the ED CCLS is notified that a six-year-old boy is being transported to the ED with a leg injury sustained in a pedestrian versus car crash. The trauma situation calls for the CCLS to quickly consider likely reactions to the accident, the ambulance ride, and the unfamiliarity of the ED. A child's likely emotional reactions are fear, confusion, and anxiety (Lookabaugh & Ballard, 2018). The CCLS interacts calmly and with empathy, providing information to both the child and adults about what is occurring and preparing them for upcoming procedures, as parents may also be extremely distressed, worried, fearful, and/or angry (Pearson, 2018).

The CCLS meets the ambulance as it arrives. On the way to Trauma Bay 1, the CCLS introduces themself as a person who helps the children in the hospital understand what is happening and tells the child that he is going to a "big room with a lot of people." The CCLS explains that each of these people has a special job to help him feel better. Along the way, the CCLS checks the pronunciation of Chun-Chieh's name with the mother (Rollins, 2018) and asks if they would like an interpreter, as the CCLS hears the mother converse in English and another language. While the CCLS thinks both Chun-Chieh and his mother understand and speak English, the CCLS knows that even with language proficiency, families sometimes prefer an interpreter during medical emergencies (Ahmann & Rollins, 2018).

Emergency Department (ED). Once in the room, the child is moved to the hospital bed. The patient, Chun-Chieh, is softly crying while his mother is reassuring him by saying, "Be strong and don't cry. You will be okay." As there are medical personnel surrounding the bed, Chun-Chieh's mom stands nearby with the medical social worker, who offers emotional support and provides necessary information and updates. In supporting Chun-Chieh's psychological adjustment and reminding him to "suppress" negative emotions in public (Taiwanese culture, like many other Eastern cultures, considers expressing negative emotions in public, including crying, as inappropriate; NAEYC, 2010; Jin et al., 2017), his mom rejoins him at the bedside as soon as there is room. The CCLS stands at the head of the bed and quietly talks to Chun-Chieh, explaining the situation to him. There may be many people talking at once, which can easily overwhelm a child, so the CCLS tries to keep Chun-Chieh focused and will ask him any necessary questions, while the physicians proceed with the examination.

The CCLS continues to assess while planning interventions for a child aged 6, an age in which the prefrontal cortex shows increased development in cognitive and emotional skills such as reasoning (understanding cause and effect) and self-regulation (Davies & Troy, 2020). Children this age are often curious about how the body works and what procedures will do to their body and may appreciate learning how machines and equipment work (Boles, 2018). An IV had been inserted by Emergency Medical Services (EMS); however, the ED staff must insert another IV. The CCLS quickly explains to Chun-Chieh that he will need another IV, letting him know that the sharp part will not stay in his arm and that what remains is just a tiny straw to give his body medicine. The CCLS shows him and his mother a tiny IV catheter the CCLS keeps in a pocket to help educate children and families and lets him feel and manipulate it. The CCLS suggests a few options for an alternate focus for him, such as counting or deep breathing, to help him better cope with the upcoming IV start. Chun-Chieh chooses to count, so the CCLS guides him by counting and offering verbal encouragement during the IV insertion. The CCLS then explains the upcoming CT scan ordered for Chun-Chieh, explaining the test to him, describing the machine as a big camera that takes pictures of the inside of your body, reassures him it

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will not touch him or hurt, talks about the sounds the machine will make, and lets him listen to the sounds on an iPad.

The CCLS is evaluating how well the interventions are working to help Chun-Chieh to cope, by assessing his behavior, coping, and engagement in distraction. For example: If Chun-Chieh does not respond well to the procedure or engage in the alternate focus, the CCLS will quickly attempt another intervention to help him better cope with the situation.

By providing procedural preparation (e.g., tiny IV catheter, description of the CT scan, a recording of a CT machine) and/or medical play (e.g., inserting an IV on a doll), a child learns what to expect and becomes familiar with the equipment, and can cope better with the situation and feel capable and successful meeting the challenges he is facing (Goldberger et al., 2018).

Waiting for Results. While Chun-Chieh and his mother wait for test results, the CCLS answers their questions, continues to assess by asking pertinent questions (such as family structure, concerns, grade in school), and provides education and information on the hospital and their situation. To support coping, the CCLS also asks Chun-Chieh to select a book, game, toy, and/or movie to focus his attention on what his mother agrees are familiar activities.

According to the transactional theory of stress and coping, people utilize a primary and secondary appraisal when faced with a potentially stressful situation (Lazarus & Folkman, 1984). In the primary appraisal, the person perceives a threat to their well-being. To help Chun-Chieh perceive the situation as less threatening, the CCLS educates and psychologically prepares him for multiple procedures (i.e., IV, CT scan) and unfamiliar situations (e.g., large room, noisy equipment) focusing on sensory information that he will see, hear, and feel (and in some procedures smell and taste) with softer language (Goldberger et al., 2018), thereby addressing primary appraisal. The secondary appraisal focuses on coping with a situation. To help Chun-Chieh cope with the experiences in the ED, the CCLS works with him to develop a coping plan that includes counting and choosing activities to offer an alternate focus. This coping plan encourages the use of child-friendly tools to cope more effectively.

Surgery Needed. The ED physician returns and informs the family that Chun-Chieh has sustained a femur fracture, will be headed to surgery, and is expected to be admitted to the hospital for a few days. The surgeon will later explain the procedure and anticipated outcomes of the surgery. The CCLS returns to provide patient-specific education, describing the operating room and surgical process, allowing Chun-Chieh to manipulate and explore the oxygen mask, and assuring him that he will have medicine to help his body sleep while the doctor repairs his leg, so he will not feel anything during the surgery.

The CCLS then describes to Chun-Chieh and his mother the unit where he will be staying after his surgery, explaining the facilities and services available to his family (e.g., family kitchen or resource room), and highlighting the colorful rooms and playroom for him. The CCLS confirms that family members, including siblings, may visit, and Chun-Chieh may have comfort items, toys, or clothes from home while in the hospital. While waiting for Chun-Chieh to be transferred to the surgical unit, the ED CCLS calls the CCLS who will care for him in the inpatient unit to ensure continuity of care for him and his family.

In-Patient Unit

Post-surgery. Surgery on Chun-Chieh's leg is successful, and he is now in his room in the pediatric orthopedic unit. He will remain in the hospital for a few days, ensuring his pain is well-controlled before discharge home. Contact with an inpatient CCLS occurs multiple times a day

over the course of his stay. Prior to his arrival, the inpatient CCLS reviewed the medical chart and consulted with the ED CCLS about Chun-Chieh's coping, response to treatments and interventions, family support, temperament, and any needs he or the family may have.

The inpatient CCLS speaks with the parents when Chun-Chieh is transferred. Chun-Chieh's mother is in the hospital every day and his father visits at night after work. The father expresses a desire to be at the hospital more, but his employer requires him to be at work, as they are completing an important project. Bronfenbrenner's bioecological model informs us that a main psychosocial challenge for hospitalized children is being separated from their family, the child's primary microsystem (Pearson, 2018). To the delight of Chun-Chieh and his parents, the CCLS arranges video conferencing calls between Chun-Chieh and his father during the father's lunchtime. A family friend is looking after Chun-Chieh's sisters, who are aged 6 and 10, so his mother may be with him at the hospital.

Coping. The CCLS helps Chun-Chieh and his family cope more effectively with his hospitalization. Procedures, such as IV starts, are explained in terms he can easily understand, and he is supported through the procedures by the CCLS, when possible. The CCLS provides ample opportunities for Chun-Chieh to play to normalize the hospital environment, encourage him to be active, divert attention from pain, reduce anxiety, explore medical equipment in a comfortable way, and increase coping.

Chun-Chieh's mother shares that her daughters are worried about their brother. Along with fear about the well-being of their brother, siblings may also be challenged by separation from parents who are spending time at the hospital (Pearson, 2018). The CCLS provides child-appropriate language the parents may use to discuss the situation with their daughters and encourages bringing them to see Chun-Chieh. The siblings come to the hospital and, with permission of the parents, the CCLS helps them understand what has happened medically with their brother, explains his current medical needs, clarifies misconceptions, and supports them in their initial visit. Play materials will be provided for the siblings, as play may help them feel more comfortable in the medical setting, express themselves, better engage with their brother, and cope more effectively.

School. The day after the surgery, Chun-Chieh expressed he was missing school and his friends. As school is an important microsystem for a child, the CCLS makes arrangements among the three microsystems (i.e., hospital, home, and school) for him to join his class remotely. With permission from Chun-Chieh's family and school, the CCLS facilitates the visit with his classmates and shares age-appropriate information about Chun-Chieh.

Discharge. Before he is discharged home, the CCLS teaches Chun-Chieh techniques for pain management and ensures his questions are answered.

Discussion

Bronfenbrenner's Ecological and Bioecological Models of Human Development

The *strengths* of Bronfenbrenner's (2005) models of human development on the delivery of child life services include two influences on human development: 1) the larger environmental contexts and 2) interactions in the immediate setting. First, the ecological model places development within the microsystem where the interactions of the child, family, and staff in a hospital setting occur and are influenced by contextual factors. The easily visualized picture of mesosystems, exosystems, and macrosystems guides assessment of relevant influences on the patient and family. The model also highlights that successful development occurs in immediate settings when a child engages in activities with skilled and understanding others, a feature of child life services. The bioecological model extends

this point by drawing attention to the proximal processes or interactions that take place among the child, other persons, objects, and symbols that drive development. CCLS are reminded that positive interactions in which they educate children and families about what they see and will experience increase competence. Additionally, characteristics of both the child and a CCLS influence interactions, emphasizing the need for reflective practitioners, one of many essential child life competencies (ACLP, 2019).

Limitations of the ecological and bioecological models as applied in child life settings include time constraints present in some medical settings such as outpatient settings. Brief encounters may limit the opportunity to assess the influence of other contextual factors on the immediate situation.

Although known for his contextual approach, Bronfenbrenner did not deeply examine the effects of racism and sexism on individual and family development; however, a few scholars using ecological theory have done so, and more are continuing (Allen & Henderson, 2023). For example, Vélez-Agosto and colleagues (2017) argued for moving culture from the macrosystem to proximal processes, in recognition that culture "is within everyday action (activities, routines, practices)" and therefore directly affects development (p. 900). Visualizing culture as carried out in everyday interactions brings an urgency to keep culture in mind along with other factors such as age and health status of a child. For example, as medical systems vary across countries, a CCLS can be aware that both their own and a family's cultural understanding and expectations of a healthcare setting will likely influence their interactions with one another and their beliefs on how children should behave and interact with others.

Transactional Theory of Stress and Coping

The *strengths* of the transactional theory of stress and coping (Lazarus & Folkman, 1984) for delivery of child life services include 1) the recognition that individuals, including children, vary in perception of threats and coping strategies and 2) the practical guidance it provides for supporting children and families through stressful events and situations.

Applying this theory to practice reminds CCLS to explore and not assume what a child perceives, or appraises, as threatening their well-being (Boles, 2018). Even with the same child, a medical procedure may be experienced first as a threat, requiring the help of CCLS to cope with fear; subsequently, with increased understanding, it could be experienced as a challenge to meet. The primary (is the situation a threat to well-being) and secondary (what internal and external resources are available to manage a threat) appraisals provide clear entry points to help children and families. CCLS can boost knowledge, an internal resource, of a potentially threatening situation through education and can help children and family members brainstorm and offer options for coping to assist them with managing potential stressors.

A *limitation* of applying the transactional theory of stress and coping may occur when considering the effectiveness of coping efforts. Lazarus (1981, as cited in Boles, 2018) advised caution about establishing criteria for distinguishing between adaptive and maladaptive coping. For example, short or long-term outcomes, culture, personal perspectives, and value systems should be considered. Particularly when the CCLS and patient differ in background, additional time is needed to understand what could be perceived as a threat and familiar coping efforts.

Cultural Competency and Humility in Child Life Profession

The child life profession is recognizing limitations of traditional theories, based primarily on white, Western, middle-class populations, and the application of theory without cultural humility and recognition of varied cultural practices (Thomas-Adams, 2022). In practice, while CCLS may utilize

theory as a guideline, they can include family in the assessment process and also understand the impact that family systems, culture, race, sexuality, or socioeconomic level can have on the child and their development.

The CCLS should advocate for the needs of families who may be inexperienced in navigating the U.S. healthcare system. Offering an interpreter may help ensure optimal care is provided to that family. Medical terminology may be difficult for even native speakers to understand, so offering interpreter services assures the family will have a more thorough understanding of the situation. The CCLS can educate the family on hospital policies and procedures that impact them and the care of their child, and check that families understand: 1) they may ask for clarification when speaking to medical staff, 2) they have a voice in care decisions made regarding their child, 3) they can disagree with the staff, and 4) they may be present and support their child for most procedures.

In the scenario presented, the parents come from Taiwan, so applying theories from the white, Western, middle-class lens may not best represent this child. As English is not the family's first language, there may be linguistic challenges. Ideally, an interpreter is utilized, but if not, the family may feel uncomfortable asking for clarification, asking questions, or disagreeing with care plans. In addition, the family may adopt hybrid beliefs of health and medicine from both Western and Taiwanese cultures and may utilize a mix of folk remedies (e.g., Chinese medicine) and Western medicine (Chen et al., 2009; Gu, 2016). Hence, being aware of the cultural differences in healthcare beliefs and habits can be critical in communicating and providing optimal care (Rollins, 2018).

Conclusion

CCLS utilize theory to help assess, plan clinical interventions, and evaluate service delivery. Theory directs a CCLS to provide care to support children's developmental needs, address their concerns, and help them develop and implement a coping plan. Theory encourages a CCLS to consider the family and community systems that may impact a child. While CCLS appreciate that theories provide a starting point for assessments and care, the profession is examining theoretical limitations (Koller & Wheelwright, 2020), and taking steps to educate the workforce and promote diversity, equity, and inclusion within clinical practice. By adopting a more contemporary examination of theory, and expanding and diversifying the workforce, CCLS can better serve all children and families.

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