

## **The Evolution of the Profession of Child Life in North America**

The child life profession has developed since the 1920's to improve healthcare experiences for children by providing play, preparation and educational programs. These child life services were necessary for the emotional stability and healthy development of hospitalized children while mitigating the fear and pain associated with treatment. The child life specialist was an early and ardent advocate of frequent family visits and parental participation in the care of the child. This philosophy was the precursor of family-centered care.

Research completed during the first half of the twentieth century attributed the alarming incidence of infant deaths in hospitals and foundling homes to the inability of babies to tolerate the sensory deprivation imposed by their surroundings and the absence of sufficient human contact. These infant studies were cautionary models for the exploration of capacities in toddlers and older children to interpret and withstand painful and frightening hospital experiences when the familiar comforts of family and home were absent.

Many children faced long hospitalizations for chronic illness. Early observations indicated distress, loneliness and the lack of stimulation within the pediatric population. This provided an opportunity for change. Play/recreation therapists and teachers were hired to organize activities, provide schooling and psychosocial support for listless and bored children. Their work often involved teaching hospital staff about the non-medical and emotional needs of children as well as orienting and supervising volunteers. At this time, most play programs were not taken seriously.

Early child life workers had much to teach the hospital about the developmental needs of children. They also had much to learn about the culture of hospital life and the interventions that caused children distress, fear and pain. In 1965, a group of pioneering women in the field met in Boston to share their work, triumphs and challenges. Their goal was to create child and family friendly hospital environments. They talked of forming a child life organization but realized they needed a large multidisciplinary organization to make significant changes in healthcare. These women established The Association for the Well Being of Hospitalized Children and Their Families. It officially became known as the Association for the Care of Children in Hospitals (ACCH, 1967) and in 1979, was renamed the Association for the Care of Children's Health. ACCH membership included doctors, nurses, child life specialists, parents and other health professionals working with children and families. The Child Life Study Section was created to help the child life profession achieve a separate identity within ACCH to continue developing its own professional practices and policies.

During the 1970's, child life professionals collaborated to define the theoretical basis of their work with children, the essential elements of professional practice that are necessary, and the requirements of an educational program to prepare students for the profession. The number of child life programs increased substantially, and colleges

developed academic programs incorporating hospital internships to prepare students to work with the hospitalized child.

In 1982, the Child Life Council (CLC) was established with its own officers and its own professional development conference. A method of professional certification was adopted which assured a standard of child life specialist practice and by 1998 a standardized Child Life Professional Certification Examination was in place. By the end of the 1980's, substantial documents had been produced: program review tools, requirements of professional competency, how to start a child life program, standards of clinical practice and standards of educational preparation.

In 1993, ACCH obtained a research grant to study the efficacy of a hospital program based in child life theory and the practice of reducing stress and anxiety. Based on the results of the Phoenix Research Project, the Clinical Practice Manual was written.

During the 1990's, a healthcare crisis developed. Some of the results of hospital restructuring and cost containment initiatives were reduction in child life specialist positions, shortened lengths of stay, increased outpatient visits as well as increased home care and hospice programs for children. In response, the CLC developed the Vision-to-Action strategic planning process. A representative group of child life professionals was elected by the general membership to study how the profession was to move forward into the 21st century. Their recommendations were brought to the membership at the 1996 conference in Albuquerque for discussion and action.

Child life, in the new millennium, continues in the traditional hospital setting (e.g., inpatient, outpatient, day program, ER etc.) as well as in many nontraditional settings. In addition to hospitals, child life specialists are employed in hospice programs, camps, early intervention programs, courtrooms, dental practices, support/bereavement groups, programs in the community, private practice etc. Child life specialists continue to advocate for and apply their skills in many venues, wherever their knowledge and expertise can protect the emotional integrity of children facing severe stressors.