SPECIAL ARTICLE

We All Need a Little TLC: An Argument for an Increased Role of Child Life Services in Patient Care and Medical Education

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ABSTRACT

Child life services (CLS) was created through a synthesis of developmental psychology, a recognition of the inherent difficulties of a hospital environment, and a desire to improve the patient experience of children. Many of the principles of CLS can be applied to other patients as well. In this article, the history of CLS is briefly surveyed, followed by a review of the successes of CLS in the hospital. An argument for an increased role for CLS in medical education and the development of a Program for Adult Life Services is then proposed.

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The purpose of child life services (CLS) is to use play and developmentally appropriate communication to inform hospitalized children and families about their condition, prepare for procedures, develop therapeutic relationships, establish coping mechanisms, and promote optimal development.¹ The first roots of CLS began in the 1920s, with dedicated play programs in the hospital.² However, CLS as its own medical specialty began in the 1960s thanks to the pioneering work of Emma Plank. The child life worker became a fixture of hospitals over the next several decades. Child life workers largely had training in child development, education, or recreational therapy.³ In 1982, the Child Life Council was formed, which facilitated the growth of child life as a distinct profession.² Since then, CLS has become an integral part of pediatric practice, both inpatient and outpatient,⁴ and has produced positive outcomes in a variety of settings. Given these successes, as reviewed below, it is reasonable to ask if the communicated focus of CLS can be expanded to include adult and geriatric patients, as well as an expanded role in medical education.

DEVELOPMENT OF CLS

The conception of CLS can be traced to the early 20th century. The field of pediatrics had only been developed in the late 1800s, and it was common to treat kids as “small adults.” Moreover, with the adoption of germ theory, infection control resulted in measures such as strict quarantine, reducing skin-to-skin contact, and social isolation. Although these measures were implemented with the health of the child in mind, these practices were challenged by 2 contemporary thinkers. René Spitz, an Austrian-American psychoanalyst, used observational study to find that children in an institution without psychological comfort and care became afflicted with developmental delay in addition to physical disease. He popularized the term “hospitalism” to describe this phenomenon. Harry Bakwin, a pediatrician, questioned the isolative conditions of hospitals for children, and instead encouraged his staff to develop friendly and personal relationships with patients

(later popularized as the well-known term tender loving care or TLC).⁵

As these observations about the shortcomings of pediatric care in the hospital were coming to light, other developments were taking place. In the 1930s, a play program had been established at Children's Memorial Hospital in Chicago, believed to be created by Anne Smith. In addition, more attention was given to developmental psychology thanks to the work of pioneers such as Jean Piaget, John Bowlby, and James and Joan Robertson.⁵ Another leading psychologist in the area of child development was Anna Freud, who served as a mentor⁶ to the woman who would be considered the mother of the child life movement, Emma Plank.

In the early 1950s, Emma Plank was recruited to the City Hospital of Cleveland by Frederick C. Robbins, a Nobel Prize-winning physician who had paved the way for polio treatment by culturing poliovirus in tissue.⁷ Robbins put her in charge of the Child Life and Education Program at the hospital then known as the MetroHealth Medical Center.⁸ It was during this time period that her most seminal work took place; in 1962, she penned her book *Working with Children in Hospitals: A Guide for the Professional Team*. In this book she combined previous understanding of hospitalism and its deleterious effects on children with modern understanding of psychosocial development and emphasized the importance of play and a team-based approach to child care in the hospital setting, with specialized training for child care providers. As Frederick Robbins wrote in the foreword to the book, “The ‘play lady’ is a well established institution. However, the concept expressed by Mrs Plank and her associates that there is need for special training and skills unique to the child care worker is not so generally realized. The well intentioned volunteer who likes children still has her place, but it would seem that the needs are greater than she can fulfill.” This discipline was given the term “Child Life” in 1967 by Robert Dombro, and an independent Child Life Council was formed in 1982, cementing Child Life as a distinct medical entity. The

Child Life Council changed its name to the Association of Child Life Professionals in 2016.⁸

Currently, to become a certified child life specialist (CCLS), one must have a bachelor's degree in any field and take additional coursework in child development, family systems, play, loss and bereavement or death and dying, research, and a child life course taught by a CCLS. In addition, 600 hours of clinical child life work supervised by a CCLS is required.⁹ Some of these requirements can be met outside of a formal CLS training program; for example, practitioners of art therapy can become certified in CLS, and indeed, training in both fields can provide synergy in connecting with patients and families.^{10,11} The goal in CLS training is to build a holistic background with which to care for the psychosocial and developmental needs of patients and their families.

SUCCESSES OF CHILD LIFE IN THE HOSPITAL

A significant factor in the success of CLS specialists is in reducing patient and parent anxiety. This has led to a host of beneficial outcomes, including less invasive procedures and fewer hospital resources. For example, use of CLS with radiographic imaging has reduced the need for general anesthesia in multiple cohorts.^{12,13} Similarly, employment of a CCLS specialist reduced the need for anesthesia by 16% in children undergoing radiotherapy.¹⁴ When a family-centered approach, including CLS, was used preoperatively, the need for sedation was reduced from 41% to 13%.¹⁵

Similarly, CLS has a track record of reducing patient and parent anxiety in multiple hospital circumstances, including imaging,¹⁶ angiocatheter insertion,¹⁷ orthopedic casting,¹⁸ intravenous line placement,^{19,20} and laceration repair.^{21,22} CLS has also been shown to reduce anxiety in invasive procedures, such as bone marrow aspiration²³ and surgery,^{24,25} and has played a role in improving quality of life in burn recovery²⁶ and palliative care.²⁷

In addition, CLS specialists, often having earned the trust of the patient, are in a unique position to discuss psychosocial

issues that might be exacerbating or interacting with their illness. In a recent survey of 110 CLS specialists, it was shown that 95% discussed psychosocial issues such as parental separation and divorce, mental illness and substance abuse at home, housing problems, abuse, bullying, and food insecurity.²⁸

A ROLE FOR CLS IN MEDICAL EDUCATION

Given the successes of CLS in overall patient care and efficacy, it would be beneficial for the principles of child life to be reflected more broadly in medical practice. One way of expanding these values is through medical education. Medical students are taught about the foundations of medical ethics and how empathy, informed consent, and patient empowerment are critical in maintaining autonomy, beneficence, nonmaleficence, and justice. In addition, they are taught about childhood development and how motor, language, social, and cognitive function evolve over time. However, the integration of these concepts (how to use someone's development and understanding to optimally inform and reassure patients) is often left to the medical student to feel out on their own.

All medical students are required to spend time in pediatric care. This provides an opportunity for medical students to learn from the expertise of a CLS specialist. Even a day-long experience working with a CLS specialist on a pediatric clerkship could allow students to have a model of effective interaction at different developmental stages, which could help facilitate more positive patient encounters throughout the rest of the clerkship. These principles of effective communication could even be generalized to nonpediatric patients because there is often a large knowledge gap between patients and providers.

A potential objection to this idea is the concern that having other specialties learn more of the principles of CLS will depreciate the value of CLS providers. However, evidence seems to indicate that the in-depth knowledge of development and communication that CLS providers obtain is

unique and not easily replaced. Moreover, the presence of a dedicated CLS specialist allows other professionals, such as nurses and physicians, to better perform their own duties with the knowledge that the patient's emotional needs are addressed.²⁹ Indeed, various case reports suggest that early exposure to CLS increases appreciation for specialists, rather than the reverse.^{30,31} It is plausible that both CLS and medicine can mutually benefit from some overlap in education.

PROGRAM FOR ADULT LIFE SERVICES

As seen in a survey of 607 CLS specialists, the most common techniques used included providing information, preparation, reassurance, and positive reinforcement. Other common techniques included breathing exercises and distraction.³² One could well argue that these techniques are effective for all patients, not just children. Indeed, the most common technique of "providing information" is considered by many to be the essence of good medicine. Patient education has become a dominant focus of health care to empower patients and include them as part of the decision-making team.³³ Informed consent is necessary to initiate treatment plans and procedures except in exigent circumstances.³⁴ It is the responsibility of a clinician to deliver information in an understandable way and avoid both information overload and emotional overwhelm,³⁵ a charge that is in many ways analogous to the need for CLS specialists to deliver information in a developmentally appropriate manner. There is also some evidence that distraction and relaxation exercises can help adults cope with devastating conditions such as burn wounds, although this literature is admittedly underdeveloped.³⁶ Finally, a specialist who can bring themselves to a level of connection with the patient in a nonthreatening manner can often be uniquely suited to assist with goals of care discussions and have input on ethical matters.

This suggests a role for a Program for Adult Life Services, or PALS. Although not named as such, the idea of applying principles of

pediatric care to adults has been recently proposed. Proponents of this idea point out that holistic approaches to patient care, such as music and creative arts therapy, can help reduce cancer pain and argue that a more welcoming, less disruptive hospital experience may better set patients up for recovery and reduce hospital readmission rates.³⁷ They also point out that a program to improve the hospital stays of elderly patients exists in some institutions: this is the Hospital Elder Life Program. This initiative seeks to prevent cognitive decline in adults through techniques such as orientation, use of visual aids, positive reinforcement, and relaxation techniques,³⁸ which mirror techniques used by CLS specialists. This program has led to significant benefits, including reduced delirium, reduced use of restraints, greater communication between staff, better understanding of geriatric care, shorter lengths of stay for hospitalized patients, greatly reduced hospital costs, and increased satisfaction of patients and caretakers.^{39–41} Given the successes in the CLS approach for both pediatric and geriatric patients, it is worth questioning whether this approach should be used for all patients. A natural starting point for such a program may be in a medicine and pediatrics combined program, where these principles can be applied to older adolescents and young adults with active support from the pediatric community. From there, it could be generalized to internal medical services and, hopefully, beyond.

CONCLUSIONS: FROM CLS TO A PROGRAM FOR ADULT LIFE SERVICES

CLS, a relatively recent innovation, has transformed medical care for children by improving communication, alleviating anxiety, and making the hospital more welcoming. Some of the positive aspects of CLS may be spread through increased exposure in medical education. Moreover, this model of patient care may well be suited for all patients, not just children, as evidenced by novel approaches such as the Hospital Elder Life Program. A Program for Adult Life Services may benefit both patients

and clinicians by facilitating more effective communication, less anxiety, and more efficient uses of hospital resources.

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REFERENCES

1. Committee on Hospital Care and Child Life Council. Child life services. *Pediatrics*. 2014;133(5). Available at: www.pediatrics.org/cgi/content/full/133/5/e1471
2. Association of Child Life Professionals. History of the ACLP. 2018. Available at: <https://www.childlife.org/about-aclp/history-of-aclp>. Accessed January 25, 2020
3. Mather PL, Glasrud PH. Child life workers: who are they and what are they doing? *Child Health Care*. 1981; 10(1):11–15
4. Brazelton TB, Thompson RH. Child life. *Pediatrics*. 1988;81(5):725–726
5. Wojtasik SP, White C. The story of child life. In: Thompson R, ed. *The Handbook of Child Life: A Guide for Pediatric Psychosocial Care*. Springfield, IL: Charles C. Thomas Publisher, LTD; 2009: 3–22
6. Plank EN. Drawings help children express their anxieties. *Hosp Top*. 1965; 43(10):93–95
7. The Nobel Prize. Frederick C. Robbins: facts. Available at: <https://www.nobelprize.org/prizes/medicine/1954/robbins/facts/>. Accessed March 22, 2020
8. Wolf J. *What Patient Experience Can Learn from Child Life Professionals*. Nashville, TN: The Beryl Institute; 2018
9. Association of Child Life Professionals. Eligibility requirements effective January 1, 2019. Available at: <https://www.childlife.org/certification/candidates/requirements-after-2019>. Accessed March 15, 2020
10. Rode DC. Building bridges within the culture of pediatric medicine: the interface of art therapy and child life programming. *Art Ther*. 1995;12(2): 104–110
11. Alpers J. Working with children who encounter medical challenges: a multimodal approach. In: Elkis-Abuhoff D, Gaydos M, eds. *Art and Expressive Therapies within the Medical Model: Clinical Applications*. New York, NY: Routledge; 2018: 24–35
12. Courtier J, Cardenas A, Tan C, et al. Nonanesthesia magnetic resonance enterography in young children: feasibility, technique, and performance. *J Pediatr Gastroenterol Nutr*. 2015;60(6): 754–761
13. Durand DJ, Young M, Nagy P, Tekes A, Huisman TA. Mandatory child life consultation and its impact on pediatric MRI workflow in an academic medical center. *J Am Coll Radiol*. 2015;12(6): 594–598
14. Scott MT, Todd KE, Oakley H, et al. Reducing anesthesia and health care cost through utilization of child life specialists in pediatric radiation oncology. *Int J Radiat Oncol Biol Phys*. 2016;96(2):401–405
15. Luehmann NC, Staubach ME, Akay B, et al. Benefits of a family-centered approach to pediatric induction of anesthesia. *J Pediatr Surg*. 2019;54(1): 189–193
16. Tyson ME, Bohl DD, Blickman JG. A randomized controlled trial: child life services in pediatric imaging. *Pediatr Radiol*. 2014;44(11):1426–1432
17. Stevenson MD, Bivins CM, O'Brien K, Gonzalez del Rey JA. Child life intervention during angiocatheter insertion in the pediatric emergency department. *Pediatr Emerg Care*. 2005; 21(11):712–718
18. Schlechter JA, Avik AL, DeMello S. Is there a role for a child life specialist during orthopedic cast room procedures? A prospective-randomized assessment. *J Pediatr Orthop B*. 2017; 26(6):575–579
19. Ortiz GS, O'Connor T, Carey J, et al. Impact of a child life and music therapy procedural support intervention on parental perception of their child's distress during intravenous placement. *Pediatr Emerg Care*. 2019;35(7):498–505
20. Sanchez Cristal N, Staab J, Chatham R, Ryan S, Mcnair B, Grubenhoff JA. Child life reduces distress and pain and improves family satisfaction in the pediatric emergency department. *Clin Pediatr (Phila)*. 2018;57(13):1567–1575
21. Hall JE, Patel DP, Thomas JW, Richards CA, Rogers PE, Pruitt CM. Certified child life specialists lessen emotional distress of children undergoing laceration repair in the emergency department. *Pediatr Emerg Care*. 2018;34(9):603–606
22. Martin HA. The power of Lidocaine, Epinephrine, and Tetracaine (LET) and a child life specialist when suturing lacerations in children. *J Emerg Nurs*. 2017;43(2):169–170
23. Hsiao HJ, Chen SH, Jaing TH, et al. Psychosocial interventions for reduction of distress in children with leukemia during bone marrow aspiration and lumbar puncture. *Pediatr Neonatol*. 2019;60(3):278–284
24. Brewer S, Gleditsch SL, Syblik D, Tietjens ME, Vacik HW. Pediatric anxiety: child life intervention in day surgery. *J Pediatr Nurs*. 2006;21(1):13–22
25. Sorensen HL, Card CA, Malley MT, Strzelecki JM. Using a collaborative child life approach for continuous surgical preparation. *AORN J*. 2009;90(4): 557–566
26. Hyland EJ, D'Cruz R, Harvey JG, Moir J, Parkinson C, Holland AJA. An assessment of early Child Life Therapy pain and anxiety management: a prospective randomised controlled trial. *Burns*. 2015; 41(8):1642–1652
27. Basak RB, Momaya R, Guo J, Rath P. Role of child life specialists in pediatric palliative care. *J Pain Symptom Manage*. 2019;58(4):735–737
28. Bottino CJ, Daniels A, Chung M, Dumais C. Child life specialists' experiences addressing social determinants of

- health: a web-based survey. *Clin Pediatr (Phila)*. 2019;58(8):851–856
29. Drayton NA, Waddups S, Walker T. Exploring distraction and the impact of a child life specialist: perceptions from nurses in a pediatric setting. *J Spec Pediatr Nurs*. 2019;24(2):e12242
 30. Legett SM. In praise of child life. *J Palliat Med*. 2014;17(11):1284
 31. Wright J. Sweet success: lessons from a child life specialist. *Nursing*. 2014;44(2):30
 32. Bandstra NF, Skinner L, Leblanc C, et al. The role of child life in pediatric pain management: a survey of child life specialists. *J Pain*. 2008;9(4):320–329
 33. Roter DL, Stashefsky-Margalit R, Rudd R. Current perspectives on patient education in the US. *Patient Educ Couns*. 2001;44(1):79–86
 34. Bernat JL. Informed consent. *Muscle Nerve*. 2001;24(5):614–621
 35. Bester J, Cole CM, Kodish E. The limits of informed consent for an overwhelmed patient: clinicians' role in protecting patients and preventing overwhelm. *AMA J Ethics*. 2016;18(9):869–886
 36. de Jong AE, Gamel C. Use of a simple relaxation technique in burn care: literature review. *J Adv Nurs*. 2006;54(6):710–721
 37. O'Brien MR, Rosenthal MS, Dharmarajan K, Krumholz HM. Balloon animals, guitars, and fewer blood draws: applying strategies from pediatrics to the treatment of hospitalized adults. *Ann Intern Med*. 2015;162(10):726–727
 38. Inouye SK, Bogardus ST Jr, Baker DI, Leo-Summers L, Cooney LM Jr. The Hospital Elder Life Program: a model of care to prevent cognitive and functional decline in older hospitalized patients. Hospital elder life program *J Am Geriatr Soc*. 2000;48(12):1697–1706
 39. Bradley EH, Webster TR, Baker D, Schlesinger M, Inouye SK. After adoption: sustaining the innovation. A case study of disseminating the hospital elder life program. *J Am Geriatr Soc*. 2005;53(9):1455–1461
 40. Chen CC, Li HC, Liang JT, et al. Effect of a modified hospital elder life program on delirium and length of hospital stay in patients undergoing abdominal surgery: a cluster randomized clinical trial. *JAMA Surg*. 2017;152(9):827–834
 41. Rubin FH, Neal K, Fenlon K, Hassan S, Inouye SK. Sustainability and scalability of the hospital elder life program at a community hospital. *J Am Geriatr Soc*. 2011;59(2):359–365