When Emma Plank first envisioned child life, she saw a need for a person with knowledge of child development to be present through hospital procedures. Although this was over forty years ago, the focus still remains the same. Plank states in her book *Working with Children in Hospitals* that, “The growing child cannot afford to interrupt the cycle of his living and growth” (1). A child with a chronic illness spends many days in the hospital while he/she should be developing socially, cognitively, and emotionally. Likewise, in today’s society, the same emphasis is placed on encouraging development for children in the hospital. When educated today, child life specialists learn about play as a tool for providing normalcy in a child’s life. Moreover, medical play is used to help children become aware of materials or objects that they may find strange and frightening. Most importantly, perhaps, this play also encourages the children’s continued development. Moore and Russ conclude that “The play context reveals developmental organization” (238). Both Plank’s 1965 work and current literature agree that play can reveal the true feelings of a child. Play is a child’s tool of expression. Clearly, the primary basis has remained the same from 1965 to present times; child life provides developmental growth through play while children are in the hospital.

Upon entering the hospital, children are in a new frightening place and are usually forced to separate from their parents. Because the development of children is a crucial aspect that child life specialists must look at, they know that bonds between children and parents are of the utmost importance. Fears that children experience often mirror their parents’ own anxieties in a medical setting. Plank describes the situation in which parents become nervous
and unsure of how to prepare children to enter the hospital. She makes note that parents can prepare children by driving by the hospital ahead of time and talking to the child about how he/she is going to the hospital to make him/her feel better. Also, mothers should explain the differences in the sleeping and eating patterns that the child will experience. However, while the mother may talk to her child about going into the hospital as a positive notion, she may have her own fears: “A mother often finds this preparation hard, and she makes up a glowing picture of how nice things are going to be” (4). Perhaps a mother’s own experiences have left her fearful.

More recent literature has explained the effects of the relationships between parents and children on children’s hospitalization experiences. Turner’s (2005) article on a study including parent-child relationships and attachment also mentions that hospitalization is a time of anxiety. According to Turner, “Research results indicate the potential for the hospitalization of young children to be a stressful experience due to the child’s age, separation from his/her parent, the discontinuity of caregiving provided in the hospital and the frightening and unfamiliar nature of hospital procedures” (p. 195). The quality of the parent-child relationship has been observed to affect the child’s coping mechanism with hospitalization. Bowlby’s theories of attachment were included to describe the benefits to a child of a secure attachment to a parent. Children with resistant or avoidant relationships may be hesitant to listen to parents’ efforts to prepare them for a medical procedure. By looking at Plank’s theory of using a mother to help a child prepare for hospitalization, Turner clarifies that there must be a bond of trust and nurture in order for the preparation to be successful.
However, it is important to keep in mind that when Plank’s work was published, the mother was most often the caregiver responsible for all of the child’s care. When preparing the child for coming to the hospital, it was emphasized that the mother was the one to get the child ready. In addition, Plank refers to situations when only the mother is asked to be involved. For example, when celebrating birthdays, “There is a fine opportunity with joint planning with the child’s mother” (46). In 1965, it seems as though the rest of the family was not taken into consideration when looking at the child’s needs. On the contrary, today’s practices of child life involve the entire family unit. The Child Life Council acknowledges members of a child’s support system and how they may be affected. The Council states, “Child life specialists can...facilitate a variety of support groups for patients and their siblings” (1760). Clearly, child life has changed from the focus solely being on the child and mother to a support system for the patient as well as his/her family.

One major difference that I have observed between past and present day child life practice is the concept of death with children. Plank appeals to the reader’s logic when she states her views of children being aware of death: “To the kindly adult, concerned to protect children from worries about themselves, particularly while they are in the hospital, it would seem most important to cover up everything which might frighten them” (32). Clearly, in the past it was a common belief that children should be unaware of the reality of the situation if it would cause them stress. Plank described that when death occurred on a children’s ward it would be lied about. Children obviously knew when a child was no longer in a room, and they could sense the anxieties of adults. In this situation the children with the same disease would be told that they had a different condition than the child who passed away. It would never be
conveyed that a peer with the same medical problems as them had passed away. Noticeably, the concept that death may occur was avoided. Plank adds, “When a young child who may conceivably die during hospitalization brings up the question of the possibility of his own death, we reassure him with great conviction and help the child in his attempts to deny the possibility” (35). Perhaps the reason why death was never addressed was because adults never wanted to deal with the subject.

On the other hand, today, when children are faced with terminal chronic illnesses, the reality of the illness is not kept secret. In fact, it can now be a role of a child life specialist to help children understand and cope with death. Burghen, Haluska, Steen, and Hinds (2004) completed research in deciding whether children should take part in end of life care. Several factors were mentioned in order to determine whether this would be appropriate, including the necessary consent from parents, the developmental age of the child, and also the emotional state of the child. Burghen et. al., concluded that “We recommend that, whenever possible, end-of-life decision making about research and innovative care options be initiated when the child or adolescent is able to participate” (176). In contrast to the ideas of Emma Plank’s time, child life specialists can see the importance of helping children make decisions involving their death. Older children may be allowed to decide about end of life care and where they want to have it, whether they want to continue specific treatments, and they have the opportunity to say goodbye to significant people in their lives. Even though this may be more emotionally difficult than lying about the medical state of patients, morally, it is giving them the facts and providing the services so that they are able to cope with death.
As years have passed, knowledge about health care environments has grown. More research and technology have left hospital workers more aware of sanitation issues and the spread of disease. The Child Life Council kept this idea in mind as they defined their goals for specialists working in hospitals. They included the goal of “[Providing] play opportunities and other experiences which foster continued growth and development and prevent adverse reactions to health care encounters.” While being in the hospital, child life specialists need to ensure that nothing they do could further impair a child’s health condition. Many of the practices that Emma Plank explains in Working with Children in Hospitals would not be acceptable today. In an information guide for parents whose children are entering the hospital, parents are asked to inform their children that they will be living in a ward with a group of other children. Present day infection controls would never allow for that many children to be in constant proximity to other children who could make them sicker. Likewise, Plank describes play materials that are used to help children cope with anxieties. She stresses that “Sawdust in a wooden box makes an excellent platform for maneuvering small animals, vehicles, and people. These toys transform sawdust into a medium for dramatic play” (42). Without a doubt, sawdust is a material that would never be allowed in hospitals today. Once again, referring to the Child Life Council, “Child life professionals have a responsibility to maintain a current understanding of research findings and participate in research that examines our practices.” Basically, as health regulations have become stricter over time, child life specialist have had to adapt.

In conclusion, as the years have passed since Emma Plank envisioned child life, more human development experts have been examining the same practices. While the goal of
providing normalcy and reducing stress through medical procedures has remained the same, more research has been placed on the psychological needs of the patients’ entire life. As outdated as some of Emma Plank’s work may seem now, without them the field would never have developed as it did. Our current understanding of child life will only continue to grow, and advances in research will add more credibility to the field of child life.

References:


