DEFINING YOUR THEORETICAL ORIENTATION

By: Kathryn Cantrell, PhD, CCLS & Ashley Blondino
Texas Woman's University

Child life specialists use developmental, psychological, and family systems theories to inform their work. A solid theoretical foundation can help child life specialists regularly draw from theories at all stages of the clinical cycle. A theoretical orientation is a tool that organizes a specialist's thinking and decision-making and allows them to predict how children and families might grow, learn, and cope with challenges.

At its core, it is a set of theories (think Piaget's cognitive developmental theory or Bowen's family systems theory) or theoretical concepts (think temperament or coping) that a child life specialist knows so well, they can easily recall and use them in their daily practice, like a toolbox to enhance their work. Every child life specialist's theoretical orientation will be unique to their clinical style, their setting, and the needs of their patients and families. In this way, a theoretical orientation is a collaboration, shaped by the children and families a specialist supports. In this article, we hope to help you define your own, unique theoretical orientation.

How to Assess a Theory's Usefulness

It is important to evaluate theories when applying them to make sure they are helpful and not harmful. We find Redmond (2015) helpful for evaluating theories. Redmond (2015) outlines central traits to consider when assessing theories: Precision and clarity, comprehensiveness, testability, usefulness, importance, simplicity, fruitfulness, contextual/culturally relevance, plausibility/believability, and language dynamic.

These traits can be found in Table 1 where they are each described. Depending on where a specialist is working and the population they are supporting, some of these traits might be more relevant than others.

For instance, a specialist working in a fast-paced setting like the ER will likely appreciate theories that are easy to remember and quick to implement. These would be theories that are straightforward and effective in their language. On the contrary, a specialist serving historically underserved communities might gravitate towards theories that are culturally and contextually relevant. It can be helpful to start by looking closely at your setting and population. What stressors do your families encounter? What aspect of development are you most concerned about? More questions are outlined in Table 1.

Table 1 on pg. 25

Table 1
Redmond's (2015) Features to Assess Theory

Theory Features	Description	Key Question
Precision and Clarity	The theory's ability to describe a lived experience with specificity.	Does the theory clearly explain a lived experience in a way that aligns with my clinical observations? In a way that aligns with patients' stories?
Comprehensiveness	The theory's ability to consider an entire domain of development.	Does this theory consider all of development? Or fully consider an aspect of development that is central to my setting and population?
Testability	The ease at which the theory's concepts can be measured empirically.	Can features of this theory be tested or assessed using research methods? How could I measure improvement?
Usefulness	The theory's practicality in a specific setting and its ability to support the clinical cycle.	Does this theory help me make clinical decisions about interventions and evaluations? Does this theory help me develop assessment questions?
Importance	The theory's value to the community where it is being used.	Does this theory consider aspects of the lived experience that are important to the patients and families I work with? Is the theory well discussed in the community or setting?
Simplicity/Parsimony	The ease at which the theory's concepts can be easily understood and remembered.	Is the theory easy to remember? Is it easy to teach to patients and families? Or medical teams?
Fruitfulness	The theory's ability to inspire additional work.	Has the theory led to contemporary ideas and sub-theories? Are these new ideas relevant to my work?
Contextual/Culturally Relevant	The theory's ability to consider the patient and family's surroundings.	Does the theory consider a patient and family's context and culture?
Plausible/Believable	The ease at which the theory aligns with the user's own observations.	Do I believe in this theory? Does it align with my lived experience?
Language Dynamic	The ease of the theory's jargon.	Does the theory's jargon help me remember and use the theory? Or does it make it less accessible?

Putting Together Your Theoretical Orientation

Theory guides every stage of the child life process: from assessment to planning, intervention, evaluation, and re-assessment. In some cases, a specialist might use one theory throughout all these stages. For example, a specialist might use Brofenbrenner's (1979) ecological theory to understand how a family copes and then use the same theory to guide their interventions and evaluations. However, this may not always be the case. Sometimes the theories that help a specialist assess a family might not be the best fit for preparing interventions. Too, the orientation might integrate concepts from several theories or just a couple, depending on the environment.

There is no perfect number of theories to use; rather, what works best for the families is the most ideal combination. Each child life position is unique, and the theories that work for one setting might not work for another. During assessment, a theoretical orientation could help a specialist choose the right questions for family interviews or identify which behaviors to concentrate on when observing play. When curating an intervention, a theoretical orientation might guide the goals and objectives of the programming. For evaluation, it could direct the kinds of questions asked to see if the intervention met its goals.

Our community relies on traditional developmental theories like Piaget's cognitive development theory (1936) or Erikson's psychosocial development theory (1950) (Brown, 2014; Turner 2018). Although these theories are clear and significant, they frequently neglect the impact of culture and context (Koller & Wheelwright, 2020). Many of the classic theories were developed by studying White children from upper-middle-class backgrounds. While the theories have been thoroughly tested, they may not accurately represent the diverse experiences of all families. Depending on your specific role and the population you support, different theories might be better suited to meet your clinical needs.

Your theoretical orientation will change depending on what helps you understand the children and families you serve. As such, it is

Figure 1

Example 1: When working with youth and young adults with HIV in an outpatient clinic, my theoretical orientation reflected the interventions I used most often. I regularly provided diagnostic education related to HIV and antiretroviral medication. Too, I provided emotional support to young adults integrating their HIV diagnosis into other elements of their identities. Lastly, I worked closely with families who shared an HIV diagnosis and worked with them to consider ways the entire family could support positive health behaviors. When doing this work, I relied on cognitive theory (Piaget) to inform my education choices, intersectionality (Crenshaw) and identity theory (Erikson, Arnett) to inform my work with young adults, and family systems theory to inform my work with entire family units (Bowen).

Example 2: When working with adolescents in a community setting providing in-home child life services, my theoretical orientation reflected the setting where I conducted my work. Being invited into someone's home allows for observations of a family's close bonds (Bowlby), how the system functions together (Bowen), and how they cope as a unit (Lazarus & Folkman). Too, I would learn about the family's immediate neighborhood and surrounding community (Sociology of Childhood) and interact with other systems like the patient's school or church (Bronfenbrenner).

Example 3: When working with children and adolescents receiving radiation therapy, my theoretical orientation reflected the learning and coping needs of my patients. When conducting simulations, I would consider the best language choices for teaching (Piaget), how repetition supports desensitization (Pavlov), what rewards might motivate my patient (Bandura, Skinner), and how best to intervene with my patient's secondary appraisal of stress (Lazarus & Folkman). I was also curious about my patient's primary attachment figure (Bowlby) and how they could support the patient through the experience.

helpful to remain knowledgeable of traditional developmental theories while also learning about contemporary theories that might be more contextually relevant. Reading updated editions of our seminal texts (Hollon et al., 2018; Turner et al., 2018; Pearson, 2017) and noticing the theories other specialists are citing in the Journal of Child Life are two ways to remain current in your theoretical knowledge.

Over time, as you support different families and face new challenges, the theories you depend on will likely evolve too. Some theories that you have depended on may fade out of relevance as children and families continue to cope with global warming, gun violence, and lack of access to affordable housing and food. Table 2 provides questions to help you tweak your theoretical approach for your specific setting as you grow into your role.

It is important to remember that your theoretical orientation is an adaptable concept that grows with you and your role. It should support your work, not restrict it. On days when your orientation feels like it might be falling short of your community's needs, consider revisiting Redmond's (2015) ideas for recommendations. To learn more about evaluating theories, we recommend reading Redmond's article here: https://dr.lib.iastate.edu/entities/publication/6159f22b-c094-49eb-9b97-94b45cc8d1e0.

Table 2
Questions for Theoretical Approach Consideration

1. What are common stressors in this population or setting?	These variables may lead to specific theories that can help with a specialist's assessment process. For example, if working with a population where medication adherence is a common concern, behavioral theories may help the child life specialist assess areas to intervene.
2. What is the developmental scope of this setting or population?	Working in the NICU, the theories specific to socialization and learning may be less helpful. Instead, it might be more beneficial to consider theories centered on relationships and systems like attachment and family systems.
3. What domain of development is most often assessed?	Depending on the nature of the setting and population, the child life specialist may focus on specific domains more than others. For example, a specialist working in a procedure setting might focus their assessments on a child's previous coping history and cognitive development instead of asking questions about their early attachment style or friendships.
4. What is the pace of this setting?	The pace of the setting can also determine the theories that are most appropriate for a theoretical orientation. Working in an environment that moves quickly, it may be most helpful to rely on theories that are parsimonious and easily recalled like stage theories.
5. What regional or future stressors might impact this population?	Some specialists may find that their theoretical orientation changes based on their setting's geography, regional politics, or local events. For example, when a community is coping with gun violence, a specialist may notice that their orientation shifts.

References:

Brown, T. (2014). Schools of thought: The influence of theory. In J. Turner & C. Brown (Eds.), T*he pips of child life: Early play programs in hospitals* (pp. 1–11). Kendall Hunt.

Cantrell, K., Harmeyer, E., & Wittenberg Camp, B. (2024). Applying theory in child life assessment. In K. Cantrell, C. Sisk, & B. Wittenberg's (Eds) *Child Life Assessment.* Cambridge Scholars Publishing: Tyne, United Kingdom.

Hollon, E., Clark, E., LeBlanc, C., & Skinner, L. (2018). Assessment and documentation in child life. In R. H. Thompson (Ed.), *The Handbook of Child Life: A Guide for Pediatric Psychosocial Care* (2nd ed.) (pp. 3-33). Charles C Thomas Pub Ltd.

Koller, D., & Wheelwright, D. (2020). Disrupting the status quo: A new theoretical vision for the child life profession. *The Journal of Child Life: Psychosocial Theory and Practice, 1*(2), 27-32.

Pearson, L. J. (2017). Children's hospitalization and other health care encounters. In J.A. Rollins, R. Bolig, & C.C. Mahan (Eds.), *Meeting Children's Psychosocial Needs Across the Healthcare Continuum* (2nd ed., pp. 1–42). PRO-ED.

Redmond, M. V. (2015). *Theory development and evaluation.* Iowa State University Digital Repository.

Turner, J.C. (2018). Theoretical foundations of child life practice. In R.H. Thompson (Ed.), *The Handbook of Child Life: A Guide for Pediatric Psychosocial Care* (2nd ed., pp. 34-54). Charles C Thomas Pub Ltd.