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# Clinical social work and the medical model : use of art and play therapy interventions

Corye Elizebeth Goodman

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Corye Goodman  
Clinical Social Work and the  
Medical Model: The Use of  
Art and Play Therapy  
Interventions

## ABSTRACT

This study aims to determine the self-identified role of clinicians working within the medical model. Secondly, the study intends to determine if art and play therapy interventions were regularly implemented by clinical social workers practicing with hospitalized children within a pediatric medical facility. The study hopes to gauge both the clinicians' understanding of possible barriers to these interventions within the medical model, and also the clinicians' beliefs about the importance of play within pediatric hospital settings as a determining factor to patients' psychological needs during their illnesses.

A mixed-methods online survey was sent to over 300 medical social workers within the United States. All 137 participating clinicians held at least an MSW and worked within a pediatric medical facility. Clinicians were asked to self-identify their primary time commitments within their current setting, their primary theoretical orientation, and their beliefs on the benefits of play, any barriers they felt existed within their current medical setting, and any examples of play techniques they utilize within the medical model.

The conclusion of the study indicates that art and play therapy interventions are not commonly utilized within pediatric medical settings due to structural barriers such as time constraints, a lack of space or appropriate materials, and the lack of exiting policies that refer patients to child life specialists or volunteers for such interventions. Further,

this study's results indicate that most medical social workers find that their primary role is to conduct psychosocial assessments, conduct patient and family counseling and psycho-education around illness and hospitalization, plan patient discharge, and serve as a case manager, which includes resource referrals for patients and families.

CLINICAL SOCIAL WORK AND THE MEDICAL MODEL: THE USE OF ART AND  
PLAY THERAPY INTERVENTIONS

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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## CHAPTER I

### INTRODUCTION

This study examines the role of the clinical social worker within a pediatric hospital setting. The study emphasizes the importance of art and play therapy psychological interventions with children who are living within a medical care facility. The study explores the intervention methods most commonly used by hospital social workers, with special analysis given to the clinical social worker's ability to practice play and/or art therapy intervention techniques within the medical model. The research touches on the empirical data surrounding the emotional needs and psychosocial symptoms of physically ill children within a hospital setting. Common feelings and fears for these children can include a sadness surrounding their illnesses, the fear of death and of being alone, and the struggle to conceptualize the physical symptoms and outcomes of their illnesses. Psychosocial needs include the need for play and creative expression, the desire for caretaker closeness, the need for participation in care and treatment, the importance and need for good relationships with the medical team, the need for physical and emotional mastery, and the need to socialize and communicate with others, especially primary caretakers, regarding their illnesses (Bjork, Hallstrom, & Nordstrom, 2006).

Prior to data analysis this study predicted that due to the limitations within the current medical model and additional demands of the medical social worker, play and art therapy interventions would not be commonly utilized with ill children living in the



hospital. The study identifies the ideologies and realities of the current medical model that prevent the common teaching and practicing of art and play therapy. It also determines the changes that are necessary in order to incorporate more effective psychological interventions into the existing medical model.

According to Nora Mindell, there is a pressing concern and need in pediatric medical units around the world to improve the quality of psychological care for children suffering from life threatening illnesses (Mindell, 1998). In the United States, it was estimated by the National Cancer Institute (2001) that cancer would be detected in 8600 children under the age of fifteen. In 2000, the number of children with cancer in the United States was calculated at 67 million, making the incident of cancer 156 cases out of every 100,000 children (Fochtman, 2006). These figures are continuing to grow. While the incident rate of childhood cancer is increasing, as well as the incident rates of pediatric genetic blood disorders and pediatric brain tumors, so is the survival rate of childhood cancers and other pediatric illnesses. With the advancement of available medical treatments, more children are surviving their illnesses and recovering to lead healthy lives with normal life expectancies. In 2000, the average survival rate for all types of childhood cancers was 78 percent. Today, the survival rate for Acute Lymphocytic Leukemia in children fifteen years old or younger is 85 percent, unlike twenty years ago when the survival rate was only 56 percent (Fochtman, 2006). Although survival rates have increased, little changes have been made in psychological interventions within the hospital setting by pediatric oncology social workers (Jones, 2006).

Traditionally, the hospital social worker takes on numerous roles within the medical model. It is common for the role of the social worker to shift depending on the medical facility. Their role could differ in community-based teaching hospitals, non-profit medical facilities, university-affiliated hospitals, and county hospitals, as each setting takes on its own culture and model of practice. The interpretation of the social worker's role also fluctuates depending on the type of medical setting and available financial funding within each institution. Camille Gregorian's (2005) research exploring the multifaceted role of the medical social work found that there are numerous roles one can hold and within a multitude of medical settings. There are many hospitals in which the social worker holds the responsibility of discharge planning, including collaboration with community mental health agencies, as well as assisting patients and families with community resources while on inpatient units and thereafter hospitalization. Yet, in other medical facilities, discharge planning is assigned to the hospital's nursing staff and clinical care coordinators, and the social work departments are primarily focused on the psychosocial concerns and needs of the patients and families.

Today, many medical institutions include social workers as part of the medical team and interpret the social workers to be the primary provider of emotional support to patients and families. It is also evident in most medical facilities that social workers regularly hold multiple roles with various responsibilities, including but not limited to: patient and family counseling, community referrals, discharge planning, interdisciplinary team consultation, collaboration and treatment planning, psychosocial assessments, child-abuse assessments, grief counseling, crisis intervention, medical team meetings and seminars, new diagnosis meetings, and multi-purpose family conferences (Gregorian,

2005). These roles can vary depending on the medical setting, available funding and primary patient unit within the hospital. Medical social workers partake in various responsibilities and make multiple contributions to the medical model, which helps social work departments around the country maintain importance and necessity within the hospital setting. However, the various roles also can create confusion and differing opinions on the skill set of the medical social worker. The more misinterpreted this role, the less likely social workers will be able to best and most effectively serve their patients and families within the hospital.

It is imperative that social work departments within hospital settings remain valuable to the medical model within their respected institutions. As a result of the financial demands on many hospital facilities, social service departments are often the first to downsize and receive cost cuts (Cowles, 2000). In order for social work services and practices to be most effectively used, the medical model should incorporate the skills and immeasurable importance of the hospital social worker, ensuring that patients receive the necessary referrals from the medical team and appropriate time for psychological care. As seen in Mizrahi and Abramson's (2000) study on the perceived role of the social worker from a physician's standpoint, *Collaboration Between Social Workers and Physicians: Perspectives on a Shared Case*, researchers suggested that most physicians were "...less likely to perceive patient problems related to the hospital environment or accessing community resources...many physicians have only a limited grasp of the complexities of social work intervention in these arenas" (p.18). Further, most physicians did not interpret the clinical social worker as proficient in delivering psychological counseling services for patients and families.

Without an appropriate understanding of the competencies and responsibilities of the social worker within the medical model, physicians will not regularly refer patients to social work departments or even recognize the psychosocial affects of hospitalization on the patient or family members. The outcome of this misinterpretation only limits patient care and reduces the psychosocial services received by patients and families within the hospital setting. It also devalues the role of social work departments within the medical models.

In medical settings where social workers are regarded as adept in practicing therapeutic interventions, the struggles of pediatric medical care still transpire. Medical treatments for childhood cancers, genetic blood disorders, and brain tumors occurring most often in children are arduous and often cause dire physical and emotional pain. Psychological interventions become extremely important in decreasing distress and long term affects of hospitalization. Social work interventions with children can help increase communication with the ill child, her family, and the medical team. Clinical social workers can assist in aiding more fluid communication between the child's emotional and physical needs and the medical team's treatment plan.

Clinical social work interventions within the hospital have the ability to decrease long term psychological affects of surviving cancer, as well as decrease anxiety and depression for children currently living with an illness. As noted by Zebrack, Walsh, Burg, Maramaldi, and Lim (2008) in their study, *Oncology Social Worker Competencies and Implications for Education and Training*, "...oncology social workers are the primary providers of psychosocial services in major oncology treatment centers and community health care settings throughout the world" (p. 354). Oncology social workers

are often the only member of the medical team with knowledge surrounding cancer and the psychosocial impact of such chronic or life-threatening illnesses. Clinical social workers also maintain a range of practice versatility, making hospital interventions fundamentally important for children experiencing life-threatening illnesses or physically ill children living within a hospital, especially with the increase in survival and recovery rates.

Controlled studies on the efficacy of psychological interventions in the prevention and treatment of psychological disturbance in chronically ill youth are scarce, especially in children under the age of ten with limited verbal skills (Garipey & Howe, 2003). Cindy Davis' study regarding the current research on hospital social workers found that from 1991-2001 only 44 peer reviewed journal articles were identified for inclusion of research assessing the effectiveness of hospital social workers implementing psychological interventions (Davis, 2004). The research does show, however, that the psychological implications of living with a life-threatening illness within a hospital setting can be vast and long lasting. As noted by Sheilds, et al (1995) the impact of childhood cancer can be described as "a series of chronic, uncontrollable, and stressful life events that have long-term impact on survivors and their family members" (p. 41). Hospital social workers can design appropriate and effective interventions in order to help prevent or at least ameliorate, as much as possible, the emotional suffering of these children in the hospital setting and in their future lives outside of the hospital.

Several medical settings lack psychosocial components when treating chronic pediatric illnesses. Limitations within the medical model can include funding, and shifting social service roles within the hospital setting, as well as time constraints and a

misunderstanding of the skills of the hospital social worker (Cowles, 2000). Hospital social workers face the stressful challenge of constantly working with numerous organizational restructurings and the demands of working within a multi-disciplinary medical team of doctors and nurses and various other medical staff. There can often be emphasis on discharge planning, length of hospital stay, and pressures to maintain a certain amount of available beds as requested by many medical insurance groups. These case management roles are important, however, and can thwart a clinician's ability to meet a patient's psychosocial needs (Davis, 2004). These structural constraints in social work practice can create medical institutions where the psychological ramifications of treatment are not prioritized during social workers interventions (Crom, Chathaway, Tolley, Mulhern, & Hudson, 1999). However, pediatric social workers within a hospital setting have an important responsibility to help meet the psychosocial needs of the children. In many hospital settings today, trained clinical social workers are often the only member of the patient's medical team able to communicate patients' implicit psychosocial needs and psychological coping with illness and hospitalization through age appropriate intervention techniques.

Empirical evidence does exist regarding the importance of play for children in their ability to cope with distress; theoretical evidence shows that children's play serves the child in alleviating anxiety and increasing adjustment (Garipey & Howe, 2003). There is a clear importance for play with children as a means of communication into the child's inner psyche, as a method for the child to process her fears and anxiety. Play also acts as a coping tool during stressful situations and events in which the child feels a loss of control. In 1971, Smitansky defined dramatic play therapy as "...including imitative role

play, make-believe in regard to objects, make-believe in regard to action and situation, and persistence [for at least ten minutes]” (Curry, 1988, p. 142). Play is a critical social work intervention and an applicable communicative tool in working with children; however, use of this type of play may be incorporated differently within an inpatient hospital setting due to physical and emotional restrictions and the current medical model.

In a hospital setting, the themes will be unique to other life circumstances, corollary the implications and meaning behind themes in play will differ with hospitalized children than with healthy children. A more comprehensive understanding of the role of the hospital social worker, the medical social workers use of play and art therapy interventions, and the ability to utilize these modalities within the medical model has relevance for social work practice, theory, education and preparation for pediatric social workers. An improved understanding of the role and responsibilities of the medical social worker will elicit enhanced psychological interventions within the medical model for future medical practice.

The research purpose for this study aims discover the current roles of pediatric hospital social workers and ability of the hospital social worker to implement play and art therapy interventions within the current medical model.

## CHAPTER II

### LITERATURE REVIEW

#### *Development and Play for Children*

Winnicott saw play as central to the therapeutic experience, believing that children's play was the means whereby children manage the transition between their inner and outer reality (Wikstrom, 2005). Most theoreticians agree that play in infancy is fundamentally sensorimotor, beginning with play with one's own body and caretakers' body. The infant's exploration of body soon transfers to that of objects and the infant's surrounding environment. During the first year of life, children with healthy development usually begin pretend gestures with external objects and their surrounding environment (Curry, 1998). Between eighteen to twenty-four months of age it is common for children to begin the transition from solely sensorimotor play skills to the capacity to use symbolism through play, with objects and surrounding environment and the use of language (Curry, 1998).

As noted by Davies (2004), "during preschool period the ability to play imaginatively is a major adaptive mechanism for the mastery of stress, as well as the primary pathway for exploration that facilitates learning and socioemotional development" (p. 321). Preschool years mark a time characterized by make-believe or fantasy play, while school aged children's use of play usually involves formal games such as board games and puzzles, as well as more reality based games and inclusion of peer relationships (Curry, 1988).



During the beginning stages of emotional development and the building of coping mechanisms, play acts as a multipurpose tool for children. Play allows children to process frustrations, confusions, and difficulties. This is largely due to children's lack of sophisticated defenses, such as repression, rationalization, and denial in fantasy (Davies, 2004). Preschool is also a time when secure attachments are an important part of the development of one's sense of the self as autonomous, self-reliant, and purposeful.

The preschooler can therefore use play as a way to "think" about her experiences, consider alternative ways of viewing her circumstances, and exploring new methods of acting out those circumstances (Oremland, 1988). In cognitive development, a preschooler's symbolic play can allow the child to practice and understand cause-and-effect thinking, it can increase the child's ability to construct narratives, and help the child gain a broader perspective of environmental situations (Webb, 1995). Play can function as a protective factor for young children, helping them learn to organize their experiences with more clarity than their limited verbal dialogue allows (Davies, 2004).

#### *History of Medical Social Work in the United States*

By the early 1900's medical practice began to shift from primarily home visits by physicians and medical practitioners, to the hospital setting as the primary site for patient care, diagnosis, and treatment (Cowles, 2000). As medical care relocated from patient's homes to the hospital, the role of the physician also began to shift. The physicians were no longer able to observe patients in the context of their living environment and social conditions. As the transition continued and the hospital setting became commonplace for medical practice, it became particularly evident that patients were emotionally affected by their illnesses, especially as patients were uprooted from their home setting and forced

to live within the hospital (Beder, 2006). Yet, physicians and nurses were not aware of the effects of the patient's social and psychological states in relation to chronic illness and medical recovery, nor did they have the proper training to interpret these effects on the patient's illnesses.

Richard C. Cabot, a physician at Massachusetts General Hospital was the first medical practitioner to introduce social workers into the hospital setting. He originally appointed Garnet Pelton, a nurse at the hospital, to fill the first position (Cowles, 2000). Ida Cannon, a registered nurse with university level education in psychology and sociology, quickly replaced Pelton as the lead social worker in the hospital. Cannon innovated the role of the hospital social worker and while helping to create the first medical social services department, became one of the leading pioneers in the field. Cannon, along with Ethel Cohen, helped to shape the role of the medical social worker as it is seen today (Praglin, 2007).

In 1905, Cannon began a small social service clinic in the back corner of the Out-Patient Department at Massachusetts General. It consisted of a small area of the hospital and was not recognized by the director or trustees of the hospital until nine years later. By 1914, Cannon and Cabot created the first official hospital Social Services Department at Massachusetts General Hospital. It was not until 1919, that the department became fully financed and recognized as an authorized department within the hospital (Praglin, 2007). Physicians were notoriously rigid in their beliefs about the role of the social worker. Physician's forbade social workers to enter inpatient units and would only allow patients referred by physicians to visit with social work staff. The medical model originally interpreted the social work department as solely a facilitator of communication

between the medical teams and the patients. Social workers were primarily needed to assist patients and families with additional resources and services beyond the hospital within the community (Cowles, 2000). Even Cabot, the leading physician for the cause, remarked that the role of the social worker was to educate the medical team on “social and psychological aspects of disease” (Cowles, 2000, p. 4). Although these practices still adhere to hospitals today, psychological interventions were originally excluded from medical social worker’s scope of practice.

While resistance and hierarchical politics between the medical professionals and social workers continued throughout Cannon’s career, Cannon worked with Cabot and developed a medical social work model that reflected the Progressive Era of the time. Cannon’s program addressed the major public health concerns of that time period, including tuberculosis, venereal disease, teenage pregnancy and immigration issues. Cannon was one of the first social workers to address the medical fields and medical professionals lack of cultural competency (Gregorian, 2005).

As noted by Praglin (2007) in her research on the cultural competence of early social work, the Progressive Era began the evolution of more moderate ideologies surrounding poverty. One’s socioeconomic status was less looked upon as immoral or due to personal failure, rather, embedded in “social and economic conditions, especially illness” (Praglin, 2007, p. 28). Hence, Cannon assessed the influence of patients and families living conditions at home, interpersonal relationships, and occupational issues on their illnesses, and then focused on the collaboration of the interdisciplinary team of social workers, physicians and nurses.

In addition to case management and interdisciplinary team collaboration, Cannon hoped medical social work would be involved in direct clinical practice with patients and families. Cannon worked to make the social work role a professional position within the hospital setting and attempted to set it apart from volunteerism through her direct clinical work. Cannon began teaching social work students, along with medical and nursing students at Massachusetts General and Boston School for Social Work. She created training programs, and full curriculums on hospital social work, as well as established professional standards. Other social service departments in hospital settings around the country and abroad soon adopted these practices.

In 1918, a group of medical social workers created the American Association of Hospital Social Workers (AAHSW). From 1919 to 1933, the AAHSW published the *Hospital Social Service Journal* (Cowles, 2000). Around the 1950's other social work specialty groups began to emerge and AAHSW collaborated with the American Association of Social Workers (AASW) to become the National Association of Social Workers (NASW) the association still stands today (Cowles, 2000). By 1924, there were 420 social service departments in United States hospitals (Rappaport, 1996).

The importance for professionalizing medical social work came around the early nineteen twenties. The need for academia and professional standards was a reaction to the introduction of Freudian psychoanalytic concepts and the extensive psychiatric and medical needs of the returning serviceman from World War I (Cowles, 2000). Medical social services were also seen with resistance by other already existing professional medical and psychiatric fields. Abraham Flexner, a pioneer in medical education, negatively remarked on the field of medical social work, stating "...social work was not a

‘profession’ because it did not have a body of knowledge rooted in science and did not focus on direct services of individuals, as much as on environmental modifications and consultation and linkage of clients to other direct-service providers” (Cowles, 2000, p. 8). Feedback such as this kept hospital administrative boards and financier’s interpreting social work departments as extraneous and low priority within the hospital for decades to come.

Criticism and the continued psychosocial needs of the patients helped the pioneers in the field prioritize additional responsibilities and attributes to the social work role. Many departments restructured to incorporate a focus on psychoanalytic theory, while continuing a dual focus on the interaction between the individual and their social context (Bywaters, 2004). The transition in roles helped the practice integrate with the medical model. By 1938, full social histories and previous social service interventions were included in patient’s medical records and by the end of WWII conferences among social workers and the medical teams were common practice (Praglin, 2007).

In the post WWII era, the ‘biopsychosocial model’ or the theoretical perspective that “...physical, psychological, and social environmental conditions tend to influence one another and must be taken into account in order to understand and help clients and their families in health settings,” (Cowles, 2000, p. 12) became a primary theoretical orientation for most medical social work departments. The biopsychosocial acted as a foreground for social work assessments of patients and families and helped the entire medical team create effective and customized treatment plans within the medical model. While almost a century has passed since the inception of social work into the medical setting, the primary focus continues to be addressing the psycho-social needs and factors

correlated with diagnosis, medical treatment, practice and care around ones medical illness (Gregorian, 2005).

Within the past twenty years there have been comprehensive changes to the delivery of health care across America. Most hospitals work within a cost-conscious culture and in efforts to ameliorate high cost care, many social work departments have made serious reductions in their delivery of care and role within the setting (Gregorian, 2005). In the 1990's a large amount of hospitals around the country were bought by 'for-profit' companies, which continued the trend of consolidation of social service departments. Many departments had to merge with other services within the hospital, such as nursing or volunteer departments. Other settings adopted the "health care systems" in order to manage the budget crises and insurance companies reimbursement demands (Gregorian, 2005).

The fusing of departments within hospitals put pressures on medical social worker's to retain their professional identity and more importantly continue to be clinically present for patients and families. These financial restructurings often influence the social work role within the hospital. For example, in many hospitals, the social worker holds the title "multi-skilled case manager," which negates all previous efforts to professionalize the role and incorporate a psychoanalytic theoretical base. Since social work departments traditionally do not generate high amounts of revenue, in many hospitals social services are often struggling to survive and maintain a professional identity (Gregorian, 2005).

The 1990's brought change in the medical insurance groups and financial demands. It was then put on the hospital social work departments around the country to

be flexible and creative with interpretation of responsibilities and care provided to patients and families. The allotted social work department budget in each medical setting created differences in the hospitals standards of care, the priority of psychological aspects of hospitalization, and the social services provided to patients and families. The pioneers of social work in health care breeched new grounds with their ability to professionalize hospital social work and create a financial and authorized space for the field. Yet, hospital social workers continue to be misinterpreted by administrators, doctors, nurses and patients (Praglin, 2007).

#### *Play with Hospitalized Children*

Early psychoanalytic writers such as Anna Freud interpreted play as valuable and important for children's sense of mastery and control over their sense of self and environment (Curry, 1998). The process of being diagnosed and treated for cancer and other life-threatening illnesses is invasive with apparent effects on children's psychosocial adjustments. Children's notion of normalcy is challenged and they are faced with multiple vulnerabilities, including the physical pain, the separation from their caretakers, family and home mingled with tremendous amounts of loss and fear (Garipey & Howe, 2003). According to Jungian theory, children's play can be a metaphor for their unconscious mind. At a time when communication and awareness is limited, play can trigger the psyche and physical processes during developmentally formative years (Mindell, 1998). According to Mindell's (1998) qualitative study, *Children with Cancer: Encountering Trauma and Transformation in the Emergence of Consciousness*, children's fantasies express "elements of reality into a spellbinding cocktail of impressions that conveys an irrational significance. Whether the object is a beloved toy,

a casual observations or a sudden turn of fantasy, the child's natural mind mingles commonplace events with chains of unconscious associations...coupled with intense emotions" (p. 4).

There is research specifically exploring hospitalized children's ability to live with life-threatening illnesses over an extended period of time. While Mindell's research does not take culture or family systems into account, it explores the importance of play and highlights children's ability to communicate their deepest feelings and fantasies through play. Self-expression has been found to help children develop the capacity to cope with the dangers and problems assailing them, it can also be seen as an indicator for future developments (Mindell, 1998).

Evaluating the fantasy, dreams, and impromptu play of children is an authentic and informative way of strengthening the clinician's comprehension of the psychological implications, defenses, and internalizations of hospitalized children (Mindell, 1998). Often the symbolic medium is the only safe medium for children to express feelings of guilt, anger, pain, and abandonment. For these children the "...distress can well up in controlled affects and dissociated states, sometimes verging on pathological dimensions" (Mindell, 1998, p. 12). Life-threatening illnesses can have a serious impact on children's emotional development and can cause much distress to children's psyche if issues around their illness are not appropriately addressed.

The themes of play and the understanding of play for physically ill hospitalized children are significant indicators of their emotional suffering and crucial for practitioners to recognize and understand. Children under ten have limited coping resources; it is possible the stress of their illnesses could change their cognitive maps. A



child is more vulnerable and susceptible to “...develop distorted notions about the cause of her illness, including mistaken associations between the onset of the illness and the coincidental external events, and is likely to regard invasive and painful medical procedures either as sadistic abuser or as punishment for misdeeds” (Davies, 2004, p. 322). A patient’s reaction to her illness, such as self-blame, self-loathing or punishment, or misunderstanding regarding the cause of her illness, can be recognizable through appropriate clinical social work interventions.

Age appropriate interventions can inform clinicians of the reactions listed above. Once recognized by the clinician, applicable therapeutic interventions can help alleviate the negative thinking and ease the child of some of her anxieties surrounding her illness. Children from ages 0-12 months undergo influential developmental changes, including the development of children’s psyche and defenses. Hospitalization can be a drastic trauma during this critical developmental period, infringing on a child’s ability to interact with the world and properly adjust back into life outside of the hospital. Allowing time and space to review the implications of the illness is imperative in the healing process for the ill child (Brooks, 1994).

Hospitalization and invasive medical protocol can cause disruptions in children’s ability to play, depriving children of one of their most principal coping mechanisms (Garipey & Howe, 2003). Research concludes that activities such as drawing or playing with toys may no longer be pleasurable or of interest to hospitalized children. The temporary loss of these mastered skills are common in traumatized children (Brooks, 1994). Therefore, a better understanding of the emotions communicated through play can help the practitioner appropriately engage in therapeutic interventions that address the

anxieties displayed in play. Therapeutic play not only helps children's stress levels and fears, however, it may assist the children in regaining their sense of mastery through their play and further help coping with feelings of loss of control found in most pediatric hospitalizations.

With many hospitalized children loss of control is a frequent source of psychological trauma and a common stressor for children and their families. A child's feelings of being out of control can infringe on her ability to cope with her illness (Koocher & Williams, 1998). The medical setting can foster feelings of dependency and children can regress to earlier developmental stages as a result of the stress of hospitalization. This is usually seen in younger children who do not fully understand their illness (Curry, 1988). Children's feelings of being out of control are further exaggerated by the separation from their home and family and the lack of power over their bodies, physical surroundings, medications and medical procedures. The defenses and reactions to these situations differ for each child and depend on temperament and age. While some children will react passively, others will employ more action-oriented responses, such as angry outbursts, physically refusing to take medications, or yelling at caretakers and medical team (Koocher & Williams, 1998). These reactions can often emphasize even more feelings of loss and lack of mastery. It is important for clinicians to recognize these feelings in hospitalized children and be aware of appropriate interventions that can help alleviate some of these reactions.

As Davies (2004) notes, "school-aged children are more aware than younger children that their illness makes them different from peers..." (p. 350). This understanding of difference can foster feelings of isolation and low self-esteem. These

anxieties can be processed through the appropriate use of play and be better understood by the clinician through their analysis of play and metaphors observed in play. While there is much information regarding the importance of play for children and the importance of play as a coping tool for children within stressful situations, there is a lack of information regarding the evaluating pediatric social worker's use of play. Some helpful themes for clinicians to understand when working with hospitalized children are those of death, sadness, fear, loneliness, and loss (Webb, 1995). The clinician should be equipped to be able to speak openly about those issues and express appropriate empathy and analysis of those anxieties and themes.

Other themes that are likely to emerge during interventions, according to Bjork, et al (2006), are feelings of wanting to communicate with caretakers about fears and death, a desire to have caretaker's physically close, building good relationships with medical staff, and the need to play and feel joy. While the hospital setting has limits and certain methods and techniques of art and play can be difficult to incorporate during therapeutic interventions, there are numerous methods that are fitting for a hospital setting. The realities of hospitalization make certain types of dramatic or pretend play unattainable for patients, however, altered play methods can still create corrective experiences for children and provide therapeutic relief and emotional mastery.

#### *Art and Play Interventions within a Hospital Setting*

Although some restrictions exist for play therapy interventions within the medical model, there are numerous methods that can be appropriately implemented in the fast paced health care setting. For example, the Ipastive Method as used in Rae's (1991)

study, *Analyzing Drawings of Children who are Physically Ill and Hospitalized, Using the Ipsative Method*. The ipsative method is:

A procedure whereby psychosocial adjustment and coping are assessed using the child's own drawings as a standard for comparison. Instead of looking solely at traits, content, or themes in a single drawing, the child's psychosocial and emotional progress is evaluated as a function of the changes in his or her drawings over time

The ipsative method involves comparing a child's projective drawings as a series. For example, asking the child to "draw a person in a hospital" three different times throughout the child's hospital stay – such as one drawing in the beginning, one drawing in the middle, and one drawing in the end of the stay at the hospital. The technique involves only a few open-ended questions thereafter drawing is complete. Questions will likely differ for each child and depend on the drawing presented. The questions can be vague and as basic as, "Can you tell me more about your picture?" The question can be slightly more directive, however, still in the scope of the design, such as "What is this person doing?" Clinicians can even more specifically ask, "How does the person in the picture feel?" The design only calls for one drawing per meeting. The design then involves analyzing the drawings over time. The social worker can assess for themes throughout and observe the change in themes in the drawings through time. The design can be used with those who are not trained in art therapy.

The analysis of drawings is not to be used as a diagnostic tool, rather as a hypothesis about a child's current psychosocial status and the change in that status as hospital time progresses and ultimately comes to an end (Rae, 1991). This design structure is efficient for hectic child health professionals to conduct an accurate emotional

assessment of children who have limited verbal skills and limited time with the social workers. These limitations can be a result of the demands of the children's illnesses and medical procedures, as well as the demands of social worker's schedule.

Other psychological intervention techniques equipped for the demands of the medical setting include work with puppets, using an array of puppets, asking similar questions as that of the Ipsative drawing method. These intervention modalities take little time and do not require superfluous tools to implement within the setting. They are examples of ways to implement art and play therapy and increase awareness regarding patient needs and stressors.

For hospitalized children play can be difficult, this can be caused by the child's regressed developmental stage making it difficult for the child to engage in symbolic play and more importantly by the intense medications and medical procedures that can make play unfeasible. As Gunter (2000) notes in his research regarding art therapy interventions as a stabilizing factor to the defense mechanism of chronically ill children, patients can be intensely preoccupied with their overwhelming feelings around their illnesses, making denial of their fears of death, loss of control, sadness, and overall depressive and aggressive affects a common defense mechanism. All of their fears of death and doubts about a stable narcissistic self-image, frustrations around hospitalization, and separation anxiety from home environment and caretakers are then processed on an unconscious level.

Gunter (2000) found success in the "Squiggle Game" in his research with hospitalized children. Winnicott originally developed this game in 1971 as a technique to communicate by metaphor during his work with children. The Squiggle Game

involves both the clinician and the child drawing together. It is a basic game that does not involve advanced art skills. Both the patient and the clinician have a piece of paper and drawing tool (pencil, marker, crayon). It begins with the clinician drawing any kind of line or squiggle on one of the pieces of paper. The patient then creates a basic drawing from the original squiggle. After the patient finishes the drawing she can tell a story about it if she is willing to do so. Either way, it concludes with the clinicians asking questions about the patients drawing. Thereafter, the patient draws a line or squiggle and then the clinician creates a drawing from the original line and tells a story and answers patient's questions regarding the drawing. The game can be continued for as long as clinician desires.

The child remains in control by leading the drawing and having the choice of rejecting or correcting the clinician's interpretations of the drawing, allowing for a needed sense of mastery over the process (Gunter, 2000). It was found to be an effective way of addressing defenses due to illness, however, not invasive enough to completely diminish the needed coping mechanisms. The drawing has the possibility of helping the clinician better understand the patient's struggles or frustrations through the use of metaphor and can help introduce new themes into the therapeutic dialogue.

Similar techniques were analyzed in a hospital setting and found to be effective in the use of metaphor and communication of needs, as well as relief of symptoms. The "Color-your-life" game involves a similar sense of mastery and control as the Squiggle Game through the use of color rather than structured drawings (Hall, Kaduson & Schaefer, 2002). More similar to the ipsative method and the Squiggle method is the "draw-your-bad-dream" intervention tool. This includes simply asking children about

their dreams. It does not identify the dreams as being the children's actual feelings; therefore children can still feel a separation from the activity and actually verbalizing their own fears or feelings (Hall, Kaduson & Schaefer, 2002). All of these activities are similar in that they attempt to access the child's acute stress reactions to her illness in a psychotherapeutic context; however, they are facilitated by avoiding direct verbal discussion around the child's difficult situation through the use of metaphor as a barrier or additional medium (Gunter, 2000).

When selecting toys and materials for play with hospitalized children, social workers must consider materials that will allow children to channel their imaginations and will not disrupt the medical setting. Materials traditionally used within a hospital setting include, play dough, watercolor paints, paper and crayons, doll houses, toy cars and trains, and coloring books (Kunzman, 1972). Children on bed rest or restricted to small hospital rooms may benefit more from board games or story telling. Researchers found that play with water in a contained arena, such as used with sponges, cups, straws, brushes, and plastic kitchen utensils, can be fascinating for children and provide sensory experiences (Kunzman, 1972). The use of books and psycho-educational videos is another commonly used medium for hospitalized children. These mediums can help clinicians effectively prepare children for the process of their medical procedures and recovery. These mediums can also be used with siblings and other family members (Kunzman, 1972 & Oremland, 1988).

The use of building blocks and blocks representing imaginary aspects of the body, such as blood cells and chemotherapy and radiation treatments is a helpful use of play

within a hospital setting (Oremland, 1988). This activity embodies aspects of repetitiveness and purposefulness, reflecting the process of mastery.

Role-playing can capture these psychological effects as well. The social worker and child can create roles with pretend “super powers” or other physically powerful and confident figures mirroring the child’s current situation, however, with the imaginary freedom to combat the feelings of vulnerabilities and fear about the child’s illness or hospitalization (Oremland, 1988). Exercises such as these can help the child create visual images of overcoming the situation. Story telling, whether it is a story the patient and clinician create together or a story from a book or common fairy tale, elicits similar opportunities for children to imaginatively master feelings around their current situation (Oremland, 1988). Depending on the developmental stage and age of the child, writing stories can produce the same affects as reading stories and help the child work through anxieties and stressors around hospitalization. All themes and metaphors observed in play with children will allow the clinician to gain insight into the patient’s perceptions of their illness and hospitalization.

#### *Pediatric Social Workers Role within the Hospital Setting*

Social work literature going back to the 1950’s has alluded to the discomfort of the perceived conflict in role and responsibilities and misunderstood clinical practice of the hospital social worker (Cowles & Lefcowitz, 1992). In most hospital settings a hierarchical structure similar to the original medical model is still embedded within the institutions, putting physicians as the most important (Dabelko & Zimmerman, 2007). These structural barriers and attitudes create a medical model in which the social workers are left with constrained responsibilities of providing assistance for transportation,



arranging post-hospital care, assisting with community referrals, and other case management and discharge planning functions, with little emphasis, time, or space for psychological interventions and psychodynamic clinical practice. Conclusions of multiple studies, including Cowles and Lefcowitz (1992) research around the expectations of the medical social worker within a hospital setting, found that medical social workers expect their responsibilities to primarily include "...counseling, psychotherapy, psychosocial problems, or emotional behavior and problems (affective-expressive tasks)" (Lefcowitz, 1992, p. 2). Unfortunately, this is often more than other health professional groups expect of hospital social workers. Rationale behind these misinterpretations includes the differences in the medical model in comparison to the biopsychosocial model, the uncertainties around social work competencies, and the territorial conflicts between departments, the political systems within the institution, and the misconceptions of the focus and practice of the hospital social worker (Cowles & Lefcowitz, 1992).

In the United States today the hospital setting still makes a strong distinction between curing a patient and caring for a patient. In Dabelko and Zimmerman (2007) study, *Collaborative Models of Patient Care: New Opportunities for Hospital Social Workers*, researcher's found the perceptions of health care providers are glib and in general the subjects felt "...hospital staff are not emotionally supportive" (p. 35). The study goes on to attest much of this to the realities of the current U.S health care system. Most hospitals are under pressures from their imposing payment systems. These financiers ultimately affect length of hospital stay and the implications for the types of medical procedures and medical protocol used for patients and families. Furthermore,

“...in the health field, discharge planning is commonly referred to as the primary function of the hospital social worker, especially when viewed from the traditional perspective of the medical model” (Dabelko & Zimmerman, 2007, p. 39).

Conventionally, the medical model produces an environment where physicians and nurses expect social workers to practice primarily with the social-environmental factors surrounding patient care, including family practice and referral pursuits, rather than emotional concerns of patient and direct clinical treatment activity with patients (Cowles, Lefcowitz, 1992). The current health care system can restrict psychological care; subsequently clinical social workers must conduct appropriate psychosocial interventions, such as play or art therapy with patients within a limited framework.

Snow, Warner and Zilberfein (2008) explored the treatment and impact of social work with inpatient care in their study, *The Increase of Treatment Options at the End of Life: Impact on the Social Work Role in an Inpatient Hospital Setting*. Researcher’s found with the medical advancements in the past twenty years there has been an increase in survival rates of many illnesses that were once considered terminal. Yet, in the United States, the health care system was not prepared for the shift. There were no professional or structural transitions created or appropriately implemented in order to handle the demands and complexity of the psychosocial needs of these patients.

Unfortunately, due to the system in place most hospitals prioritize case management, such as assuring bed availability and insurance approvals. As Miller et al. (2007) conclude, the reality still remains that social work interventions are effective in improving quality of life with patients with advanced cancer, and medical social work involvement will help patients cope with hospitalization and the psychological aftermath

of surviving cancer or other life threatening illnesses. Therefore, a shift needs to take place in order for medical social workers to be able to properly perform those needed interventions.

Researchers Snow et al (2008) remark on the current focus on discharge planning in acute care hospital. Their research suggests the outcome of prioritizing discharge planning includes inadequate time for appropriate psychosocial interventions, such as art or play therapy methods, with hospitalized patients. This becomes especially true for patients who are too ill to be discharged. Since the clinical social worker is often the communication bridge between the patient and the patient's medical team, and they are most often considered part of the medical team and included in many patient conferences and medical rounds, it is important they remain informed on psychosocial needs of patients and families.

Most modern medical facilities are equipped with playrooms for patients and siblings. These facilities are usually staffed with hospital volunteers and child life specialist whose primary role with patients is to conduct play and art activities. However, volunteers and child life specialist are not part of the medical team, consequently they do not have routine collaboration with the medical team members regarding patients ability to cope with hospitalization and their psychosocial needs. Most importantly, they are not trained as social workers in assessing the psychological needs of patients. Therefore, the play does not elicit the same analysis by child life specialist or volunteers as it would if done by a trained clinical social worker.

CHAPTER III  
METHODOLOGY

*Formulation*

The research purpose for this study aims to discover the interpreted role of and intervention methods most commonly used by clinical social workers within a medical setting. Once the roles and interventions methods are more accurately exposed, the study infers the frequencies of art and play therapy interventions within the hospital setting. The research puts an emphasis on the clinical social worker's ability to perform such interventions, including observed limitations (if any) and perceived scope of practice. The research also inquires about the participant's belief in art and play therapy interventions as important in assessing the psychosocial needs of hospitalized children.

The research questions asked in this study were - what is the current interpreted role of the pediatric hospital social worker? Do pediatric hospital social workers commonly utilize play and art therapy interventions? Do pediatric hospital social workers believe play and art therapy to be effective psychological interventions? If these methods are not being used then what are the reasons or barriers to these interventions? Would pediatric hospital social workers recommend play and art therapy interventions? Do pediatric hospital social workers believe that analyzing themes in play will help social workers better infer about both the individual and overarching emotional needs of children within a hospital setting? What are the most common theoretical orientations of

the medical social worker with ill children? If play interventions are being used, then what are techniques most commonly practiced within the medical model? These inquiries were contrived from research on the current perceived role of the hospital social work and the current literature on the importance of art and play therapy intervention methods.

### *Research Design*

The study utilized a mixed-methods quantitative design with both descriptive statistical data and content analysis. The design was appropriate for the study since it allowed researcher to obtain a large amount of responses from all over the country in a short time span. This design also allowed for descriptive statistics. The purpose of the study was to better infer the role of the clinical social worker within the medical model of practice, particularly their use of art and play therapies within this setting. Researcher self-constructed an online anonymous twenty-one question structured survey through the Survey Monkey, an online survey publishing service.

The design included fixed questions, allowing for participants to only choose between provided answers. A small amount of open-ended questions were included within the design. These questions were added in order to obtain more refined and distinguished responses about specific art and play therapy intervention techniques used by participants, as well as participants identified theoretical orientation within their current work setting. The survey included the proposed research questions, as well as demographic information such as environmental setting, licensure status, type of licensure, years in practice, and primary patient unit. Please refer to Appendix A.

The research design was based on researcher's experiences as a clinical social

worker within a pediatric medical setting and the presented literature on the subject. The questions were designed to elicit the type of information needed to answer proposed research questions. The design is quantitative in nature, including mostly multiple-choice questions, with few open-ended and short answer questions for more in-depth analysis. The open-ended questions were additionally incorporated for the researcher to better understand the phenomenon in the participant's own words and ensure that no assumptions were made about the role of the medical social worker, the barriers to art and play techniques within the medical setting, the theoretical techniques mostly commonly practiced by participants, and the actual use of play within the medical model. This methodology was chosen in order to obtain more descriptive statistics on a group with limited descriptive data and prior empirical evidence.

Corollary, due to the quantitative nature of the survey a much larger amount of clinicians were able to participate from hospitals around the country in a limited time frame, unlike if this were a solely qualitative design. The design allowed clinicians to anonymously describe their role within the scope of the survey and explain their use (or lack of use) of art and play therapy interventions without taking too much of clinicians time and without inconveniencing clinicians with an in person interview. This method was also a cost effective way of obtaining a large and diverse sample. The survey was only intended for medical social workers, holding at least an MSW, currently working within a pediatric medical care facility with inpatient-hospitalized children.

### *Sample*

The sampling process for this design included both fixed methods and snowball sampling methods in order to gain participants. All the participants were clinical social

workers, working within a pediatric medical care facility with chronically ill children or inpatient hospitalized children. Consent was gained from 137 participants (N=137). The participants included 11 male and 123 female clinicians with 3 participants not disclosing gender. For this design there was no presented data involving race or ethnicity of participating clinicians. Of the participants, 131 held a MSW, one participant identified as a MSW candidate, one participant identified as additionally holding a doctorate degree in social work (DSW), and one participant identified as additionally holding a Masters of Education (M. Ed), lastly one participant identified as additionally holding a Masters of Science. Of the 137 participants, 107 had obtained licensure status and 30 had not obtained licensure status. The participants with licensure status included 8 different types of licensure. Table 1 in the Findings Chapter breaks down the sample by licensure status.

#### *Data Collection*

On February 5, 2009, researcher received written approval from the Smith College Human Subjects Review Board (HSR). The board approved the research design as adequately protecting the rights of intended participants and set appropriate research guidelines. Please refer to Appendix B. Thereafter HSR approval, the researcher informed the social work department at Children's Hospital Los Angeles of research requirements and intended research project during a scheduled weekly social work team meeting. Following the researcher's verbal explanation, researcher sent the informed consent page as an email on February 12, 2009. Please refer to Appendix C.

The emailed informed consent page explained the research study, the purpose of the study and the goals of study. The informed consent gave specific participation requirements, stating that participants must hold at least an MSW in order for

participation to be valid. Informed consent included a brief overview for the need of the study for the advancement of pediatric social workers within a hospital setting and the importance of understanding the emotional needs of physically ill hospitalized youth. The email specifically addressed the intended use of the collected data, ensuring data would only be used as a tool to help better understand the role of the medical social worker, with a focus on the use of play and art therapy intervention methods within the medical model.

The informed consent included confidentiality protocol and confirmed that confidentiality of the participants will be upheld throughout the entire process including during the data analysis process. The informed consent assured participants the contents of their information would only be used for the purpose of the study and kept for three years as a result of federal law; however, no personal information such as names would or could be used due to the anonymity of the research design. Additionally, the informed consent requested and encouraged participants to forward the email along to other pediatric medical social workers who matched participation guidelines.

Each participant signed the informed consent when they clicked the “I Agree” icon at the end of the page. By agreeing to the informed consent, participants were automatically led to the online survey. If participants clicked the, “I Disagree” icon they were led to a ‘skip logic’ page. The ‘skip logic’ page encouraged the reader to forward the original informed consent email to other pediatric medical social workers. Please refer to Appendix D. Data was collected until March 22, 2009, at which time a valid amount of participants had successfully completed the survey. The survey was properly



closed by researcher on the Survey Monkey website. The data was then downloaded onto a zip drive.

### *Recruitment*

In addition to the social work department at Children's Hospital Los Angeles, informed consent was forwarded as an email to researchers FFA, Grace King, LCSW with requests for her to forward it to those clinicians who fit necessary criteria for the research study. Informed consent was sent as an email to researcher's thesis advisor, Colette Duciaume-Wright MSW, LCSW, who posted the link on the San Antonio local chapter NASW website for recruitment purposes. Informed consent was sent as an email to fellow Smith College School for Social Work community members who work in or have worked in pediatric medical settings, including the researcher's previous FFA, Cheryl Spurlock, LCSW. Informed consent was forwarded as an email to personal friends and family in the field with requests for recruitment support.

Researcher became a member of the Association for Pediatric Oncology Social Work (APOSW) and the Association of Social Work in Health Care (ASWHC) for recruitment purposes as well. Once a member of these online associations researcher posted a web link on available forums. The web links led to researcher's informed consent page. Within the post, it was requested and encouraged members forward the information to fellow clinicians in the field. Informed consent was individually emailed to all of the listed clinical social work members on the associations available list serves. In those emails, it was requested and encouraged for potential participants to forward the information to fellow clinicians in the field. Informed consent was specifically emailed to the board of directors and chair members of both listed associations (APOSW and

ASWHC). Researcher made individual phone calls to the presidents and vice presidents of both of these associations. During phone calls the researcher explained the intended research study and the research design with requests for assistance with recruitment.

The process of recruitment involved outreach to as many pediatric care facilities as possible, including the researcher posting on oncology social work websites and association pages, the researcher utilizing internship at the time of recruitment, and the researcher advocating for the study through phone calls and emails. This process also included snowball sampling. Potential participants were encouraged to help with recruitment by forwarding the emailed informed consent colleagues within the medical social work field. Informed consent was sent as an email to over 300 medical social workers within the United States. The presented information was sent to medical social workers in all 50 states. The data collection process began on February 12, 2009, and the survey was formally closed on March 22, 2009.

#### *Data Analysis*

Once the researcher closed the survey, the results obtained by Survey Monkey were downloaded onto a zip drive. Researcher forwarded the materials to the Smith College School For Social Work Statician, Marjorie Postal. All open-ended questions were, as accurately as possible, transcribed by researcher into a codebook. Transcription included those questions which requested written responses, such as question numbers 20 (theoretical orientation) and 21 (example of play therapy inventions in current practice), as well as shorter open-ended questions throughout the survey, including question numbers 1 (gender), 2 (most advanced degree), 4 (type of licensure other than those listed), 7 (current work setting other than those listed), 9 (primary patient unit) and 19

(any additional observed barriers other than those listed). All of the coding for this design was nominal. All of the downloaded results were kept on a separate zip drive and sent to Smith Statician.

Descriptive statistics were used to describe the interpreted role of the presented sample of clinical social workers practicing within an inpatient medical facility. Additionally, descriptive statistics were used to describe the participant's use of art and play therapy interventions within their medical setting. Researcher analyzed the data manually and Smith Statician provided descriptive statistics for collected data. Researcher utilized such computer programs as Survey Monkey and Microsoft Excel to further deduce the numerical and ordinal data. Survey Monkey was used for frequencies and valid percents of each data set and Microsoft Excel was used for charting the descriptive statistical findings.

## CHAPTER IV

### FINDINGS

The research questions asked in this study were: what is the current interpreted role of the pediatric hospital social worker? Do pediatric hospital social workers commonly utilize play and art therapy interventions? Do pediatric hospital social workers believe play and art therapy to be effective psychological interventions? If these methods are not being used then what are the reasons or barriers to these interventions? Would pediatric hospital social workers recommend play and art therapy interventions? Do pediatric hospital social workers believe that analyzing themes in play will help social workers better infer about both the individual and overarching emotional needs of children within a hospital setting? What are the most common theoretical orientations of the medical social worker with ill children? If play interventions are being used, then what are techniques most commonly practiced within the medical model? All of the participants in this study held MSW degrees and were clinicians within a medical setting with children.

#### *Demographics of Participants*

##### *Gender*

The total population of the sample was 137 participants (N=137). The first demographic characteristic outlined the participant's gender. The majority of the participants identified as female. There were 123 female participants that completed the survey; this population was 89.8% of the sample. There were 11 participants who

identified as male, which constructed 8.0% of the sample population. There were 3 participants who did not identify their gender; this population included 2.2% of the sample. Please refer to Table 1.

#### *Most Advanced Degree and Licensure Status*

Participants varied in most advanced academic degree obtained within the field and licensure status within the field. One of the qualifications for participation included having at least a Masters in Social Work (MSW) degree. However, the design also inquired about more advanced degrees of the participants, asking specifically about DSW and PhD level degrees. Within the sample, 134 participants identified as obtaining an MSW, with a majority of 97.8% of the sample. Only one participant identified as having a DSW or PhD in the field, representing only .7% of the sample. Two of the participants identified as having another degree outside of a MSW, DSW and/or PhD. These participants made up 2.2% of the sample population. These degrees were noted as a Master's in Education (M. Ed) and a Master of Science. While 6 participants disclosed other aspects of their degree status in allotted space in this section of the survey, only the 2 responses noted above were significant responses to the research and the descriptive data presented. Please refer to Table 1.

Within the sample, 107 of the participants identified as being licensed social workers, making up 78.1% of the sample. Thereby, 30 of the participants identified as not being licensed social workers, representing 21.9% of the sample. Gender, most advanced degree, and licensure status of the sample population are outlined in Table 1.

Table 1

Demographics of Sample: Gender, Most Advanced Degree, Licensure Status

Gender	Frequency	Valid Percent
Female	123	89.9%
Male	11	8.0%
Missing	2	2.2%

  

Most Advanced Degree	Frequency	Valid Percent
MSW	134	97.8%
DSW	1	.7%
Other	2	1.5%

  

Licensure Status	Frequency	Valid Percent
Yes	107	78.1
No	30	21.9

*Current Work Setting*

The survey identified 4 different hospital setting categories: academic or university affiliated hospital, a county hospital, a privately funded hospital, or a freestanding medical care facility. The majority of the sample worked within an academic or university affiliated hospital or privately funded hospital for this study. A small amount of the participants were involved with a freestanding medical facility or county hospital. The breakdowns were as follows: 70.8% with a frequency of 97 participants worked within a university affiliated hospital. There were 20 participants working within a privately funded hospital, making up 14.6% of the sample population. There were 11

participants who identified as working within a freestanding facility, representing 8% of the sample, and only 2 participants working in a county hospital, making up 1.5% of the sample population. Please refer to Table 2.

In this question, participants were given the option to select ‘other’ as an answer choice, if their work setting was not listed. These answers were nominally coded by researcher and fell into two categories, non-profit hospitals and community based hospitals. There were 7 participants who responded with this option, making up 5.1% of the sample population. Please refer to Table 2.

Table 2

Current Work Setting

Current Work Setting	Frequencies	Valid Percent
Academic/University Affiliated	97	70.8
County Hospital	2	1.5
Privately Funded Hospital	20	14.6
Freestanding Medical Facility	11	8.0
Other: Non Profit Hospital or Community Based Hospital	7	5.1

*Years in Practice and Training in Art and Play Therapy Interventions*

The survey questioned the participants on the number of years they had worked with chronically or terminally ill youth within an inpatient hospital setting. The fixed

categories included, less than 1 year, 1-5 years, 5-10 years, more than 10 years. Of the 136 participants who responded to the question (with one missing system for this question), it was found the highest percent of years in practiced was from 1-5 years with 62 participants identifying with this grouping at 45.6%. There were 35 participants who had worked within the field for over ten years, representing 25.7%. The 5-10 year sub group included 23 participants at 16.9%. Lastly, 16 of the participants identified as working for less than 1 year within a medical setting, making up 11.8% of the participants. Please refer to Table 3.

The survey inquires participants training in art and play therapy intervention methods within their current medical setting. There were 4 missing responses for this question. Interestingly, of the 133 responses it was found that 124 of the participants at 93.2% did not receive training in art or play therapy interventions in their current work setting. Only 9 of the participants identified as receiving training representing a small percent of 6.8% of the sample. Please refer to Table 3.



Table 3

Years in Pediatric Medical Social Work and Training in Art/Play Therapy

Years in Medical SW	Frequency	Valid Percent
Less Than 1 Year	16	11.8
1-5 Years	62	45.6
5-10 Years	23	16.9
More Than 10 Years	35	25.7

  

Training in Art/Play	Frequency	Valid Percent
Yes	9	6.8
No	124	93.2

*Social Work Roles Within the Medical Model*

The participant's were asked to indicate, as best they could, their time commitment to a list of medical social work roles in a liker type scale format. The time commitment sub groups included, never, every 3-6 months, every month, every 2 weeks, weekly, multiple times per week and daily. The roles listed were as follows: patient and family counseling, administrative duties, patient and family education, program development and/or evaluation, social work or continuing education, research within the field, time committed to provided clinical supervision and receiving clinical supervision, community organizing, grant-writing, community referrals and resources, discharge planning, crisis intervention and code blue situations, pre-admission and new diagnosis meetings, family conferences, interdisciplinary team support, team meetings and consultation, medical rounds, bereavement counseling and time spend conducting psychosocial assessments

with patients and families.

For each listed role there were participants who did not respond, missing systems are included at end of Table 4. Table 4 displays the frequencies (listed in parenthesis under listed percentages) and valid percents for each social work role and the time commitment predicted by participants for each role. Please refer to Table 4.

Table 4

Time Commitment and Social Work Roles

	Never	3-6 Months	Monthly	Every 2 Weeks	Weekly	Multiple Times Per Week	Daily	Missi ng Syste ms
PT/Fam Counseling	1.5 (2)	.7 (1)	3.7 (5)	1.5 (2)	10.3 (14)	27.2 (37)	<u>55.1</u> (75)	.7 (1)
Admin Duties	7.4 (10)	3.7 (5)	5.2 (7)	1.5 (2)	12.2 (16)	20.7 (28)	<u>49.6</u> (67)	1.5 (2)
PT/Fam Education	.8 (1)	0.0 (0)	3.1 (4)	5.3 (7)	11.5 (15)	32.1 (42)	<u>47.3</u> (62)	4.4 (6)
Program Devel/Eval	6.6 (9)	<u>27.4</u> (37)	22.2 (30)	5.2 (7)	19.3 (26)	11.9 (16)	7.4 (10)	1.5 (2)
SW/Cont. Ed	3.0 (4)	<u>39.3</u> (53)	37.0 (50)	8.1 (11)	8.1 (11)	2.2 (3)	3.0 (4)	1.5 (2)
Research	<u>57.0</u> (77)	29.6 (40)	4.4 (6)	1.5 (2)	5.2 (7)	0.0 (0)	2.2 (3)	1.5 (2)
Providing Clinical Supervision	<u>60.7</u> (82)	2.2 (3)	5.2 (7)	4.4 (6)	13.3 (18)	8.9 (12)	5.2 (7)	1.5 (2)
Community Organizing	<u>65.9</u> (82)	20.7 (28)	5.9 (8)	2.2 (3)	3.7 (5)	0.0 (0)	1.5 (2)	1.5 (2)
Grant- Writing	<u>82.4</u> (112)	15.4 (21)	1.5 (2)	.7 (1)	0.0 (0)	0.0 (0)	0.0 (0)	.7 (1)
Receiving Clinical Supervision	17.5 (24)	4.4 (6)	31.6 (43)	7.4 (10)	<u>30.9</u> (42)	4.4 (6)	3.7 (5)	.7 (1)
Comm. Referrals/Res ources	0.0 (0)	0.0 (0)	2.2 (3)	3.7 (5)	9.6 (13)	32.4 (44)	<u>52.2</u> (71)	.7 (1)
Discharge Planning	17.0 (23)	8.1 (11)	10.4 (14)	7.4 (10)	10.4 (14)	17.8 (24)	<u>28.9</u> (39)	1.5 (2)

	Never	3-6 Months	Monthly	Every 2 Weeks	Weekly	Multiple Times Per Week	Daily	Missing Systems
Crisis Intervention/ Code Blue	13.6 (18)	<u>19.7</u> (26)	16.7 (22)	9.1 (12)	15.2 (20)	18.9 (25)	6.8 (9)	3.6 (5)
Pre –Admin / New Diagnosis	5.9 (8)	8.1 (11)	18.5 (25)	17.8 (24)	22.2 (30)	<u>23.0</u> (31)	4.4 (6)	1.5 (2)
Family Conferences	1.5 (2)	8.8 (12)	19.1 (26)	<u>23.5</u> (32)	19.9 (27)	22.8 (31)	4.4 (6)	.7 (1)
Interdisciplinary Team Meetings	1.5 (2)	.8 (1)	4.5 (6)	1.5 (2)	24.2 (32)	27.3 (36)	<u>41.7</u> (55)	3.6 (5)
Interdisciplinary Team Support	0.0 (0)	1.5 (2)	7.5 (10)	4.5 (6)	29.1 (39)	<u>37.3</u> (50)	20.9 (28)	2.2 (3)
Interdisciplinary Team Consult	0.0 (0)	.7 (1)	3.7 (5)	5.2 (7)	21.5 (29)	31.9 (43)	<u>37.0</u> (50)	1.5 (2)
Medical Rounds	10.4 (14)	2.2 (3)	3.7 (5)	1.5 (2)	24.6 (33)	27.6 (37)	<u>29.9</u> (40)	2.2 (3)
Bereavement Counseling	5.9 (8)	<u>31.1</u> (42)	23.7 (32)	20.7 (28)	14.1 (19)	4.4 (6)	1.5 (2)	.7 (1)
Conduct Psychosocial Assessments	1.5 (2)	2.2 (3)	2.2 (3)	7.4 (10)	18.5 (25)	31.9 (43)	<u>36.3</u> (49)	1.5 (2)

The findings for this dataset are important to the research aims presented in this study. The trends found in this dataset reflect how the sample self-identify their most commonly utilized responsibilities within the medical model and hospital setting. On a

daily basis, the majority of the participants identified as practicing patient and family counseling, completing administrative duties, as well as completing patient and family education within the hospital. Other daily majorities included providing patients and families with community referrals and resources, patient discharge planning, interdisciplinary team support and consultation, attending medical rounds, and conducting psychosocial assessments.

Other trends for primary responsibilities included interdisciplinary team support, attending new admission and pre-diagnosis meetings, and receiving clinical supervision. These roles were found to occur at least as weekly responsibilities, if not conducted multiple times per week. It was found that on average, every two weeks (valid percent of 23.5%) of the participants attended family conferences within the hospital. It was also found that pre-admission and new diagnosis meetings were very close in statistical data ranging from monthly to multiple times per week, 25 (18.5%) of the participants reported they attend these meetings every month, 24 (17.8%) reported that they attend these meetings every two weeks, 30 (22.2%) of the participants reported they attend on a weekly basis and very closely related 31 (23.0%) of the participants stating that they attend these meetings multiple times per week. This question, as well the results for participants practice of crisis interventions and code blues, showed results in which the findings were in very close proximity between each time frame.

The findings for practicing crisis intervention and code blue interventions reveal that the majority of the sample practices these intervention techniques every 3-6 months within the hospital with 26 (19.7%) of the participants reporting this time frame. However, 25 (18.9%) participants stated they practice these intervention techniques

multiple times per week. There were 22 (16.7%) of the participants who stated they conduct these interventions on a monthly basis and 20 (15.2) of the participants stated they do them weekly. Interestingly, there were 18 (13.2%) participants who reported never conducting such interventions.

There were several responsibilities within the hospital setting that involved trends with very low participation. For instance, 82 participants (60%) of the participants stated that they never provide clinical supervision. This statistic correlates appropriately with earlier findings, which revealed that 78 participants (57.4%) have only been working within the hospital setting for under 5 years. This finding makes providing clinical supervision less likely, as it is typically a more seasoned clinical responsibility. Community organizing was another social work responsibility in which the findings conclude that the majority of the participants at 90 (66.7%) never practice such activities. Conducting research within the social work field was another responsibility in which the trend included low participation. There were 77 (57.0%) who stated they never conducted research within the field, 40 (29.6%) reported conducting such research every 3-6 months. Similarly, 112 (82.4%) of the participants reported never practicing grant-writing activities within their current work setting.

#### *Utilization of Play Interventions*

Interestingly, participants were asked about if they commonly practice art and play interventions within their current practice. The majority of the participants at 72.6% stated that they did not practice such interventions. Only 37 participants at 27.4% reported utilizing such practices. Please refer to Table 5.

Table 5

Utilization of Play and Art Therapy Interventions

Utilization of Play	Frequency	Valid Percent
Yes	37	27.4
No	98	72.6

*Frequency and Effectiveness of Play Interventions*

Participants were asked how often they utilize such interventions with patients on a likert type scale. The trends for this data set are similar to the findings listed above. There were 69 or 51.1% of participants who stated they never utilize such interventions. There were 13.3% who identified as using such interventions once a month and 11.1% who identified as using such interventions every three to six months. There were only 13 participants, representing 9.6% who reported using such interventions multiple times per week and 4 participants at 3.0% who reported using them daily.

Yet, the majority of participants reported to find play interventions effective psychological interventions. For example, participants were asked if they believed these interventions to be effective techniques within the setting on a liker type scale. There were 100 participants at 74.1% who felt these interventions were sometimes effective. There were 32 participants (at a valid percent of 23.7%) who reported they find these interventions to always be effective. There was only 1 participant at .7% who reported these techniques as never effective. Please refer to Table 6.

Table 6

Frequency Play Interventions and Effectiveness of Play Interventions

Frequency of Interventions	Frequency	Valid Percent
Daily	4	3.0
Multiple Times Per Week	13	9.6
Weekly	8	5.9
Every Two Weeks	8	5.9
Monthly	18	13.3
Every Three to Six Months	15	11.1
Never	69	51.1

  

Effectiveness	Frequency	Valid Percent
Always Effective	32	23.7
Sometimes Effective	100	74.1
Rarely Effective	2	1.5
Never Effective	1	.7

*Recommendations of Art and Play Therapy*

Findings suggest that clinicians within this sample would recommend play and art therapy to other medical social workers. It was found that the majority of participants at 57.0% stated they sometimes recommend play therapy. Further, 36.3% reported they would always recommend such interventions. There was only 4.4% of the sample that noted they would rarely recommend and the minority of the sample at 2.2% reported they never recommend such intervention styles. Please refer to Table 7.



Table 7

Recommendations of Play and Art Therapy

Recommendations	Frequency	Valid Percent
Always Recommend	49	36.3
Sometimes Recommend	77	57.0
Rarely Recommend	6	4.4
Never Recommend	3	2.2

*Barriers of Art and Play Therapy within the Medical Model*

Participants were asked to identify any barriers within their setting to the use of art and play therapy interventions within a fixed array of barriers listed. There was also space at the end of the question for participants to self-identify barriers (listed below) they found within their setting that were not listed. Participants were allowed to mark as many reasons as they thought applicable to question. The trends for the most common reasons for the lack of use of such interventions included: other hospital team members, such as child life specialist and volunteers engage patients in therapeutic play (71.5%), time constraints (56.9%), too big a work load to manage art and play therapy intervention styles (43.1%), art and play therapy are not in the scope of job responsibilities (37.2%), and lack of training or experience with such interventions (33.6%).

The minority of participants noted that at 2.9% noted they did not believe there were any barriers within the current setting. There were also a small percent of participants at 8.0% who reported they thought there were organizational difficulties that inhibit the use of these intervention styles. Lastly, 3.6% of the participants stated they

felt there were too many general restrictions within the medical model to implement such interventions. Some of the self-identified barriers included; No appropriate clinical space within current setting, patient’s illness is too severe for play/art therapy, working primarily with caregivers, since placed on neonatal and infant unit, No appropriate resources within current setting for such interventions. Please Refer to Table 8.

Table 8

Barriers for Use of Play within Medical Setting

Barriers	Frequency	Percent
No barriers	4	2.9
Time constraints	78	56.9
Too big of a work load to manage such interventions	59	43.1
Out of scope of practice	51	37.2
Organizational difficulties within hospital	11	8.0
Other team members engage in such interventions	98	71.5
Restrictions within medical model	5	3.6
Lack of training	46	33.6
Other Barriers	16	11.7

### *Theoretical Orientation*

The participants were asked to self-identify the theoretical orientation they most often utilize with children in their current hospital setting. There were 85 participants who responded to this question and 102 participants who skipped this question. Researcher coded the responses and discovered 29 different theoretical orientation types. Themes for the most often utilized theoretical orientation included, strength-based perspectives, family/child/person centered, family systems theory, supportive counseling, medical crisis theory, ego supportive theories, psychodynamic theory, solution focused, bereavement counseling, dynamic systems, psycho-educational theories, biopsychosocial models and case management. From these responses the researcher deduced that most of the medical social workers within the sample worked from a dynamic, person/family centered approach. However, the findings of psycho-educational and case management are consistent with previous findings, deducing that this sample of clinicians work to educate patients and families and assist patients and families with resources and referrals.

Other theory types that were mentioned were brief counseling theories, Erickson's life cycle theory, motivational interviewing, expressive therapies, play therapies, empowerment theory, and functional social work theory. The theories that were sparsely reported in the data set included visualization/insight oriented therapies, humanistic theory, self-psychology and cognitive behavioral theory. There were multiple participants who noted coming from an 'eclectic theory base' and stated which multiple theory systems used most often.

### *Examples of Play*

Participants were asked to give a brief example of a typical use of play or art therapy interventions within their current setting. Of the participants, 76 answered this question and 111 skipped this question. Researcher coded the responses and came up with 27 different examples of play within the dataset. The most prevalent examples of play within the sample included, medical play with dolls or medical equipment and materials. Some of the materials mentioned were dollhouses with nurse and doctor figures, plastic medical supplies typically used such as needles, stethoscopes, and other tools. Examples that also fit into this category included the use of ‘blood cell blocks,’ which are little blocks that represent blood cells within the body.

The other most prevalent trends for this dataset included examples of clinicians drawing with patients. Drawing examples included self-portraits, family portraits, and patients within the hospital. Many clinicians labeled this use of drawing as part of the patients ‘illness narrative.’ Other examples of clinicians using ‘illness narratives’ involved clinicians working with patients to create coloring books displaying their illness narrative from beginning, middle and end. Some clinicians stated creating such books with patients and their siblings during expressive interventions. Similar examples included the use of ‘cancer color sheets’ with patients and siblings of patients. Other clinicians noted the use of psycho-educational videos and bibliotherapy with patients and families within the hospital setting. Another expressive intervention involved the use of guided imagery with patients and families.

A majority of the responses involved the use of board games, playing with puzzles and card games with patients during hospitalization. Some of the clinicians

reported engaging in role-plays with patients around their illness or fears around their illness. Another trend with clinicians involved behavior charts within patients rooms, playing games around patient's worries and/or fears with the use of 'punch pillows.' Some less significant examples of interventions in the data set included sand tray therapy, expressive work with clay, and scrape booking. Lastly, of the responses there were participants who did not answer question and reported that they did not use such interventions. There were also participants who stated that they 'referred out' for such intervention techniques.

## CHAPTER V

### DISCUSSION

This chapter presents the study's findings in comparison with the current literature on play and art therapy with hospitalized children and the self-identified role of the medical social worker. Secondly, the chapter discusses the intrinsic strengths and limitations within the study and the inferences for social work practice and future research.

#### *Current Findings and Previous Literature*

According to the sample of clinical social workers presented in the study, play and art therapy intervention methods are not commonly used within the medical model. However, the findings did suggest that the sample found play and art therapy to be effective psychological interventions for hospitalized children. These findings closely correlate with Cowles and Lefcowitz (1992) literature suggesting that medical social workers believe the psychotherapy and emotional behavior issues observed in affective-expressive tasks, such as art and play therapeutic techniques, to be an important aspect of the work. Yet, due to the current medical model, a majority of hospital social workers practice mostly with the social-environmental stressors with their patients and families.

The results for the sample's interpreted role within the hospital setting infer that medical clinicians practice patient and family counseling, administrative duties and patient and family education, as well as patient discharge planning, interdisciplinary team support and consultation, attending medical rounds and conducting psychosocial

assessments. These findings are consistent with Cowles (2000) and Gregorian (2005) literature on medical social worker current roles and responsibilities today. These findings are also comparable to Snow et al (2008) literature regarding the focus on discharge planning within medical social work departments around the country.

The study's findings include much emphasis on work within the interdisciplinary team, in terms of interdisciplinary team support, consultation and meetings including medical rounds. The findings imply that among the sample a primary time commitment for medical social workers includes the interdisciplinary team. Current literature does allude to the importance of the social worker as a member of the medical team, as noted in Mizarahi and Abramson (2000), Cowles (2000), Zebrack, et al (2008) and Crom et al (1999). However, these works did not highlight the frequency with which social workers collaborate and work with the other medical team members as seen in the study's findings.

The findings around the current barriers within the medical model for the use of art and play therapy interventions are somewhat consistent with the presented literature. However, the findings propose that the primary barriers are that other team members, such as child life specialist and hospital volunteers, engage patients in play and art activities. Other major barriers found within the sample were time constraints within current medical setting and too big of a workload to handle such intervention techniques. These findings were consistent with current literature as mentioned in Cowles (2000). These findings are not consistent with Cowles literature in terms of issues of funding within hospitals. The findings do not emphasize of the use of funding and the shifting roles due to structural changes within the precarious medical setting. This was not found

in the presented data of this study, and there were no mention of insurance groups interference or funding restrictions as a cause for the lack of use of art and play therapy within hospitals. Structural obstacles that were presented in the study's findings include physical space and necessary physical materials within the hospital setting for such interventions.

The findings for theoretical orientation were vast and extended the current literature regarding commonly used theoretical practice of medical social workers. The data did attain that the biopsychosocial model, medical crisis theory, and bereavement therapy are used within the medical setting, as seen in Cowles (2000), Mindell (1998), Jones (2006) and Gregorian's (2005) literature on the role of the medical social worker. The results revealed many other psychoanalytic theoretical bases for medical practice as well, such as strength-based perspectives, family/child/person centered care, family systems theory, supportive counseling, Erickson's life cycle theory, ego supportive theories, motivational interviewing, and functional social work theories. While less common, the use of cognitive behavioral theory, self-psychology theory, and humanistic theory, were still reported by clinicians in the sample. These findings bring new insight to the use of psychoanalytic theory and clinical work within the medical model. These findings also imply that although the majority of participants may not utilize art and play therapy techniques within their current setting, the participants are utilizing psychoanalytic practice and theory base with patients and family. There were only few participants who noted solely practicing from a case management framework.

The findings regarding examples of play and art therapies within the medical model also produced vast results. There were a numerous amounts of overlap between



the current literature on the subject and the presented data. The findings displayed the use of medical play with dolls, equipment and materials, such as dollhouses plastic medical supplies and building blocks. Interventions such as these were seen in Oremland (1988), Kunzman (1972) and Curry (1988). The use of drawing, color game sheets and workbooks, and creating artwork was found to be a prevalent use of art techniques utilized by sample. These examples correlate with the literature of Gunter (2000) and Rae (1991), as well as the works of Oremland (1988), Kunzman (1972) and Curry (1988). Story telling, role-playing, psycho-educational videos and board games were also found within the study, these findings are seen in current literature and consistent with previously presented literature, such as Oremland (1988), Kunzman (1972) on the use of art and play within the medical model.

The findings did suggest examples beyond the presented literature, such as scrape booking with patients and siblings, behavior charts with patients, ‘punch pillows’ as an expressive exercise took, sand tray therapy. The findings did entail a number of participants who stated they refer out for such interventions. Unfortunately, it was not noted what members of the medical team received such referrals for these interventions.

#### *Strengths and Limitations of Study*

The results for the study support researcher’s original predictions regarding the limited practice of art and play therapy within the medical model due to structural demands and protocol. The findings also supported the researches predictions that medical social workers believe in the effectiveness and benefits of play with hospitalized children. The findings connect with researcher’s original discussion on the importance of psychodynamic theory base within the medical setting. The findings for the interpreted

role of the medical social worker were also consistent with researcher's original predictions on the priority of case management, discharge planning, and administrative duties. However, the findings did suggest that psycho-educational practice and patient and family counseling are as well at the forefront of hospital social work.

For this study quantitative data was implemented due to its distinct and consistent nature. It was helpful for researcher to collect concrete descriptive statistical information regarding the presented research questions, rather than transcribe verbal responses if a more qualitative methodology was used. Another, more tangible benefit of the quantitative nature of this design was its cost-effectiveness given the large amount of participants (Anastas, 1999). The design allowed participants to self-disclose in an anonymous and speedy manner. The design tolerated a very large sample in a limited time frame and as a result was able to generate a very significant sample size, adding more validity to the dataset. An aspect of the study that would not have been obtainable if a qualitative design was applied. Additionally, the design permitted researcher to send the survey to all 50 states, as compared with one geographic location or region. This generated findings that can be more generally applied to the medical social work community.

In conjunction with the advantages of the design for this study, there were subsequent disadvantages due to the method of data collection. The design posed several limitations around the type of information obtained by the researcher. For example, researcher inquired about participant's patient unit and type of medical setting. These questions generated interesting data towards the overall findings, however, there were no correlative testing done on this information. However, if a qualitative design was

utilized, researcher could have gained a more integrative and expansive insight on the differences of roles within each patient unit and the expectations of each participant due to their designated patient setting.

The participant's patient unit had much influence on their role within the hospital setting. For instance, if placed on a neonatal, ICU or an emergency type setting then those participants work with patients and families greatly differs than if placed on an oncology unit or chronic illness unit. For example, several participants noted that art and play therapy interventions were not within their scope of practice due to the nature of their patient unit. Participants on such units stated they primarily work with infants and parents or caregivers, or work on an intensive care unit where most of the patients are unconscious due to severity of illness or injury. On units such as these, clinical practice solely involves work with parents, caretakers and other family members. If a qualitative method was employed, researcher could have obtained more information and in depth research about the nature of care provided by the participants due to their primary patient unit.

The majority of literature and research for this study was based on the role of clinicians when practicing within acute long-term patient settings. Therefore, it is a limitation that the design did not specifically require only medical social workers, holding at least an MSW, working exclusively on units that involve long-term medical care and chronic illness. The diversity of patient units represented by sample may have affected the outcome of the research. There were 17 patient units represented in the dataset, eight of these units were not particularly applicable to presented literature due to the nature of the unit. These units included, CTICU, PICU, NICU, Cardiology

Outpatient, Emergency Dept., Oncology Outpatient Clinic, Outpatient Surgical, and SW Managers. If more boundaries were in place regarding the type of medical social worker permitted to be part of the design, data presented would have applied more accurately to the study.

Furthermore, there was much emphasis put on funding within the presented literature, however, the design did not incorporate or highlight within any questions the samples beliefs on how their current settings use or lack of use of provided funding affects their ability to practice art and play therapy interventions with patients. There were some responses around the barriers of the medical model to play interventions that suggested the lack of space and materials within participant's current setting. These barriers imply that some medical settings do not have the funding to support such interventions. A qualitative design or a design that put more of a focus on the effects of funding could have produced more information around these financial barriers.

Another limitation includes the lack of information regarding race and culture within the medical setting and in practice with hospitalized youth. The only demographic information inquired throughout the study involved geographic location and participants were able to self-identify gender. Implications for race and culture were not included within the literature presented for this study and therefore, researcher believed to be outside of the scope of this design. However, examining a more diverse sample population would have allowed researcher to explore the role of race, culture, and ethnicity influence the use of art and play therapy interventions and the self-identified role of being a social worker within the medical model.

### *Implications for Policy and Practice*

Gaining knowledge on the roles of the pediatric medical social worker and the use of such clinical interventions as art and play therapy within the medical model has implications for social work practice and policy. Research on the importance of play and art for children living within a hospital setting and the limits of such interventions can influence medical social work departments to implement more time and space for these types of intervention methods. It could also allow social work department managers to prioritize such interventions and provide seminars and training on these interventions. With proper training and prioritizing of such interventions, medical social work teams could understand the benefits of play and art therapy and be given tools and suggested materials in order to understand how to utilize and implement such interventions within the medical model. Information within this study implies that more training on art and play therapy needs to take place for social workers within hospital settings.

Furthermore, the study found a primary barrier to be the ability to refer such interventions out to volunteers and child life specialist within the hospital. Literature found in this study can help medical social work departments understand the benefits of trained psychodynamic social workers implementing such interventions. For instance, due to clinical social work training, clinicians are generally more able to understand the metaphors and themes communicated by patients when conducting such interventions, more so than untrained volunteers and child life specialist, who are not considered part of the medical team.

Information found in this dataset regarding the role of the clinical social worker within the medical model indicates that medical social work practice does prioritize

patient and family counseling and psycho-dynamically addressing environmental and psychological stressor due to hospitalization, rather than a sole focus of discharge planning and case management. The study also discovered that there is more room for growth with addressing age appropriate psychological interventions with hospitalized children and re-structuring some departmental barriers, such as policy on referring out for services and policy around time allotted for psychological interventions with patients. Attention to these areas of medical social work practice could help further clinician's ability to meet the psychological needs of patients living within the hospital setting.

#### *Implications for Future Research*

Future research surrounding the role of the clinical social worker within the medical model and the use of art and play therapy intervention methods is important for the improvement of medical social work departments around the country. Future research around the implication of one's primary patient unit, number of years in practice and licensure, as well as the affects of funding on primary theoretical orientation and intervention styles are all important aspect of the field to explore.

Research focused on how primary patient unit correlates with most commonly utilized intervention techniques would benefit the field. A more qualitative look into the specific role of the pediatric oncology social worker may shed light the use of art and play therapy interventions and the role of the pediatric social worker when solely involved in long term care. Specifically seeking out oncology and other medical social workers involved in long term patient care may improve information on the clinical social worker's ability to meet the psychological needs of patients within the medical model.

The design inquired about number of years in practice and number of years with current licensure. This information was not correlated with data found regarding training in play and art therapy and data found on utilization of such interventions. Future research pertaining to the length of time working as a clinician within the medical model and the length of time licensed as a clinical social worker may lead to further insight on the ability to incorporate art and play therapy into regular practice.

The consequential ramifications around hospital funding are highly identified within the current literature as a barrier to clinical social work practice within the medical model. Further research regarding clinician's beliefs around the effects of funding or lack of funding around their clinical practice and their implementation of psychological interventions with patients would shed light on needed changes around the use of hospital funding. Clinical directors would be able to better advocate for social work department needs if more is known on how funding directly effects clinical practice and the use of art and play interventions.

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## Appendix A

Anonymous Online Survey:

**1. Gender:** \_\_\_\_\_

**2. Most Advanced Degree:** \_\_\_\_\_

**3. Licensure status:**

\*YES

\*NO

**4. What type of licensure did you obtain?**

\*MSW

\*DSW/PhD

\*Other (please specify)

**5. How many years have you had your current licensure?**

\*Not licensed

\*Less Than 1 year

\*1-5 years

\*5-10 years

\*More Than 10 years

**6. How would you categorize your geographic location?**

\*Urban

\*Suburban

\*Rural

**7. What is your current work setting?**

\*Academic/University-Affiliated Hospital

\*County Hospital

\*Privately Funded Hospital

\*Free Standing Medical Care Facility

\*Other (please specify)

**8. How many years have you been a clinical social worker within an inpatient medical setting with chronically or terminally ill youth?**

\*Less Than 1 year

\*1-5 years

\*5-10 years

\*More Than 10 years

**9. In your current setting, what is your primary patient unit?**

---

**10. Did you receive training in art and/or play therapy intervention methods in your current medical setting?**

\*Yes

\*No

**11. Please indicate, as best you can, your time commitment to the following roles within your medical setting.**

	Never	Every 3 to 6 Months	Every Month	Every 2 Weeks	Weekly	Multiple times per week	Daily
Patient/Family Counseling							
Administrative Duties							
Patient/Family Education							
Program development and/or evaluation							
Social work/continuing education							
Research							
Providing clinical supervision							
Community organizing							
Grant-writing							
Receiving clinical supervision							
Community referrals/resources							
Discharge planning							
Crisis intervention/Code Blue							
Pre-Admission/New Diagnosis							
Family Conference							
Interdisciplinary team support							
Interdisciplinary team meetings							
Interdisciplinary team consultation							
Medical rounds							
Bereavement counseling							
Conduct psychosocial assessments							

**12. Do you believe play and art therapy interventions are helpful for clinicians to assess the emotional needs of children within an inpatient hospital setting?**

\*Always helpful

\*Often helpful

- \*Rarely helpful
- \*Not helpful

**13. In your current practice do you commonly utilize play and art therapy interventions?**

- \*Yes
- \*No

**14. On average, how often do you utilize these interventions with your patients?**

- \*Daily
- \*Multiple times per week
- \*Once a week
- \*Every two weeks
- \*Once a month
- \*Every three to six months
- \*Never

**15. Do you believe play and art therapy to be effective psychological interventions?**

- \*Always Effective
- \*Sometimes Effective
- \*Rarely Effective
- \*Never Effective

**16. In your estimation, what percentage of your population benefit from art and play therapy interventions?**

- \*0-25%
- \*25-50%
- \*50-75%
- \*75-100%

**17. If you do practice art and play therapy interventions, how long have you used these methods in your work?**

- \*Do not practice these interventions
- \*Less than 1 year
- \*1-5 years
- \*5-10 years
- \*More Than 10 years

**18. Would you recommend play and art therapy interventions to other clinicians within a medical setting?**

- \*Always Recommend
- \*Sometimes Recommend
- \*Rarely Recommend
- \*Never Recommend

**19. In your practice, do you believe there are any barriers to your use of art and play therapy interventions with your patients? (Please note all that apply)**

- \*No Barriers
  - \*Time constraints
  - \*Too big a workload to manage art and/or play therapy intervention styles
  - \*Art and play therapy intervention methods are not in the scope of my job responsibilities
  - \*There are organizational difficulties that inhibit the use of these intervention styles
  - \*Other hospital team members, such as child life specialist and volunteers, engage patients in therapeutic play
  - \*There are too many restrictions within the current medical model to implement such interventions
  - \*Lack of training or experience with such interventions
  - \*Other (please list any other structural barriers to the use of art and play therapy interventions in your work place)
- 

**20. What is your primary theoretical orientation with chronically and terminally ill patients?**

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**21. Can you give a brief example of a typical intervention method that involves play or art therapy from your practice?**

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## Appendix B

February 5, 2009

Corye Goodman

Dear Corye,

Your final revisions have been reviewed and all is now in order. We are happy to give final approval to your interesting study.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Colette Duciaume-Wright, Research Advisor

## Appendix C

### Clinical Social Work and the Medical Model Anonymous Survey Informed Consent

**Dear Participant:**

**My name is Corye Goodman and I am a graduate student at Smith College School for Social Work. While working on my master's in social work, I am required to do a master's thesis based on a research project. The data found in this project may also be used for other presentations and publications, as well as for my thesis. With my current internship as my inspiration, the purpose of my research is to provide an in- depth look at how one sample of clinical social workers interpret their role within a pediatric medical setting. Within this sample, I am interested in discovering the interventions most commonly used by clinicians in a pediatric medical setting and specifically look at clinician's use of play or art therapy intervention methods within the medical model.**

**Your perspective is important and valuable to further the development of research on the role of the medical social worker, an area of clinical social work where research is limited. I would like for you to be a participant in this study. In order to participate, you must be a clinical social worker, holding at least a master's degree in social work (MSW) and you must work in a pediatric medical setting. Participants must be able to read the English language and complete this short anonymous survey, conducted through Survey Monkey. The survey begins with demographic information such as gender, number of years working within a medical setting, geographic location and licensure status. The majority of the questions focus on your preferred intervention styles, your interpretation of your primary role within your current setting, your use of art and play therapy interventions, and the current barriers (if any) surrounding these intervention styles within the medical model. The survey includes multiple-choice questions and only two short answer questions to further understand your role in your current medical setting.**

**Confidentiality will be maintained throughout the entire data collection and analysis process. I will keep data on a separate H drive and not process information on my personal computer. The information will be used solely for the intended research project. Through the use of Survey Monkey, all information is anonymous. Due to the anonymity of the study, it is impossible to withdraw once participants submit the survey. Please do not include names or any identifying information when discussing cases. After the data analysis is complete, I will keep all survey materials in the locked file cabinet for three years, according to federal regulations. This is a very low-risk study and your participation is completely voluntary. You may choose to omit any questions in the survey. I will accept the completed survey until April 30, 2009. Thank you for your time and participation in this study!**



**If you have any questions or concerns regarding your rights or any aspect of the study, please feel free to contact me: corye.goodman@gmail.com or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.**

**CLICKING ON THE 'I AGREE' BUTTON INDICATES THAT YOU READ AND UNDERSTAND THE ABOVE INFORMATION AND HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS. IT INDICATES THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

\* Agree

\*Disagree

## Appendix D

### **Do Not Consent “Skip Logic” Page:**

Thank you for your time and consideration. Please contact me if you change your mind and would like to participate.

Please feel free to forward the survey link to fellow clinicians working in a pediatric hospital setting.

Take Care,

Corye Goodman  
corye.goodman@gmail.com