

2016

Medical Social Worker's Understandings of Spirituality in Patient Care

Sarah Huiskes

University of St. Thomas, Minnesota, huis9309@stthomas.edu

Follow this and additional works at: https://ir.stthomas.edu/ssw_mstrp

Part of the [Clinical and Medical Social Work Commons](#), and the [Social Work Commons](#)

Recommended Citation

Huiskes, Sarah, "Medical Social Worker's Understandings of Spirituality in Patient Care" (2016). *Social Work Master's Clinical Research Papers*. 610.

https://ir.stthomas.edu/ssw_mstrp/610

This Clinical research paper is brought to you for free and open access by the School of Social Work at UST Research Online. It has been accepted for inclusion in Social Work Master's Clinical Research Papers by an authorized administrator of UST Research Online. For more information, please contact libroadmin@stthomas.edu.

Medical Social Worker's Understandings of Spirituality in
Patient Care

by

Sarah E. Huiskes, MA

MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota

In partial fulfillment of the Requirements for the Degree of Master
of Social Work

Committee Members

Catherine L. Marrs Fuchsel, PHD, LICSW, LCSW

Clare Larsen, LICSW

Patricia Kane, LICSW

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publically present the findings of the study. This project is neither a Master's thesis nor a dissertation.

SPIRITUALITY IN PATIENT CARE

Abstract

Spirituality is defined as “an individual’s connection or relationship with God or with some other kind of transcendent being or dimension (Hodge & Horvath, 2011, p. 307).” Based on past literature, a patient’s spiritual or faith belief has the potential to influence their healthcare outcomes, coping ability, decision-making surrounding their healthcare, as well as their quality of life (Puchalski, Ferrell, Otis-Green, & Handzo, 2015). As social workers in the medical setting aim to provide psychosocial support, the inclusion of a spiritual assessment to determine the spiritual and faith needs of each patient in order to deliver individual patient care seems necessary. The purpose of this study is to examine medical social workers’ understanding of spirituality in patient care. The study included qualitative interviews with eight graduate level social workers who have professional experience in a medical setting. The interviews examined areas related to professional experiences in assessing and providing spiritual care in a medical setting and six themes were discovered: (a) Assessing Religion Versus Values, (b) Presence of a Spiritual Assessment, (c) Social Workers Comfort with Spirituality, (d) Social Workers Expectation to Assess Patient’s Spirituality, (e) Education and Training, and (f) the Role of Chaplains and Clergy. The findings of this study indicated there was a lack of training and education provided to social workers within this professional area. In addition, there was a lack of consistency in the assessment of spiritual beliefs due to uncertainty of professional role and expectations. The findings also support the importance of language when assessing for spirituality and the relationship between personal and professional comfort in providing spiritual care.

Keywords: spirituality, social workers, qualitative, assessment, education

SPIRITUALITY IN PATIENT CARE

Acknowledgements

I would like to first express my gratitude to my research chair, Dr. Catherine Marrs Fuchsel, for the endless amount of support and guidance she provided throughout this process. Her genuine dedication to her student's success was evident in her positive attitude, kind presence, and her gift for research education. I would also like to thank my committee members Clare Larsen and Pat Kane for their support and willingness to provide professional guidance throughout my research project.

The support of my family and friends has undoubtedly provided me with the encouragement and strength to complete this project and achieve this milestone in my graduate education. Additionally, I would like to thank my fellow classmates who provided continuous encouragement and support through each step of this project.

I would like to sincerely express my appreciation to each of the eight individuals who participated in this study. I am grateful for their willingness to share their experiences and insight in order to further support social work research. Finally, I want to thank them for the incredible service they provide clients and families each day as social workers.

SPIRITUALITY IN PATIENT CARE

Table of Contents

| | |
|---------------------------|----|
| Literature Review..... | 3 |
| Conceptual Framework..... | 17 |
| Methods..... | 20 |
| Findings | 27 |
| Discussion..... | 40 |
| References..... | 51 |
| Appendix A..... | 55 |
| Appendix B..... | 57 |
| Appendix C..... | 60 |
| Appendix D..... | 61 |
| Appendix E..... | 63 |

Medical Social Worker's Understandings of Spirituality in Patient Care

The supportive nature of a patient's spirituality and/or faith and the potential it has to provide insight and direction within the medical setting is not considered to be a new revelation. Spirituality is defined as "an individual's connection or relationship with God or with some other kind of transcendent being or dimension (Hodge & Horvath, 2011, p. 307)." It has been found that spirituality has the capacity to address patients' questions of purpose and meaning of one's life as well as support who we are as a person (Stewart, 2014). As one faces an experience as a patient in the medical setting, the value or significance of one's spirituality may be heightened or has the potential to be examined. In a study completed in 2014, approximately 76% of Americans endorsed a belief in an organized religion according to a publication by The Pew Research Center (America's Changing Religious Landscape, 2015). This statistic demonstrates the prominent place that religion and spirituality continues to hold in American culture. Based on past literature, a patient's spiritual or faith belief has the potential to influence their healthcare outcomes, coping ability, decision-making surrounding their healthcare, as well as their quality of life (Puchalski, Ferrell, Otis-Green, & Handzo, 2015).

As social workers in the medical setting aim to provide psychosocial support services to patients in times of uncertainty and vulnerability, the inclusion of a spiritual assessment to determine the spiritual and faith needs of each patient in order to deliver individual patient care seems necessary. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) included a revision in their 2001 standards requiring the inclusion of an administration of a spiritual assessment to patients in the medical setting (Hodge, 2006). JCAHO standards specifically aim to assess a patient's

denomination of faith, spiritual beliefs that are considered to be significant to the patient, and spiritual practices that are part of the patient's life (Hodge, 2006). This additional patient care requirement introduced by a high accrediting body in health care increases the necessity of this type of patient care assessment to be used and understood by medical social workers. As a profession, it is important to examine the role of social workers in assessing these patient needs and ultimately determining the appropriate method of supporting each patient's individual spiritual and faith needs.

The act of examining a patient's spirituality has been considered to encourage a patient-centered model of care that supports the whole person and approaches this individual belief system as another relationship within the patient's life (Stewart, 2014). Information provided by a spiritual assessment has the potential to be a significant contributing factor to a patient's overall function and coping in the healthcare setting. As professionals in the medical setting whose role encompasses helping to support the psychosocial needs of patients, medical social workers are inherently working to meet the individual needs of each patient, which includes their spiritual and faith-based needs. An important component to meeting these individual religious or spiritual needs is the completion of a spiritual assessment to gather information regarding the presence and prominence of this patient demographic.

Despite the evidence indicating the significance of attending to this individual aspect of patient care, the current social work educational and professional environment does not provide the professional training or competence in the area of spiritual care to provide students or professionals in this field with the tools necessary to meet this patient care need. Spiritual care is the "aspect of health care that attends to spiritual and

religious needs brought on by an illness or injury (Spiritual Care, 2003).” Aspects of spiritual care can include: being fully present and compassionate, actively listening to a patient’s hopes and fears, completing a spiritual history, and consciously observing the mind, body, and spiritual needs of patients and their families (Puchalski C. M., 2001). The potential complexity of a patient’s faith and spirituality in addition to the lack of training social worker’s receive in this area can result in a lack of competency or comfort in addressing these patient care needs as medical social workers. Social work professionals have the capacity to use their education and skills to assess and provide care to patients that reflect their individual spiritual and religious needs to support the goal of supporting the “whole” person. The data that is gathered from this research project has the potential to encourage the support of providing an increase in educational and professional opportunities for current and future social workers. This additional educational and professional development is necessary in order to adequately prepare social workers to approach this aspect of patient care with the cultural competency and skill base necessary for individualized spiritual patient care.

This qualitative research project focuses on exploring the personal and professional individualities that contribute to a social workers assessment and provision of spiritual and religious care in the medical setting. The following research question will be examined: what are medical social workers’ understandings of spirituality in patient care?

Literature Review

The ability of social workers to provide appropriate services to meet the needs of all of their clients with the inclusion of their spiritual and religious beliefs is necessary

(Gilligan & Furness, 2006). This professional requirement is met through a combination of self-awareness, professional development and education, and limiting the barriers that prevent this aspect of client services from being provided. Each of these components contribute to the overall competency of social workers to fulfill this professional responsibility and promote future progress and awareness of the role of social workers in addressing client's spiritual and religious needs.

Self-Awareness

Cultural competence and responsibility. According to the NASW Standards for Cultural Competence in Social Work Practice, social workers have the capacity to use cross-cultural skills to demonstrate their understanding of the role that one's culture plays in the helping process, which includes spiritual beliefs (NASW Standards for Cultural Competence in Social Work Practice, 2001). An individual's culture can include the personal belonging one identifies as their religious and/or spiritual background, and one's cultural competence in the area of religion supports the act of recognizing, and valuing the beliefs of clients in a way that protects and preserves their dignity (Hodge, 2006). As social workers, much of the cultural competence that one demonstrates is reflected in their professional and personal self-awareness to avoid harm to clients in the services that they provide (Hodge, 2006). The process of discussing a patient's spiritual history includes specific areas of self-awareness that need to be considered including the act of showing respect of a patient's belief, despite the potential presence of significant differences in the beliefs that may represent the social worker (Larocca-Pitts, 2008). In addition, the cultural responsibility that comes with assessing a patient's spiritual needs requires the ability of the clinician to determine when a patient's needs are outside of the

clinician's training and scope of practice and warrants a referral in order to adequately meet the patient's needs (Larocca-Pitts, 2008).

The act of discussing a patient's spiritual history and needs should always have a person-centered focus and maintain emphasis on the patient's spirituality, not on the spirituality of the clinician (Puchalski et al., 2015). Despite the sense of relatedness that can occur with a shared religious or spiritual belief, the focus of the assessment should entirely be centered on the patient's needs in order to allow for an honest dialogue to occur without the influence of the clinician's own beliefs (Puchalski et al., 2015). The valuable role that a social worker plays in a spiritual assessment allows for the potential vulnerability that a patient may have in regards to their spiritual beliefs to be less prominent due to the lack of religious affiliation that the social worker represents (Stewart, 2014). However, the safe and impartial role that the social worker can represent (Stewart, 2014) is only possible if the social worker continually maintains a focus on the patient's spiritual story and needs without the inclusion and influence of her/his own spiritual beliefs.

It has been determined that the simple act of a professional showing interest in a patient's spirituality has the potential to provide a therapeutic intervention due to the comforting nature of this interaction (Larocca-Pitts, 2008). When looking at what is considered to be a critical aspect of providing spiritual care in the medical setting, the presence of a compassionate individual who is fully present in the moment to witness the patient's experience has the potential to provide a sense of healing that may be felt by the patient simply due to the context of the relationship between the patient and the clinician (Puchalski et al., 2015). The incredible value of the compassionate relationship itself

between the patient and the medical staff when approaching the topic of spirituality has been determined to provide the foundation for better understanding a patient's needs and resources through the act of listening to their story (Puchalski et al., 2015).

Professional definition and expectations. The lack of a professional definition of spirituality can leave social workers with an uncertainty regarding how to approach this aspect of patient care. A study showed that a social workers social context, which included where they live and practice, impacts how they describe the term spirituality (Barker & Floersch, 2010). This study also discovered that the social workers interviewed centered their definitions of spirituality using the social work values as a foundation, especially within the framework of "starting where the client is," which was considered to provide the social workers with support as they approached this topic which did not have any clear definition applicable to every patient (Barker & Floersch, 2010). As a result of this lack of clear professional definition of spirituality in the context of client and patient care, it is crucial for social workers to gain a comprehension of their own spirituality and how it potentially impacts their professional service to clients, in addition to ensuring that there is separation of their own spiritual beliefs and their clients, to ensure the ethical use of spirituality in their professional practice (Barker & Floersch, 2010).

The National Association of Social Workers Code of Ethics states "social workers also should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly (National Association of Social Workers, 2008)." This awareness is

directly related to the concept of spiritual competence and the role it plays in the personal and professional life of social workers.

The development of spiritual competence is one that is considered to be ongoing through the education, information gathering, and skills that a professional acquires over time (Hodge & Bushfield, 2006). The development of spiritual competence is accomplished through: (a) the awareness of one's own spiritual understanding and any biases that accompany that understanding, (b) the empathetic comprehension of a client's spiritual beliefs that does not include negative biases, and (c) the skill to use therapeutic interventions with clients that meet their spiritual needs and beliefs (Hodge D. R., 2004).

The development of a professional's spiritual self-awareness has the potential to be a challenging experience due to either a realization of their own limitations in this area of their life, as well as the acknowledgement of any conscious or unconscious negative attitudes or beliefs that may be present within their own belief system (Hodge & Bushfield, 2006). Despite the difficulty that can at times accompany this development of self-awareness, the importance of acknowledging how our own spiritual attitudes and beliefs were developed based on our relationship within the dominant cultures of our society and the potential influence of privilege and social power each of these has on our worldview is extremely valuable (Hodge & Bushfield, 2006). It has been determined that the most crucial aspect of one's spiritual competence is the understanding and realization of one's spiritual beliefs and view of the world because the fundamental end result is to reach a point that allows an individual to not just accept, but also appreciate the worldview of people of different faiths and spirituality (Hodge & Bushfield, 2006)

Spiritual care and self-awareness. The social work value of respecting diversity is directly related to the importance of social work students and professionals making an effort to gain awareness of their client's individual understanding of the world (Senreich, 2013). Spirituality has been thought to contribute to an individual's search and discovery of purpose and meaning in their life (Barker & Floersch, 2010). At times, this meaning and purpose can be directly related to any illness or suffering that an individual may be experiencing at some point in their life (Barker & Floersch, 2010). The concept of spiritual care is one that is patient-centered and emphasizes the importance of supporting patients when they explore meaning and purpose of their life and promoting the connection with themselves and any spiritually sacred presence (Callahan, 2015). Due to the sensitive nature of this type of patient care, it is imperative that social work students and professionals take into consideration their own personal perspective on the topic of spirituality both in the sense of personal beliefs and/or biases in relation to this topic as well as general views surrounding this subject (Barker & Floersch, 2010). The process of self-reflection and awareness can support the personal evaluation of the potential impacts that one's spiritual beliefs can directly or indirectly have on their professional practice both with clients that share similar or different belief systems than themselves (Barker & Floersch, 2010). A student's self-awareness is developed with educational support and direction in order to foster the growth of a professional self and further acquire the skills used for self-reflection (Urdang, 2010). The need for competent supervision to support the development of a student's self-awareness is critical and necessary for their future employment in the social work profession, which is optimally accomplished during the education process (Urdang, 2010). Ultimately, a social worker's own personal values,

prejudices, and beliefs have the potential to impact how effective they are with their clients and those they serve (Heydt & Sherman, 2005). It is ultimately the goal of spiritual care and a social worker's self-awareness to "develop an expansive, spacious quality for listening to patients with respect, compassion and non-judgment and to assist patients in achieving healthy integration of the illness experience by "unpacking" core beliefs, engaging in a mature and evolving spirituality (Stewart, 2014, pp. 71-72)."

Social Work Education and Competency in Spirituality

It has been stated that a "culturally competent" practice is one that highlights both a comprehension and appreciation of the impact of an individual's faith and spiritual belief (Gilligan & Furness, 2006). There is a concern surrounding the lack of training that social workers have received in the area of spiritual competency due to the agreement of the relevance of this client need in practice settings, the requirement of the NASW Code of Ethics to address this aspect of client services, and the requirement of the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) for healthcare institutions to implement the assessment of spiritual beliefs of clients (Hodge & Bushfield, 2006). However, it has been found that both social work educators and professionals have difficulty implementing the area of spirituality into the assessment and interventions of their clients using the bio-psycho-social-spiritual framework (Senreich, 2013). In addition, there is research that demonstrates that although social workers implement their client's spiritual beliefs into the therapeutic interventions within their practice, they have not received the educational training to competently do so (Senreich, 2013). This is concerning due to the NASW Code of Ethic's inclusion of the importance of practicing within the competence of your service provision and only providing services

to clients in areas in which you have received education and training (National Association of Social Workers, 2008). Sheridan and Amato-von Hemert found that over 30% of the sample they questioned utilized the use of spiritually oriented interventions with clients despite having limited practice and educational experience (Sheridan & Amato-von Hemert, 1999). The concern regarding these research results centered on the finding that almost two thirds of the sample had limited educational and professional training in the area of religion and spirituality in graduate schools, yet still provided spiritual and religious services and interventions to clients that may be considered to be sensitive in nature (Sheridan & Amato-von Hemert, 1999). Ultimately, there are circumstantial needs for the inclusion of a client's spirituality to be integrated into the services and assessments provided by social workers despite not having the educational and professional training opportunities to support this need. This perspective further supports the need for students to receive education in the spiritual assessment and intervention of clients to provide the essential guidance and preparation to provide services, which reduce the incidence of harm to the client they are working with as a result of a lack of competency (Sheridan & Amato-von Hemert, 1999).

The manner in which to define spirituality within the profession of social work has contributed to the challenge of fully implementing it into the area of social work education and the use within social work practice (Senreich, 2013). The individual nature of spirituality brings challenges to defining it within the context of social work practice due to it currently only being representative of what is considered to be common belief systems instead of representing the individual nature of the spiritual relationship (Senreich, 2013). The interdisciplinary research indicates that the experience of

spirituality is commonly defined as an overall consciousness of one's fundamental part of the world (Callahan, 2015). The ability to define spirituality specifically within the practical and professional field of social work requires both the incorporation of social work values as well as the overall ability to be implemented with all clients (Senreich, 2013). More specifically, this definition must encompass the immense diversity that is associated with any client's spirituality and encourage the ongoing demonstration of the social work values that are exhibited each day by social work students and professionals within the spiritual work with clients (Senreich, 2013). The inclusion of spirituality within the bio-psycho-social-spiritual model for an accepted social work practice must adequately address the need for both a clear framework that guides professionals and students to provide this type of client services as well as a definition that respects the belief systems of all client's spiritual relationships (Senreich, 2013). The definition of spirituality within the profession of social work has the potential to be a great guiding force for all professionals and students who are attempting to navigate this current client need without the standardization and support of the social work core values.

Educational contributions. The educational competency of social workers does not only evolve from practical experiences and educational dialogue but is also embedded in the information that is distributed in the textbooks that are expected to be read by social work students both at the undergraduate and graduate level. The importance of examining the content within the social work textbooks is due to the possible professional influence they have on students during their coursework based on the education and ethical material that is included in the content of each book (Hodge, Baughman, & Cummings, 2006). This is especially significant due to the student's beliefs and attitudes

about certain populations discussed during their educational coursework that remains influential throughout a student's career (Hodge, Baughman, & Cummings, 2006). A study looking at influential social work textbooks and the prevalence of faith groups and their portrayal found that the presence of evangelical Christians and Muslims had almost no visibility in the textbooks despite their prominence in our culture (Hodge, Baughman, & Cummings, 2006). The concern about the lack of presence with these two groups within these texts relates to the message this communicates to students about their relevance to our society and the overall message these texts are communicating about religious groups (Hodge, Baughman, & Cummings, 2006). The textbooks that were analyzed in this study found these specific religious groups are typically portrayed in a negative light, specifically as individuals who are thought to attempt to enforce their beliefs on other people whereas the liberal groups are portrayed as individuals promoting social justice, which ultimately is not communicating to students objective information about the multicultural civilization they are going to be serving as professionals (Hodge, Baughman, & Cummings, 2006). As we examine the role that spirituality will continue to play in the professional work of social workers, we must consider how this topic is being communicated to those who will be the future of our profession as they learn the fundamental beliefs and opinions that may be present throughout their career.

Barriers To Professionals Assessing Patient's Spirituality

The historical progression of social work shifted when the focus became more strongly tied to professionalization and science and ultimately leading to spirituality being considered outside of the field of social work (Senreich, 2013). However, there has been a transformation in social work practice which now emphasizes the importance of

the person-in-environment perspective and self-determination and is closely assessing the role of the spiritual and religious assessment and services within the social work profession (Furman, Benson, Grimwood, & Canda, 2004). In addition, with the revision to the Code of Social Work Ethics by the National Association of Social Workers, there is an expectation that social workers have a respect of their client's religious beliefs in their responsibilities as a profession and the services they provide (National Association of Social Workers, 2008). However, even with the professional shift of acknowledging the importance of a client's spirituality both within the medical setting as well as other settings, there continues to be hesitancy by some professionals to fully accept this as a component of social work services due to a combination of professional and personal apprehensions.

Potential client impact. The presence of a spiritual perspective and an overall comprehension of spirituality are considered to be necessary skills for providing holistic care in the medical setting (Lennon-Dearing, Florence, Halvorson, & Pollard, 2012). The continued growing number of distinctive cultural groups in the U.S. has further supported the importance of professional awareness of different worldviews, which are based on markedly diverse values (Hodge & Bushfield, 2006). It is this growing number of diverse values that are representative of the patients and clients that are provided social work services which further supports the importance of competence and implementation of spiritual beliefs within the social work scope of practice. Unfortunately, there can be personal opinions that are supported by the dominant culture that may influence one's opinions of different worldviews, which can result in biases and ultimately if not addressed can lead to a constricted understanding and acceptance of these worldviews as

valid (Hodge & Bushfield, 2006). When evaluating the impact of spiritual and religious biases and prejudices, it is evident that these type of views held by social workers have the potential to negatively impact the services they provide in a similar way that influence services to other populations where biases are held such as a client's race, gender, sexual orientation or even their ethnicity (Hodge, Baughman, & Cummings, 2006).

When assessing what is considered to be a critical aspect of providing spiritual care in the medical setting, the presence of a compassionate individual who is fully present in the moment to witness the patient's experience has the potential to provide a sense of healing that may be felt by the patient simply due to the context of the relationship between the patient and the clinician (Puchalski et al., 2015). Research has determined that from a patient's perspective, a significant spiritual need in the medical setting is met through the high quality of interactions they experience with medical staff through respectful conversations, friendly facial expressions and body language, empathy, trust, and integrity (Hodge & Horvath, 2011). Each of the components of the high quality interactions patients have expressed a need for are vital to discussing the spiritual histories and needs of patients in the medical setting. There is the potential for therapeutic interactions to be disrupted if there are personal or professional biases that are interfering with a social worker's ability to meet these patient needs in a way that supports their coping and adjustment in the medical setting. This is especially significant due to a patient's spirituality having the potential to influence many decisions in their life including ones that are related to their healthcare and especially their end of life decisions (Puchalski et al., 2015).

Professional insights on spirituality and social work. In a study examining the opinions of faculty regarding the inclusion of religion and spirituality in social work curriculum, one concern was shared regarding the possible disruption of the current relationship between church and state being separate in the current social work programs (Sheridan, Wilmer, & Atcheson, 1994). This concern was further supported by participants expressing the importance of a professional maintaining separation of their own personal beliefs from the work with their client and the potential for client harm due to any biases that may be held by that professional (Sheridan et al., 1994). There was also a significant question of whether addressing a client's spiritual or religious needs went beyond the scope of professional practice in social work (Sheridan et al., 1994). Each of the concerns communicated in this study depict a challenge in determining the role of social work in addressing the spiritual needs of clients and discerning what concerns are related to professional issues versus those that are of a personal nature.

Essentially, the concept of spiritual competence focuses on an ability to understand the nature of how a patient's religion/spirituality is contributing to their development and overall current functioning (Callahan, 2015). This competence also works to ensure that client's dignity is protected through not only the social worker's awareness of the client's spiritual values but also through respecting those beliefs as a professional (Hodge, 2006). This competence can only be achieved through the preparedness that comes from social workers addressing personal and professional values related to religion and spirituality that may impact the clinical services they provide, especially in instances when their belief system may be significantly different than those of their client or challenged due to their client's specific religious practices (Hodge,

2006). A lack of addressing professional and/or personal spiritual values and biases has the potential to negatively impact the services that a social worker may provide a client and lead to unnecessary harm to the client (Hodge, 2006).

Social work and spiritual care. According to the requirements that were implemented by JCAHO in 2001, a spiritual assessment should at least include information regarding a patient's denomination of faith, spiritual beliefs that are considered to be significant to the patient, and spiritual practices that are a part of the patient's life (Hodge, 2006). A patient's spirituality may be viewed as an additional relationship in the patient's life, by assessing that relationship with the patient, the social worker is providing services that meets a patient-centered model of care, and works to meet the individual needs of the whole person (Stewart, 2014).

A value in having social workers address this patient need is partially due to their lack of religious affiliation during a patient's medical experience, thereby increasing a patient's comfort in addressing any spiritual questions in the presence of a professional that is considered to be safe from any religious association or obligation (Stewart, 2014). This is especially important due to the act of discussing a patient's spiritual history focusing more on how the patient's beliefs assist in their functioning in the time of an illness versus the actual specifics of the beliefs themselves (Larocca-Pitts, 2008). In this regard, the gathering of information should be directly related to the evaluation of a patient's functioning and coping, which is considered to be valuable to a social worker's overall assessment of a patient in the medical setting and can influence the supportive services that would meet the individual patient needs. The simple act of a social worker inquiring about a patient's faith has the potential to provide therapeutic value due to the

level of coping support that can accompany this belief system, which ultimately initiates a caring interaction between the patient and social worker (Larocca-Pitts, 2008).

Although there are questions surrounding the role of social workers in the area of patients spirituality and the assessment of those needs, when one takes a step back to look at the value of the inclusion of this aspect of the social worker and patient relationship, one might consider this to be critical to ensuring that the supportive needs of each individual patient are met. It is clear that in order to provide competent services in the area of a patient's spirituality, a social worker must engage in the professional and personal work necessary to proficiently deliver this type of care, which begins with the education and training to prepare social workers for this area of service. The value of self-awareness, education, and the ability to address personal and professional barriers is essential to provide spiritually based services in a manner that reflects the core values and ethics of the social work profession. This can only be accomplished with the documented support of these services within the professional scope of practice.

The potential for a patient's spirituality to be a vital coping tool in a time of illness should be sufficient enough to warrant greater attention and professional awareness to this issue than is currently offered. As a profession, it is our ethical obligation to further examine how we will support this service need in the future and take the steps necessary to competently approach it with each and every client and patient.

Conceptual Framework

The theoretical lens through which to examine the topic of social worker's understanding of spiritual assessments and care in the medical setting helps to determine the overall framework of the data and information gathered and analyzed during the

research process. In order to accurately relay the complex nature of this topic, the use of systems theory provides a lens to examine the topic of social work and spirituality in a manner that utilizes both the behavior and social environment perspectives. Systems theory focuses on the results of the interactions that occur between individuals and their environments as a way to analyze human behavior (Hutchison, 2013). More specifically, systems theory is interested in the overall acclimatization of people to different circumstances within their lives and ultimately the role that those incidences of acclimatization have in the shaping of those circumstances (Hutchison, 2013). Systems theory does not provide specific interventions or contexts in which to approach problems or behaviors, but rather allows for a way to enhance understanding of behaviors by looking at the dynamics within the client systems to allow for interventions that are balanced within the client and their environments (Friedman & Allen, 2014).

Social systems are generally separated into categories based on the size and complexity into levels of micro, mezzo, or macro level (Friedman & Allen, 2014). Microsystems are considered to be small systems that include individuals and pairs of individuals. Mezzosystems tend to be inclusive of an individual's extended family, their supportive systems, and other groups in their lives. Finally, macrosystems typically include the communities and societies that are a part of an individual's life (Friedman & Allen, 2014). The systems themselves exchange information with their environment in order to regulate the goals of the system being supported by the outputs the system is releasing, which is termed feedback and can be at an internal level as well as an external level within the environment (Friedman & Allen, 2014). A systems ability to be considered functional is often a result of whether it is considered to be a closed or open

system, meaning that the system itself is in a constant state of change within the larger environment that surrounds it through the cause and effect that results in the state of ongoing change (Friedman & Allen, 2014). More specifically an open system is associated with constant engagement with their environments, whereas a closed system is isolated from their environment (Bertalanffy, 1969).

There are different types of environmental contexts that can be directly influenced by the systems that are in place for each individual including: family, community, political involvement, social networks, economic, physical health, and religious and cultural identity (Kondrat, 2013). The relationship between a person and their environment is one of ongoing exchange, which means that just as a person can influence their environment, their environment can impact the individual (Kondrat, 2013). Within the person-in-environment framework the concept of coping is directly related to the manner in which one's system approaches each of these life circumstances (Friedman & Allen, 2014), especially in medial circumstances and in direct relation to the presence of one's spiritual and religious beliefs. The process of coping includes both the act of problem solving in addition to one's capacity to have control over negative feelings that may be present (Friedman & Allen, 2014). The process of coping is the relationship between the external presence and the internal unease that results from the external stress presence, which in turn develops into a person's desire to learn a coping response (Friedman & Allen, 2014). In these situations, one would depend on the defenses and coping skills that are already in place to approach these stressful circumstances however, if those coping skills and strengths have been depleted, the ability for them to continue to cope with the stressor is limited (Friedman & Allen, 2014).

The manner in which one approaches coping with stressful circumstances for example, an illness or hospitalization, is first managed utilizing supportive systems already in place such as one's spiritual or religious beliefs and community. It is evident that the support of this already present system has the potential to promote healthy coping for individuals at the beginning of these experiences and utilize the individual's already present strengths. Also, as we examine the social workers understanding of spirituality in the medical setting, it is important to assess what systems both professionally and personally are in place that contribute to the work they provide for clients in the area of spirituality. The systems may be the result of professional, educational, personal, and cultural influences that contribute to how this client need is approached. However, regardless of the how these systems originated, it is important to consider their presence and influence when examining the overall awareness of spirituality for social workers in the medical setting.

Methods

Study Design

This section will provide descriptive information on the design of the research study. Due to the nature of the purpose of this qualitative study, the use of Grounded Theory helped inform the study's design. Grounded Theory is "a research methodology for developing theory by letting the theory emerge from, or be "grounded" in the data (Monette, Sullivan, Dejong, & Hilton, 2014, p. 222)." This theory evaluated medical social worker's understanding and awareness of spirituality in the medical setting by utilizing an exploratory approach to provide research on this topic, which currently is limited in availability.

The qualitative interviews focused on three distinct areas of interest. The first area focused on gathering demographic information about each of the participants in regards to their age, gender, years of professional work, religious affiliation, and education level. The second area examined how social workers assess for spirituality in one's practice, each participant's theoretical orientation, and the relationship between the participant's spirituality and the spiritual services they provide in the medical setting. The third area looked at the comfort level of the participants in providing spiritual care, their perception of patient's interest in having these beliefs addressed in the medical setting, the educational preparation for this professional area of focus, and each participant's opinion of the role of social workers in providing spiritual care in the medical setting.

Sample and Sampling Procedure

The participants of this study were medical social workers with an educational background of LGSW or LICSW. The sample was produced using a random sampling frame from a mailing list provided by the State of Minnesota Board of Social Work. The sample included 999 randomly chosen individuals from the mailing list with a professional affiliation with a medical institution in Minnesota. To adequately meet the goal of this research project, which is only looking to assess a specific population of professional social workers in a specific professional setting, the use of a nonprobability sample seemed appropriate for this project (Monette, Sullivan, Dejong, & Hilton, 2014). There were limitations to using this type of sampling including a potential lack of ability to declare representation of an entire population as well as sampling error (Monette et al., 2014). However, the exclusive nature of the project's research question being pertinent

to a specific professional setting and social work population provides a benefit for the use of a nonprobability sample. The potential research participants were each sent an informative email about the study (Appendix A). The individuals who were interested in participating in the study responded with an email expressing their interest and with the researcher, a time was scheduled for their interview. A final email was sent to follow up with any participants that did not respond in two weeks using the same email format as the introductory email. The goal of this research project was to include at least 8 participants, however the participation email was sent to a larger number of social workers to increase the probability that at least 8 participants were recruited.

Protection of Human Subjects

The participants had an opportunity to review the research study consent form and signed the form indicating consent to participate in the interview and study prior to the interview occurring. The consent was obtained from the Institutional Review Board (IRB) from St. Catherine University (Appendix B). The confidential nature of the interview was discussed with each interview participant in addition to including how the participant's identity would remain confidential throughout the research process.

The interviews took place over the telephone in a private office room to maintain confidentiality of the information that was discussed. The interviewer did not reference the identity of the participant during the recorded interview or within the transcribed data that was gathered from the interview. The participants are only identified within the research documents by an assigned letter such as participant A and participant B. In addition, the research assistant who aided with the process of cross-checking analysis of data, consented to maintaining participant confidentiality by signing a confidentiality

agreement prior to having access to any research materials (Appendix C). Any research correspondence by email or electronic documents was kept within a secured computer that was only accessed with the use of a password. Following each interview, the collected audio data was transferred to a computer that is only accessible by a passcode and the audio-recorder was stored in a locked file cabinet. Any additional documents and recordings containing research content were kept in a secured file cabinet that is only accessible with a key. The research study documents and other materials will only be kept until May 31st, 2016; at that time all materials will be securely destroyed.

In the event that the interview process caused any emotional distress to the participants, due to the nature of the questions pertaining to a potentially delicate element of one's personal and professional identity, an informational document providing available resources for further support to address any distress that resulted from the interview was provided to each participant (Appendix E). The resources included supportive services that are available in local communities in the state of Minnesota.

Data Collection

The data was gathered using semi-structured interviews, and all communication occurred over the telephone. The method of the interview was based on the participant's preference, either a face-to-face interview or through the use of a telephone. In the event the participant preferred a face-to-face interview, the location of the interview would have occurred in a public building and would have been determined by the participant and interviewer to ensure the confidentiality requirements and needs of the participant were met for this research project.

Due to the nature of this research topic, the interview consisted of both open and closed ended questions, which included specific demographic information, and personal responses from participants, which were reflected in the data. Each interview was recorded using an audio recording device to ensure accurate documentation of the interview was obtained. The interview itself was semi-structured to allow for the same questions to be included in each interview but allowed for probing questions to provide opportunities for each participant to more clearly answer a question if needed (Monette et al., 2014).

The qualitative interview included questions that were aimed at gathering information pertaining to social workers understanding and perception of spiritual care in the hospital setting (Appendix D). The initial questions were specifically intended to collect demographic information on each of the participants such as their gender, level of education, age, religious affiliation, and years of professional experience. The questions that followed assessed each participant's use of spiritual assessments in their work with patients, the source of their comfort level providing this type of patient care, their professional level of competency in this area and the source of that competency, as well as their opinion of the role of social work in providing spiritual care. Finally, there were questions looking specifically at each of their professional theoretical orientations and how this orientation was reflected in their approach to spiritual care of patients in the medical setting. The content of the questions were composed specifically to gain information that was relevant to themes enclosed within the literature review to assist in collecting applicable data.

Data Analysis

The data that was gathered from the qualitative interview was analyzed using a content analysis method as a means to interpret the content of the interviews into quantitative data for further examination (Monette et al., 2014). The qualitative content was assessed during the detailed transcript evaluation of each interview once by the researcher and once by the research assistant to highlight common themes found by both readers. The prominent common themes within the interviews were discussed and agreed upon by both the researcher and the research assistant prior to being used as the coding system for this research project. The researcher and research assistant attempted to develop coding themes, which are both exhaustive for pertinent content and mutually exclusive for specific definitions of content (Monette et al., 2014).

The level of measurement used to measure each variable was frequency counts, which specifically measured how often a variable was present within the interviews (Monette et al., 2014). The frequency counts were based on the examination of each of the interviews to determine which themes were occurring at an increased occurrence to warrant being included as a theme. This type of level of measurement was also utilized during the cross-checking of coding schemes that were conducted by a research assistant to increase the reliability of the coding system.

The coding was open and not limited to existing coding schemes due to the data that was driving this research project being based on grounded theory. The data gathered from this research evolved from the themes that materialized during the collection of the data, the data analysis, and coding process and work to contribute to the development of the research theory (Monette et al., 2014).

Validity and Reliability of Data

The validity of the data gathered from this research was based on whether the themes and codes we designated as part of the content analysis were successful in assessing what we aimed to measure with this study (Monette et al., 2014). To strengthen the validity of this project, the use of content validity assisted in determining whether the measurement tool utilized in this study adequately provided data that is representative of the elements that were being studied (Monette et al., 2014).

The reliability of the measures used within this research study was dependent on whether consistent outcomes were being found each time the data is analyzed (Monette et al., 2014). To increase the reliability of the data gathered for this research, the use of cross-checking the coding data by a research assistant further strengthened the reliability of the data collected.

Strengths and Limitations of Study

A strength of this study was the potential for the data gathered to further support future discussions and examinations of the relationship between social work and a patient/client's spirituality. The examination of this relationship is present within the services that professionals provide in not only the medical setting but in other settings where JCAHO has defined spirituality as a patient care expectation. Additionally, by providing data looking specifically at the educational and professional competency that social workers identified in this area of service, the results have the potential to encourage further discussions and research examining the current educational and professional offerings that support skill development in this area.

A limitation of this study was the organization of the sample of participants being not entirely random but rather a result of geographical convenience for the researcher

based on the contact information provided by the State of Minnesota Board of Social Workers. This was a limitation because this sample is not a representation of the entire population that was being researched. In addition, the small sample size also limited the study's ability to yield data that was a strong representation of the entire population of social workers being researched. Finally, my professional experience in the medical field had the potential to contribute an element of bias based on the patient interactions I have had focused on the topic of spirituality, however there were reliability and validity measures in place which attempted to limit the influence of any biases on the analyzed results.

Findings

The present section will provide demographic information about the participants in addition to the overall findings of the research study. There were six themes present within the interviews conducted with medical social workers. The six themes present within this study included: (a) Assessing Religion Versus Values, (b) Presence of a Spiritual Assessment, (c) Social Workers Comfort with Spirituality, (d) Social Workers Expectation to Assess Patient's Spirituality, (e) Education and Training, and (f) Role of Chaplains and Clergy. Throughout this section the identity of the participants will be referenced using an assigned letter including A, B, C, D, E, F, G, and H. There were 8 individuals interviewed for this study, all of which identified as Master level social workers with professional experience in the medical setting. During the interviews with these eight participants, six participants identified holding the licensure level of LICSW and two identified holding the licensure level of LGSW. The participants all identified their gender as female and ranged in age from 33 years old to 74 years old. The

professional setting of each of the participants ranged from inpatient to outpatient medical facilities and the patient demographics whom the social workers provided services for included: a) veterans, b) hospice patients, c) mental health patients, d) pediatric patients and their families, e) anti-partum and post-partum mothers, f) Emergency Department patients, and g) community hospital services. The research participant's years of professional social work practice ranged from 2 years to 50 years. Each of the six research themes will be thoroughly discussed in the following sections.

Assessing Faith Versus Values

The first theme that was present within the findings of this study is 'assessing religion versus values.' This theme focuses on how the approach to assessing a patient's spirituality can differ based on whether one uses language of religion versus faith and values. Many of the participants utilize language that is reflective of values and faith instead of religion when addressing this topic with patients. The reasons for this varied from wanting to approach the topic from a context which may be considered more comfortable for patients, a result of the social workers own comfort with the topic, as well as the professional usefulness of the information tending to be of a more cultural or values nature. Participant B stated, "I sort of ask kind of non-religious questions to get at more spiritual answer. Sometimes that is useful and sometimes they see right through me and they say move on." Participant D shared in reference to their spiritual assessment, "a lot of that really focuses on what their cultural belief um more so for it is a about cultural. I don't do so much directly with you know with religious other than I umm I defer that a lot to our chaplains." Participant D also included, "So to get a feel of what is their belief

in kind of the medical care they are getting umm what are their you know spiritual or cultural beliefs in regards to [their] baby.”

It appeared from the interviews that the use of language that specifically spoke to the nature of culture and values was considered to be beneficial within the social work assessment of needs of patients in the medical setting. Participant E shared how the gaining of this type of information is valuable to their work with patients and families stating:

I think mostly I feel like that has led me to understand more about the cultural difference around spiritual beliefs. We have lots of families that come here from other cultural backgrounds so we will assess some of the spiritual beliefs that impact their medical decision making.

The importance of using language that supports whatever faith or value system a patient has was further supported through the professional experience of Participant F who stated:

I have also had a number of atheist clients who by the question alone start to get offended, “well why do you think I have to have a religion,” and it’s helping educate people too that looking at faith and looking at values doesn’t necessarily mean organized religion.

Participant F also shared:

I think it is important when I, I find when I assess religion or spirituality that we are really looking at both do they have an identified religion or religious practice but also just in general faith and values umm being able to assess all of that cause

a lot of folks have a value system and a faith that they follow but aren't technically what they would define as religious.

It appeared from the interviews that the language a social worker uses to investigate this aspect of a patient life is relevant to not only the information that is obtained but also the comfort that one might feel sharing the information with a social work professional.

Presence of a Spiritual Assessment

This theme looked at whether or not the social workers incorporated a spiritual assessment into the scope of services they provided patients in the medical setting. The interview questions focused on whether the participants assessed their patient's spirituality, specific details regarding how they assessed this aspect of patient care, and whether their assessment was structured or unstructured. The majority of the participants stated that either they do not incorporate a spiritual assessment into their practice or do not perform it consistently. The nature of what is considered a spiritual assessment varied from participants in regards to the information that was gathered and content of the questions used. Participant E stated, "we typically don't go a lot into this spiritual care portion only because we have our chaplains that do most of that work." Participant H agreed with this stating, "you know the assessment when I was looking at this question I was thinking you know I don't really do an assessment." The presence of diverse types of spiritual assessments was further reinforced by Participant A with the following statement:

Well, its, I am going to be real upfront with you that it is not great. But what it is a lot of time during the interview portion we will ask the person if there anybody

we can call for you, do you have a minister or would you like us to make contact with the person that is on call at the hospital? And half the time a lot of the clinicians don't even do that but it is even on our template when we interview people "what is your faith," "would you like us to call somebody," so we are directed to do it...it just does not always get done if we are feeling like it is not an issue.

The content of the questions that are asked were found to vary among the social workers when assessing for spiritual beliefs with the patients they were serving. Participant C stated, "And so I ask if you have a church you are affiliated with um do you want us to contact your church?" Participant B shared this when asked what a spiritual assessment looked like in her practice:

Well that would be easy, it is not much of one, I know other, like mental health therapists and nursing do some screening and intake they will ask if they have any religious affiliation and spiritual support and I usually tend to read that and then probe a little more.

However, there were a few participants who endorsed actively assessing for spirituality in their patient population. Participant F shared, "part of the general psychosocial assessment umm required by DHS, you ask about belief systems." Participant G who followed a structured format and completed a psychosocial assessment with a team of providers stated:

You would ask for spiritual identity how they, if they had any spiritual or religious affiliation, if they were connected to umm a place of worship, umm if

they felt like they had any desire or need for services in that area and then umm, that would often be something that I would then allow the chaplain to take over.

Overall, it appeared from the participants responses that there was a lack of consistency in not only the presence of a spiritual assessment within their practice but also in the content of the assessment itself, which resulted in fairly significant range in the overall assessment of this patient demographic.

Social Workers Comfort with Spirituality

This theme focused on what personal and/or professional experiences influenced the participants' comfort regarding patient's spirituality. Specifically, whether the participants' comfort was based on their personal beliefs, professional experience, professional education, a lack of competence in this area, or a lack of skills in facilitating discussions related to a patients' spirituality. For many of the participants, their comfort with patient's spirituality stemmed from their professional experience, however there was also a significant amount of comfort that was brought to participants based on their own personal beliefs. For some participants like Participant G there was a combination of both professional and personal contributions to their comfort surrounding a patient's spirituality, they shared: "I think a lot of the comfort comes from initially personal beliefs, and then certainly after working for awhile the professional experience plays more of a role." Participant H also felt that it was a combination of personal beliefs and professional experience that contributed to her comfort level with patients' spirituality stating, "certainly my personal beliefs Sarah is an important one, umm its my professional experience here in the sense of people who have lived a long life umm even if there has been no say formal religious background they somehow frequently believe in

a higher power.” Participant F shared how their own personal beliefs support their comfort in addressing patients’ spirituality by stating:

It is all about helping an individuals do that search for truth and meaning that there is no specific right answer and it is about the search, it is about finding wisdom and values through multiple sources and I think that personal value of mine helps with the professional.

Participant F included how personal beliefs can be a challenge in supporting patients’ spirituality by reporting: “I have had colleagues before who personal values structures were more rigid and they would talk about how they found it challenging then to work with people whose values were so very different from theirs.” In regards to the relationship between one’s own comfort based on personal beliefs and a patient’s spiritual beliefs Participant A stated:

I learned through the years that um respecting one’s spirituality and suggesting to them that they go to their spiritual backup for support is probably one of the most effective resources I can offer people um so there is that and I also know that with myself that I have found at times my faith has been very comforting to me better than sometimes even a therapist and I am not, I don’t know what I am, I do not even know what faith I practice but I am just happy when I hear someone has a belief system because I always figure that is probably half the battle for them when it comes to, well at least we have somebody who can help work with them and someone they trust and believe in.

In regards to the role that professional experience plays in a social worker's level of comfort with a patient's spirituality Participant E shared:

I think mostly I feel like that has led me to understand more about the cultural differences around spiritual beliefs. We have lots of families that come here from other cultural backgrounds so we will assess some of the spiritual beliefs that impact their medical decision making.

The presence of one's own comfort level surrounding the topic of patient's spirituality can be directly related to one's own background and experiences, which can impact one's confidence and competence level in this area. This experience was shared by Participant D stating:

You know I think it is just so it is just so touchy and I feel like umm I was never given, you I grew up, I am young, Caucasian, and I grew up in a very white area, western Minnesota and it is rural and so growing up I did not have a lot of diversity just religion/spirituality wise.

Participant D also shared how this is related to her professional experience when she said:

So having that exposure to dealing with other cultures and spirituality beliefs and religions is hard and then come and be working in the cities, specifically with this population where it is becoming more and more current like I really have to get in touch with that so the competence/confidence I have not totally felt comfortable.

It is evident that one's own comfort with the topic of a patient's spirituality can stem from varied areas of one's life both personally and professionally. It appears from the

participants' responses that comfort in this area of patient care is potentially an ongoing process of development throughout one's life and career.

Social Workers Expectation to Assess Patient's Spirituality

This theme examined participants' feelings regarding whether it was a professional expectation of medical social workers to assess patients' spiritual and religious beliefs. The interview question outlined the purpose of this assessment being related to examining the patients' coping mechanisms and/or support system. The majority of the participants agreed that assessing for patients' religious and spiritual beliefs was a professional expectation for social workers in the medical setting as part of their professional assessment. Participant D shared her agreement with this professional expectation stating:

I should at least be able to have a basic assessment tool or understanding of saying ok this person, these are their beliefs and umm how can we work with them on that in regards to their treatment plan or things like that.

Participant D reflected on how this was directly related to the services she provides by sharing:

I think it is important to have an understanding because how can a social worker advocate for patients if we aren't understanding things like this is why they are refusing something because it is a huge piece of their spirituality and culture....

The need for assessing these beliefs for patients for the sake of determining what support systems are available was also shared by Participant E:

In the sense that it is important to identify and assess something that is a support to them so if there is a situation in which they need further support you talk with them about how they can get a hold or access those support people or systems.

Participants reinforced the need for this type of assessment especially because of the potential for additional support being available for patients who consider this an important aspect of their lives. Participant B agreed by stating, "I think it is an important part of many people's lives." The nature of the assessment having the potential to provide valuable information related to the emotional and physical health of patients is important, suggested by Participant G when they stated:

I think it is a responsibility if you are doing a thorough psychosocial assessment...I think it is a part of a thorough psychosocial assessment because spirituality is part of you what makes up the person and it does impact their spiritual, sorry, the spiritual beliefs will impact their emotional health and their physical health.

In addition to the support that may be available to patients by assessing for religious and spiritual beliefs, a participant also shared the importance of this assessment from professional position. Participant F stated that it is an expectation of social workers to assess these needs "from an ethical standpoint and an accreditation standpoint." It was apparent from the majority of the responses that the participants felt it was a professional expectation of social workers to assess the religious and spiritual needs of patients. Specifically, this type of assessment was considered to be critical due to the supportive role the social workers may play in the patient's life, as well as the value of a thorough assessment, in addition to the ethical obligation of the social work profession.

Education and Training

The role of education and training in the area of spiritual care was investigated to determine how prepared social workers were to competently assess and provide services to patients based on the education and training they had received both professionally and through formal education. The participants' responses indicated a remarkably consistent theme supporting a lack of professional and educational training in the area of religion and spirituality. In addition, their training did not provide the knowledge and experience desired or needed to provide these services in their professional role. Participant B reflected on whether their education and training provided them with the knowledge to assess and provide these services stating, "I would have to say no, I do not remember anything in school on religion. I do not remember any special training ever in any place I have ever worked about religious assessments, spiritual assessments." Participant A agreed by sharing, "Oh not at all. Nothing was mentioned and I do not think anything in my internships either." This was also supported by a response by Participant D who stated:

Not really....I kind of felt like my years of graduate school it was more like these are your different cultures but it didn't really dig into like working with them more in-depth umm....I did not feel like that was pushed in any of the education classes I took.

When asked whether their professional and educational training provided them with the experience and knowledge to competently assess and meet the spiritual and religious needs of patients, three participants responded "no." Participant F generally felt despite

not receiving any specific education and training in the area of religion or spirituality, they could rely on the fundamentals of social work practice stating:

You know the grounding, core principles in social work of meeting the client where they are at and all the umm courses on looking at diversity in general and when there is diversity between therapies and client. I think all of those really helped but a lot of times they weren't specifically naming in regards to religion or values but the concepts all translate nicely.

Overall, it was apparent from the responses of the participants that their professional and educational training did not provide them with the preparation needed in order to approach spiritual and religious assessments and needs of patients with the skills and knowledge that was warranted for this specific type of service.

Roles of Chaplains and Clergy

The final theme focused on the relationship between social workers and chaplains and/or clergy in working to address patients' spiritual and religious needs in the medical setting. This theme was relevant in the participants' responses both within the context of referrals to these professionals as well as an expectation that services related to a patient's spirituality and religion beliefs would be provided by clergy and chaplains and in fact not social work staff. When discussing spiritual assessments Participant G stated:

...psychosocially the spiritual/religious at least in my experience there has always been chaplains, so there is someone there who is there to specifically deal with people's spiritual and religious roles so I don't think it would be my role as a social worker to thoroughly investigate.

Participant C shared that during their assessment of a patient's spirituality the role of the chaplain is prevalent. Participant C reported:

And so I ask if you have a church you are affiliated with umm du you want us to contact your church? Do would you like your pastor or priests to make visits, would you like us to send a letter so they can do a spiritual assessment and let our pastor umm hospice chaplain know? We ask if they would like hospice chaplain visits?

The referral to chaplains for spiritual and religious needs of patients was also supported by Participant E who shared, "We don't have a structured evaluation for that, the chaplains have more of a structure around that, we do have standard questions I think in our assessment that feel out their spiritual supports in general." For one participant the spiritual assessment question she uses directly focuses on the role of a chaplain or clergy member to provide spiritual support. Participant A stated, "it is one question and um it is would you like us to bring in a spiritual advisor for you or do you have somebody that you would like to have help you at this point." The role of the chaplain can be relied on by social work staff to not only assess for those needs but have the skills to address them as stated by Participant D:

I rely a lot on the chaplains to really dig into that.....We have a chaplain that devotes just to the birth center umm so they have a lot of knowledge with women, pregnancy, and all of that stress so they take more of the you know when it comes to if they are Catholic or if they are Lutheran so those things.

The role of chaplains and clergy in providing services, which aim to support spiritual and religious beliefs of patients, appears to vary among the participants. This was evident in responses questioning the capacity for social workers to assess and provide services to meet these needs and whether this is only a patient care area for chaplains and clergy to attend to.

The research findings that were gathered through the interviews with eight participants shared insight into the complex areas of assessing and providing patient care related to religion and spirituality. As a result of these interviews, there were a total of six themes that were recognized within the data gathered. The six themes presented within this study included: (a) Assessing Religion Versus Values, (b) Presence of a Spiritual Assessment, (c) Social Workers Comfort with Spirituality, (d) Social Workers Expectation to Assess Patient's Spirituality, (e) Education and Training, and (f) Role of Chaplains and Clergy. Within the following section, the researcher will explore how the themes collected within this study are relevant to the current literature investigating medical social workers understanding of spiritual care in addition to the strengths and limitations of this research study, as well as look at the implications for future research, social work practice and policy.

Discussion

This study aimed to investigate medical social workers' understanding of spirituality in providing patient care in the medical setting. Specifically, the research question examined the professional and personal attributes that may be influencing the presence of services addressing this aspect of patient care. The research looked to assess

whether this need is being assessed, in what capacity, and the role of social work in providing these services. This research topic was explored through conducting eight qualitative interviews with social workers with professional experience in a medical setting. The following sections will assess the relationship between the findings of this research study and the current literature related to this topic, as well as discuss the strengths and limitations of this study, possible implications for future research, social policy, and social work practice.

Relationship to Current Literature

Lack of education and training. This section aims to examine the similarities and differences between the data that was gathered from this study and the current literature related to this topic. The theme related to lack of education and training in assessing and providing spiritual care to patients in the medical setting was found to be significantly pertinent both to the data that was gathered in the study as well as within the current literature. Despite the requirements by both the NASW Code of Ethics and the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) to address and implement the spiritual assessment of clients, there is still concern regarding the lack of training that social workers have received in the area of spiritual competency (Hodge & Bushfield, 2006). The majority of the social workers interviewed for this study indicated that the education and training they received did not address assessing or providing spiritual care in the medical setting and ultimately did not prepare them for providing this type of support in their professional practice. There was reference made by the participants regarding the education they received related to the core principles of social work being helpful in meeting the client where they are and working with diverse

populations. However, there were very few educational opportunities addressing spirituality or religion to prepare students and professionals for this aspect of social work services. One study found that social workers focused their definition of spirituality when working with clients using the social work values, specifically applying “starting where the client is,” especially since there was not a clear definition of this topic that met the needs of every patient (Barker & Floersch, 2010). This could be related to the current challenge in how the social work profession defines spirituality, which can leave uncertainty both within the profession as well as the area of social work education in how to implement its presence (Senreich, 2013). However, due to current literature indicating the presence of social workers applying the spiritual beliefs of clients they are working with into their therapeutic services despite having not received educational training related to this aspect of client services (Senreich, 2013), there continues to be a need to address this discrepancy in the education and training provided to students and professionals related to the topic of spirituality and religion.

Assessment of spiritual beliefs. A culturally competent practice has been considered to incorporate the appreciation and comprehension of the impact of an individual’s faith and spiritual belief (Gilligan & Furness, 2006). Despite the potential value of assessing for this patient need, the majority of the participants indicated they either do not incorporate a spiritual assessment into their practice or do so inconsistently. There were participants questioning whether assessing for spirituality was in fact part of the social work role, which is also found in the current literature to be debatable with significant questions of whether addressing a client’s spiritual or religious needs went beyond the scope of professional practice in social work (Sheridan et al., 1994).

However, a revision to the Code of Social Work Ethics included the expectation that social workers have a respect of their clients' religious beliefs in their responsibilities as a profession and the services they provide (National Association of Social Workers, 2008). There was significant variability in both the presence of a spiritual assessment and the content of the assessment among the participants in this study. JCAHO implemented requirements in 2001 indicating that a spiritual assessment at a minimum should assess for a patient's denomination of faith, spiritual beliefs that are considered to be significant to the patient, and spiritual practices that are part of the patient's life (Hodge, 2006). The findings of this study indicated that among the participants there is a lack of consistency regarding both the presence of a spiritual assessment as well as the information that is gathered despite the support and requirements specified by professional organizations indicating that not only is this valuable but it is an expectation for social workers.

Professional expectations related to spiritual care. The findings of this study found that they majority of the participants felt it was a professional expectation for social workers to asses for patients' spiritual and religious beliefs in the medical setting. The importance of this assessment to participants was related to the social workers' need to advocate for their patients as well as understand what support systems are in place for the individuals they work with. It was also felt that a thorough assessment included a spiritual component, which is related to the current literature regarding spiritual competence stating this professional competence is grounded in the ability to comprehend how a patient's spirituality and/or religion is contributing to their development and current functioning (Callahan, 2015). Additionally, the lack of religious affiliation that is represented by social workers further assists in alleviating any

vulnerability a patient may feel in addressing their spiritual beliefs or asking questions regarding spirituality in the medical setting (Stewart, 2014). It is evident that both the participants of the study and the current literature support the need for spiritual/religious needs of patients to be assessed, especially because it has been found the act of a social worker inquiring about a patient's faith can have the potential to provide therapeutic value in and of itself due to the caring interaction it initiates between the patient and social worker (Larocca-Pitts, 2008).

Role of chaplains and clergy. The findings of this study captured a theme that was not found to be as present in the current literature, which was the social worker's view regarding the role of chaplains and clergy in providing spiritual care in the medical setting. The participants in the study indicated that it is often considered to be a responsibility of chaplains and clergy to thoroughly assess and provide needed spiritual care for patients. Further, it was an area of uncertainty for many participants whether a patient's spirituality was considered to be a professional area in which a social worker was expected to be actively engaged in. In contrast, the current literature suggests there is a need for clarification regarding the role of social work in the assessment and services related to spirituality and supports the need and expectation for social workers to be directly involved in assessing for this patient care need. Further, the National Association of Social Workers Standards for Cultural Competence in Social Work Practice state social workers have the capacity to use cross-cultural skills to support their understanding of the role of culture in the helping process, which includes spiritual beliefs (NASW Standards of Cultural Competence in Social Work Practice, 2001).

It was apparent within this section that there were similarities in the data produced by this research project and the current literature regarding this topic. The similarities were present in the themes of a lack of education and training as well as the professional expectation to assess patient's spirituality. The disparities between the participant data and the current literature were present in the themes regarding lack of consistency and presence of spiritual assessments and the role of clergy and chaplains. Overall, the findings of this study and current literature both supported the importance of this topic further being explored for clarification and examination of professional expectations and responsibilities.

Strengths and Limitations of the Study

There were several strengths found within this study. The first strength is the potential for the data gathered to further support future discussions and examinations of the relationship between social work and a patient's/client's spirituality. The examination of this relationship is present within the services that professionals provide in not only the medical setting but in other settings where JCAHO has defined spirituality as a patient care expectation. This study provided data looking specifically at: a) medical social workers' perceptions of their educational and professional competency related to spiritual care, b) assessing faith versus values, c) the use of spiritual assessments, d) social workers' comfort with spirituality, e) a professional expectation to assess patients' spirituality, and f) the role of chaplains and clergy in relationship to patient's spiritual care. Another strength of this study is present in the valuable professional experiences that were shared by the participants of the study citing specific areas in need of further development, personal insight into the topic of spiritual care and the vital individual and

environmental considerations that must be taken into consideration regarding this aspect of patient care. As a result of the experiences shared by the participants the information that was gathered has the potential to encourage further discussions and research examining the current educational and professional offerings that support skill development in this area.

There were also limitations present in this study. One such limitation of this study was that the sample of participants was not entirely random, but rather a result of geographical convenience for the researcher based on the contact information provided by the State of Minnesota Board of Social Workers. This was a limitation because this sample is not a representation of the entire population that was being researched. In addition, the small sample size also limited the study's ability to gather data that was a strong representation of the entire population of social workers being researched. Additionally, the variety of work settings that were represented by the sample resulted in fairly variable professional expectations and services provided by social workers in their medical setting. This was considered a limitation due to the diversity related to job requirements, patient interactions, and types of assessments completed and the difficulty in being able to distinguish how relatable these findings were to the entire population of medical social workers. Finally, my professional experience in the medical field had the potential to contribute an element of bias based on the patient interactions I have had focused on the topic of spirituality. However, there were reliability and validity measures in place, which attempted to limit the influence of any biases on the analyzed results.

Implications for Social Work Practice

The information that was gathered from this study has many potential implications for social work practice. The theme of lack of professional education and training pertaining to spiritual assessment and care was present throughout the data provided by participants as well as in the current literature. This represents an area in need of further attention and investigation to address the deficit in the education and training we provide social work students and professionals to deliver competent services in this area. The need for additional education appears to be on multiple levels both within the context of assessments as well as how to approach spiritual care for patients in the medical setting. As a result of this study, the researcher suggests an increase in education both on a student and professional level. This would be addressed both within the course work requirements of students, their field placements, and professional supervision. The valuable role of clinical supervision for new professionals may assist in addressing any lack of training or education in the area of spiritual care to work towards increasing their spiritual competence as professional social workers. Finally, the incorporation of education related to the role of spirituality and religion within the biopsychosocial perspective that often is used to approach mental and physical health would communicate the importance this aspect of one's life in the sense of meaning as well as in support and coping mechanisms.

Additionally, the need for consistency and awareness of the role of social work in the spiritual care of patients needs to be clarified. Both within the current literature and participant interviews it was evident that there continues to be a lack of consistency regarding the role of social workers in assessing and providing spiritual care in the medical setting. It is this researcher's suggestion that this issue concerning professional

service expectations be addressed both from a professional organizational level as well as an educational level. The students and professionals in the field of social work desire that an organizational position be established to allow for a unified approach to the provision of service related to spirituality and religion.

Implications for Policy

The research gained from this study has possible implications for social policy both at the macro and mezzo level. At the mezzo level, the data gathered has the potential to promote further discussions and progress on the future of social work education and professional expectations. These discussions need to occur at an organizational level to produce the results and direction needed to support the current discrepancy present among the social work community who participated in this study. This discrepancy was related to the participant's education and training in spiritual care as well as their role in providing services to patients related to this area. Specifically, a consensus would have to be built regarding the role of social work in assessing and providing spiritual care. The result of this consensus would assist in determining the course of action related to increasing educational opportunities both for social work students on an undergraduate and graduate level as well as professional social workers in the field. The mezzo level policy change would have to be based on the future directions of the social work profession determined both by the National Association of Social Workers as well as accredited schools who support social work education programs.

The social work policy implications that could result from this research are closely related to the development of policies directly related to additional requirements supported by health care organizations to address spiritual and religious needs of medical

patients. Despite recent policy implementations by JCAHO related to the expectation that these patient beliefs are being assessed; it is evident from the participants of this study that there continues to be uncertainty regarding these expectations which has resulted in a lack of consistent service related to the area of spiritual assessments and care. A macro policy change from health care legislation would assist in further supporting the importance of including this aspect of individuals' beliefs in their medical care. This legislation would also provide direction related to a standardized spiritual assessment tool, which could be easily implemented into a variety of medical institutions to ensure that each patient was provided with the same opportunity to have their spiritual beliefs assessed. This type of policy change would not only support the health care organizations in working to assess the individual needs of each of their patients but also support the growing cultural diversity of the American population.

Implications for Future Research

The implications for future research largely focus on the role of spirituality and religious beliefs and their relationship to the medical environment, specifically related to patient care experiences. Although there has been growing research on this topic recently, there continues to only be limited information on how incorporating a patient's faith and spirituality into their medical care experience has any influence on them emotionally, physically, or psychologically. An increase in research supporting the importance of including spirituality into one's medical care has the potential to further expand awareness and a desire to implement it into professional practice. The research that is needed stems both from qualitative and quantitative data. The qualitative research would need to examine specifically a patient's individual experiences and the effect of

spirituality and religion on those experiences to determine if there was either a positive, negative, or lack of influence based on the patient's perspective. The quantitative research would investigate the physiological and psychological patient outcomes and whether the variable of including spiritual assessment and care contributed to patient medical outcomes (length of hospitalization, pain medication, mental health, health care decisions, acceptance and coping). The data gathered from these types of research studies have the potential to encourage further discussions and progress on the area of spirituality in the medical setting.

In conclusion, the findings of this study showed many similarities to the current literature related to social workers' understanding of spiritual care in the medical setting. However, there were also areas based on participant data as well as current literature, which revealed a need for further research and practice consideration to increase awareness of this topic both in a professional and educational social work context. The data gathered from the personal and professional experiences of each of the eight participants support valuable implications for social work practice, policy and future research. The area of spiritual assessment and care in the medical setting continues to warrant further research to ensure the diverse and personal beliefs of each patient are not only assessed but respected as potential partner in their healing.

References

- Barker, S. L., & Floersch, J. E. (2010). Practitioners' understandings of spirituality: Implications for Social Work Education. *Journal of Social Work Education, 46*(3), 357-370. doi: 10.5175/JSWE.2010.200900033
- Bertalanffy, L. (1969). *General system theory*. New York: George Braziller.
- Callahan, A. M. (2015). Key concepts in spiritual care for hospice social workers: How an interdisciplinary perspective can inform spiritual competence. *Journal of the North American Association of Christians in Social Work, 42*(1), 43-62.
Retrieved from <http://stthomas.summon.serialssolutions.com>
- Friedman, B. D., & Allen, K. N. (2014). Systems theory. In J. R. Brandell, *Essentials of Clinical Social Work* (pp. 3-20). Sage Publications, Inc.
- Furman, L. D., Benson, P. W., Grimwood, C., & Canda, E. (2004). Religion and spirituality in social work education and direct practice at the millennium: A survey of UK social workers. *British Journal of Social Work, 34*(6), 767-792.
doi: 10.1093/bjsw/bch101
- Gilligan, P., & Furness, S. (2006). The role of religion and spirituality in social work practice: Views and experiences of social workers and students. *British Journal of Social Work, 36*, 617-637. doi: 10.1093/bjsw/bch252
- Heydt, M. J., & Sherman, N. E. (2005). Conscious use of self: Tuning the instrument of social work practice with cultural competence. *Journal of Baccalaureate Social Work, 10*(2), 25-40.

- Hodge, D. R. (2004). Spiritual and people with mental illness: Developing spiritual competency in assessment and intervention. *Families in Society, 85*(1), 36-44.
doi: 10.1606/1044-3894.257
- Hodge, D. R. (2006). Template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. *Social Work, 51*(4), 317-326.
doi: 10.1093/sw/51.4.317
- Hodge, D. R., & Bushfield, S. (2006). Developing spiritual competence in practice. *Journal of Ethnic & Cultural Diversity in Social Work, 15*(3/4), 101-127.
doi: 10.1300/J051v15n03_05
- Hodge, D. R., & Horvath, V. E. (2011). Spiritual needs in health care settings: A qualitative meta-synthesis of clients' perspectives. *National Association of Social Workers, 306*-316. doi: 10.1093/sw/56.4.306
- Hodge, D. R., Baughman, L. M., & Cummings, J. A. (2006). Moving toward spiritual competency: Deconstructing religious stereotypes and spiritual prejudices in social work literature. *Journal of Social Service Research, 32*(4), 211-231. doi: 10.1300/J079v32n04_12
- Hutchison, E. D. (2013). Social work education: Human behavior and social environment. *Encyclopedia of Social Work*. National Association of Social Work and Oxford University Press, Inc.
doi: 10.1093/acrefore/9780199975839.013.616
- Kondrat, M. E. (2013). Person-in-environment. *Encyclopedia of Social Work*. National Association of Social Work and Oxford University Press, Inc.
doi: 10.1093/acrefore/9780199975839.013.285

Larocca-Pitts, M. A. (2008). FACT: Taking a spiritual history in a clinical setting. *Journal of Health Care Chaplaincy, 15*, 1-12.

doi: 10.1080/08854720802698350

Lennon-Dearing, R., Florence, J. A., Halvorson, H., & Pollard, J. T. (2012). An interprofessional educational approach to teaching spiritual assessment. *Journal of Health Care Chaplaincy, 18*, 121-132.

doi: 10.1080/08854726.2012.720546

Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, Seventh Edition. (2015). Retrieved from <http://medical-dictionary.thefreedictionary.com/spiritual+care>

Monette, D. R., Sullivan, T. J., Dejong, C. R., & Hilton, T. P. (2014). *Applied Social Research: A Tool for the Human Services*. Belmont, CA: Brooks/Cole, Cengage Learning.

National Association of Social Workers. (2001). *NASW Standards for Cultural Competence in Social Work Practice*. Retrieved from <http://www.socialworkers.org>

National Association of Social Workers. (2008). *Code of Ethics*. Retrieved from National Association of Social Workers: <http://www.socialworkers.org>

Pew Research Center: Religion and Public Life. (2015 May 12). *America's Changing Religious Landscape*. Retrieved from <http://www.perforum.org>

Puchalski, C. (2001). *The role of spirituality in health care*. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305900/>

- Puchalski, C. M., Ferrell, B., Otis-Green, S., & Handzo, G. (2015 June). *Overview of Spirituality in Palliative Care*. Retrieved from UpToDate:
<http://www.uptodate.com>
- Senreich, E. (2013). An inclusive definition of spirituality for social work education and practice. *Journal of Social Work Education, 49*(4), 548-563. doi:
10.1080/10437797.2013.812460
- Sheridan, M. J., & Amato-von Hemert, K. (1999). The role of religion and spirituality in social work education and practice: A survey of student views and experiences. *Journal of Social Work Education, 35*(1), 125-141. Retrieved from
<http://www.jstor.org/stable/23043449>
- Sheridan, M. J., Wilmer, C. M., & Atcheson, L. (1994). Inclusion of content on religion and spirituality in the social work curriculum: A study of faculty views. *Journal of Social Work Education, 30*(3), 363-376. Retrieved from
<http://www.jstor.org/stable/23042950>
- Stewart, M. (2014). Spiritual assessment: A patient-centered approach to oncology social work practice. *Social Work in Health Care, 53*(1), 59-73. doi:
10.1080/00981389.2013.834033
- Urdang, E. (2010). Awareness of self- A critical tool. *Social Work Education, 29*(5), 523-538. doi: 10.1080/02615470903164950

Appendix A

Email Correspondence For Potential Research Participants

My name is Sarah Huiskes and I am a graduate student in social work at St. Catherine University and the University of St. Thomas. I am conducting a research study under the supervision of Catherine L. Marrs Fuchsel, PHD, LICSW, LCSW, assessing social worker's understanding and opinions of spiritual care in the medical setting. Due to the recent increase in attention and requirements surrounding this aspect of patient care, my hope is to utilize this research to support the social work role in providing spiritual care in the medical setting as well as bring attention to barriers that may be present in addressing this professional topic.

I would like to invite you as a professional social worker to participate in this research study if your professional work currently is within a medical setting. Your involvement would consist of an approximately one hour face-to-face or phone interview, which will be decided based on what is most convenient and preferable for you.

Thank you for your time and consideration of participating in this research study. If you are interested in being a part of this research study or if you have any questions about the study itself, please contact me using the information included below. I look forward to hearing from you.

Sarah Huiskes

Contact Information:

Sarah Huiskes

Graduate Student of Social Work

St. Catherine University and the University of St. Thomas

Phone – xxx-xxx-xxxx

Email- xxxxxxxx@stthomas.edu

Appendix B

What are Medical Social Workers Understandings of Spirituality in Patient Care?

INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating what are medical social workers understandings of spirituality in patient care. This study is being conducted by a graduate social work student at St. Catherine University under the supervision of Catherine L. Marrs Fuchsel, PHD, LICSW, a faculty member in the School of Social Work. You were selected as a possible participant in this research because of your current position as a social worker in a medical setting. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to examine medical social worker's understanding of spiritual care in hospital settings. Approximately 8 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to engage in one semi-structured interview that will take approximately one hour to complete. The interview consists of 14 questions and will focus on the demographic information of the participants, professional views on spiritual care provided by social workers, and professional competence in the area of spirituality. The interview will be recorded to assist with future transcription of the data for analysis. The data gathered will also be cross-checked by a research assistance to ensure validity of analysis.

Risks and Benefits of being in the study:

The study has minimal risks and there are no direct benefits to you for participating in this research. In the event that the interview process causes any emotional distress to the you as the participant, due to the nature of the questions pertaining to a potentially delicate element of one's personal and professional identity, an informational document providing available resources for further support to address any distress that resulted from the interview will be provided to each participant. Additionally, the data gathered from this research has the potential to introduce new insight and information for further examination of this topic within the profession of social work.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results in a locked file cabinet in my home and only I and my advisor will have access to the records while I work on this project. The recordings of the interviews will be kept on a computer that is only accessible with a password on secure network. The transcriptions of the recordings will also be analyzed by a research assistant for the purpose of cross-checking the data analysis. The research assistant has signed a confidentiality agreement endorsing that the research material they have access to in their role will be kept confidential (Appendix C). I will finish analyzing the data by May 31, 2016. I will then destroy all original reports, recordings, and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

New Information:

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

If you have any questions, please feel free to contact Sarah Huiskes at xxx-xxx-xxxx or xxxxxxxx@stthomas.edu. You may ask questions now, or if you have any additional questions later, the faculty advisor, Catherine L. Marrs Fuchsel, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study.

I consent to participate in the study. I also agree and consent to the recording of the interview with the use of audiotaping for transcription purposes.

Signature of Participant

Date

Appendix C

Research Assistant/Translator Confidentiality Agreement

I am conducting a study examining medical social worker's understanding of spirituality in patient care.

This study is being conducted by: Sarah Huiskes, MA, St. Catherine University and University of St. Thomas.

Confidentiality Statement:

Confidential information includes all data, materials, products, technology, audiotapes, computer programs and electronic versions of files saved to portable storage devices.. No personally identifying information will be attached to the documents that are accessible to the research assistant. Any documents or electronic files produced by you will not include information that will make it possible to personally identify participants in any way. All questionnaires and translation documents are to be kept in a locked file. No one else will have access to the records. No one else will have access to the computer on which translation documents and electronic files will be prepared. All questionnaires and translation documents will be returned in their entirety to the researcher. Once translation documents have been completed and an electronic file compiled, you will contact the researcher who will personally collect them. Any and all electronic versions of transcripts will be deleted from your files upon delivery of records to the researcher.

Contacts and Questions

My name is Sarah Huiskes. If you have questions, you may contact me at xxx-xxx-xxxx or xxxxxxxx@stthomas.edu. You may also contact the St. Catherine's University Institutional Review Board at 651-690-7739 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Agreement of Confidentiality:

I, _____, have read the above information and agree to confidentiality as stipulated above. I further agree not to disclose, publish or otherwise reveal any of the confidential information received from the researcher or interview participants.

Signature of Research Assistant

Date

Signature of Researcher

Date

Appendix D**Interview Questions**

Participants Age: _____ Participant Gender: _____

1. Licensure Level:
 - a. LGSW
 - b. LICSW
2. Years of Professional Experience: _____
3. Current patient population you work with and services you provide:

4. Can you describe what a spiritual assessment looks like in your practice?
5. Do you follow a structured spiritual assessment format? _____
6. Is your comfort surrounding a patient's spirituality based on (mark all that apply)?
 - a. Personal beliefs
 - b. Professional experience
 - c. Professional education
 - d. Lack of competence in this area
 - e. Lack of skills in facilitating these discussion
7. In your experience, do you find that patient's you work with are interested and/or comfortable in discussing their religious and spiritual beliefs?

8. Do you feel that it is a professional expectation for social workers in the medical setting to assess each of their patient's spiritual and religious beliefs for the purpose of examining their coping mechanisms and support systems?

- a. Yes
 - b. No
9. Did your professional and educational training provide you with the experience and knowledge to competently assess and meet the spiritual and religious needs of patients?
- a. Yes
 - b. No
10. Can you describe your theoretical orientation to practice?
11. Can you describe the relationship between your theoretical orientation and spiritual care?
12. Participant Religious Affiliation (Check All That Apply):
- a. Christian
 - b. Buddhist
 - c. Jewish
 - d. Hindu
 - e. Islam
 - f. Agnostic
 - g. Atheist
 - h. Other
13. Does the medical institution you work for have a spiritual or religious affiliation?

Appendix E

State of Minnesota Community Resources

Information Provided By: The National Alliance on Mental Illness

www.namihelps.org

Metro Area Mental Health Crisis Response

Anoka: 763-755-3801

Carver/Scott: 952-442-7601

Dakota: 952-891-7171

Washington: 651-777-5222

Ramsey: adults - 651-266-7900, children - 651-774-7000

Hennepin: adults - 612-596-1223, children - 612-348-2233

Urgent Care for Adult Mental Health (Ramsey, Dakota and Washington counties)

402 University Ave. E., St. Paul - Walk-ins Welcome

651-266-7900, also is a 24/7 Mobile Crisis Team and Crisis Phone Line

Monday - Friday 8:00 a.m. to 9:00 p.m.

Saturday - Sunday 11:00 a.m. to 3:00 p.m.

National Suicide Prevention LifeLine -1-800-273-TALK (8255)

Mental Health Minnesota- www.mentalhealthmn.org

Warmlines- Open Tuesday-Saturday 4 PM to 10 PM

Metro: 651-288-0400

Toll Free: 877-404-3190

