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<u>Walden University</u>

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Ronald E. Davis

has been found to be complete and satisfactory in all respects,
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Walden University
2021

Abstract

Social Worker Perceptions of LGBT Cultural Competent Practice Within Hospitals

by

Ronald E. Davis

MSW, University of Akron, 2004

BSW, Youngstown State University, 2003

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Social Work

Walden University

August 2021

Abstract

Social work cultural competence within a hospital setting has gained importance due to the various changes to how health care is delivered within the United States hospital system. Lesbian, Gay, Bisexual and Transgendered (LGBT) individuals seeking care have reported negative experiences and discrimination, adversely impacting their treatment in a hospital setting. Those experiences have resulted in decreased use of medical treatment. Researchers have established the need for increased levels of cultural competence from social workers within hospital settings to develop rapport with LGBT individuals when delivering social work services as a part of the hospital treatment team. With cultural humility and cultural competence serving as conceptual frameworks, this study examined the relationship between social work perception of cultural competence and cultural humility in practice with LGBT individuals within a hospital setting. Data were collected using an individual interview setting. This qualitative study utilized data collected and analyzed from interviews with six social workers. The participants were recruited via various social media social work professional groups. Analysis of the data consisted of reviewing transcripts to the study to establish final themes for the study. A total of three themes for the study were identified, which included, lack of formal educational opportunity/preparedness, cultural humility as a preferred approach, and continual learning essential to social work practice. These findings provide insights for social workers working with LGBT individuals in hospital settings. The utilization of cultural humility, when combined with a client centered approach, can positively impact the social worker's cultural competence with LGBT individuals in a hospital setting.

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Dedication

This study is dedicated to the social workers working with hospital settings. May your work continue to be valued and contribute to successful patient outcomes. I would also like to thank musical artists Dave Matthews Band and The National for providing the soundtracks that helped me push through to continue writing when others may have stopped. Your musical works is inspiring and provided a great landscape to complete this project. Finally, I would like to thank my wife, Nadine, children, and countless friends and family that have pushed or cheered me on along this journey.

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Chapter 1: Introduction to the Study

Introduction

Hospital social workers serve traditionally marginalized individuals at their most vulnerable of circumstances on a regular nursing floor (RNF) (Boskey et al., 2019; Craig & Muskat, 2013; Fox, 2019). These patients present at the bedside with their own cultural traditions, beliefs, and value systems. Social work as a profession expects culturally competent practice to be provided to all individuals regardless of race, culture, sex, sexual orientation, or gender (NASW, 2017). Because of these characteristics, lesbian, gay, bisexual, transgendered (LGBT) individuals may be at risk of being subjected to treatment that does not include cultural competence or cultural humility in practice within a hospital setting. While issues in providing culturally competent care exist from medical professionals, there remains limited research on these issues as it pertains to social work practice within a hospital setting.

This project used a basic qualitative research design and explored how social workers describe their perceptions of cultural competence and cultural humility when providing services on an RNF in a hospital setting to the LGBT population. Individual interviews with social workers focused on exploring how social workers describe their perceptions of cultural competence and cultural humility when providing services on a RNF in a hospital setting to the LGBT population. Culturally appropriate care is defined in this study as interventions and practice methods that reflect cultural differences while meeting the specific needs of individuals seen through a lens that focuses on bio-psycho-social-spiritual factors.

In the following sections, the background for the study is presented, which identifies issues associated with LGBT accessing medical care. The problem statement then explores the lack of literature focusing on social work perceptions of cultural competence and cultural

humility in practice. The purpose of exploring how social workers describe their perceptions of cultural competence and cultural humility when providing services on a RNF in a hospital setting to the LGBT population is then discussed. Next, the research questions to guide the research study are presented. Then, the conceptual framework discusses how cultural competence and cultural humility guide the study. The nature of the study is then discussed. Definitions that are pertinent to the study are then outlined. Finally, assumptions, scope and delimitations, limitations, and significance of the study are discussed.

Background

LGBT individuals accessing medical services within a hospital report a higher incidence of depression, mental health issues, and report higher rates of suicide (Beder, 2003; Sandberg & Grant, 2017; Trepper et al., 2010). LGBT individuals report higher rates of suicidal thoughts, feelings of rejection, and lack of trust in medical service providers (Margolies & Brown, 2019). These LGBT individuals are less likely to return for medical services due to the feeling of rejection and lack of understanding from medical service providers (Margolies & Brown, 2019).

LGBT individuals report an inability to connect with and trust their care provider when seeking medical services. This disconnect often is due to a lack of empathy and understanding from healthcare providers when seeking out healthcare services and feeling unsure of whether the provider understands and accepts their LGBT identity when seeking health care services (Baker & Beagan, 2014; Kortes-Miller et al., 2018; Nolan et al., 2019). Lack of cultural humility from service providers reduces the quality of mental health services provided to LGBT individuals, dramatically decreasing individual motivation to seek mental health assistance (Lin, 2016). Standards of medical practices within a hospital setting and common knowledge of a cultural difference may not necessarily be communicated between a patient and health care

provider within their interaction, causing miscommunication between the two (Margolies & Brown, 2019). This lack of understanding, interest, and/or humility toward another person's perceived identity and culture can play a role in quality of care received within a medical setting. Thus, it prevents LGBT individuals from accessing services as well as continuing with potentially important follow up care after an initial visit (McCormick et al., 2018; Singh & Durso, 2017; Steele et al., 2016).

Social workers are called to serve marginalized populations, to which LGBT individuals belong. These patients bring their own traditions, beliefs, and values to the helping relationship, expecting that social service providers will fully respect them (Coolen, 2012). Because of LGBT patient specific vulnerabilities related to sexual orientation and gender, social workers often are called upon to act as their advocates or as sources of additional support while navigating the health care setting. While issues in the provision of culturally sensitive care within health care exist, there remains limited recent research on these problems and the perceptions of social workers called upon to provide culturally competent care. This presents a unique challenge in completing a relevant literature review but further affirms the appropriateness for this study as it adds to the current body of growing knowledge. Social work as a profession is one that is required to provide culturally competent care to all individuals regardless of individual characteristics (NASW, 2017). Eliciting perceptions of experiences in hospital practice from social workers may give an indication on the current use of cultural humility and cultural competence on an RNF in the hospital setting.

Problem Statement

The current literature discusses general hospital experiences of persons identified as heterosexual; however, it does not provide a clear discussion of experiences of social workers

providing culturally competent care to an LGBT individual. Additionally, the literature is limited in regard to the perceptions of experiences on cultural humility as a primary tool of use from social workers when providing care to LGBT individuals in a regular hospital setting, not attached to a specific diagnosis or illness.

Currently, limited attention is given to those identified as LGBT and how they are provided medical services (Bristowe et al., 2016). Additionally, limited research is available to show preparedness of medical social workers working within medical settings, as well as their experiences in providing medical services that is aligned to the cultural needs of the LGBT population. However, present research from social work students within an academic setting show that students presently rate their experiences of cultural competence from their social work education studies very high (Delavega et al., n.d.; Held et al., 2019; Nicholas et al., 2019; Toros, 2019).

Much of the current literature focuses on providing medical services by healthcare professionals to an LGBT individual within the medical setting seeking preventative care for a specific diagnosis (Bidell & Stepleman, 2017; Goldbach et al., 2018; Kortes-Miller et al., 2019). Various research shows that LGBT individuals have concerns that prevent them from using general medical care services due to factors such as increased levels of feeling discriminated in society, lack of authenticity and understanding of their lifestyle from a service provider, and loss of social support from family and/or friends (Nolan et al., 2019; Siegal & Hoefer, 1981).

Culturally competent practice within social work agencies for medical services of the LGBT population rests on the power and willingness of social workers to use humility and empathy towards understanding an LGBT individual's unique identity while providing needed services that are culturally aligned to the needs of the LGBT population (Thomas et al., 2009).

Research primarily has looked at the perceptions of the therapeutic relationship among nurses and physicians with the LGBT population in a hospital setting (Klein & Nakhai, 2016; Margolies & Brown, 2019). However, research on perceptions of LGBT competence and humility with social workers has primarily focused on students' perceptions of their educational experiences within an academic setting (Dessel et al., 2019; McCarty-Caplan, 2018a; Toros, 2019). Perceptions of LGBT competence and humility from social workers providing care within a hospital setting can help identify how current medical social workers approach and provide services to LGBT individuals and potentially identify gaps in culturally competent care to LGBT individuals across hospital settings.

Purpose of Study

The purpose of this study is to understand how social workers describe their perceptions of cultural competence and cultural humility when providing services on an RNF unit of a hospital setting to LGBT individuals. I used a basic qualitative approach to gather data via individual interview interviews with medical social workers within a hospital setting. The individual interviews were used to gather the responses from social workers regarding their perceptions of cultural competence and cultural humility use when providing care to LGBT individuals on an RNF unit within a hospital setting.

Research Questions

RQ1: How do medical social worker perceive their experiences of using cultural humility to deliver medical social work services in a hospital setting to LGBT individuals?

RQ2: What key characteristics or skills do medical social workers perceive are needed to effectively demonstrate cultural competence and humility with LGBT individuals in a hospital setting?

RQ3: How do medical social workers describe culturally competent practice with LGBT individuals in a hospital setting?

Conceptual Framework

The concepts of cultural competence and cultural humility frame how this research examined and analyzed the perceptions of cultural competence of a medical social worker within the hospital setting. Cultural competence is the ability to work with diverse cultures. It includes having self awareness in regards to belief and bias, knowledge of another group, and skills needed that may help provide care to another while possessing these skills in both assessment and intervention (Rossi & Lopez, 2017). Cultural competence includes the ability to communicate and express understanding to those of another gender, social class, and sexual orientation (Boskey et al., 2019c; Garran & Werkmeister Rozas, 2013; Margolies & Brown, 2019). Competence is demonstrated through clinical competence, professional training, and ethical care (Boskey et al., 2019a; Kumagai & Lypson, 2009) .

The traditional model of cultural competence serves as a useful foundation for developing practitioner knowledge of cultural awareness (Kleinman & Benson, 2006; Danso, 2016). Cultural competence offers a way to recognize cultural differences and to develop successful communications skills for interacting with various populations. Critics claim that this model erroneously sees cultural competence as static, with a final point of arrival where a practitioner ultimately becomes "competent" rather than seeing cultural competence as the result of a lifelong learning and training process achievable through constant self-introspection, education, and training (Tervalon & Murray-Garcia, 1998).

For this study, I also used cultural humility as a supplemental practice standard, as introduced and defined by Tervalon and Murray-Garcia (1998). As a concept, cultural humility

states that cultural competence is a product of an individual's lifelong learning and development, whereby the practitioner participates in continuous self-reflection and self-examination. It places particular emphasis on promoting ongoing self-awareness and treats the client as an expert on their situation and experience (Fisher-Borne et al., 2015). Practitioners when using cultural humility must minimize the imbalance of power in their relationship with patients and acknowledge the extensive amount of cultural resources and strengths that may empower the client (Mosher et al., 2017). Striving to learn about other cultures, traditions, and practices helps expand the practitioner's knowledge base (Barsky, 2019). A shift in perception, as well as the implementation of practice, are fundamental here with health care social workers using the framework of cultural humility to guide practice interventions and resources utilized in the field. Cultural humility within social work practice builds upon the idea of prioritizing care needs of the oppressed that confronts systemic forces that drive health, economic, and social inequalities that oppress and marginalize on both the institutional and individual level of practice (Fisher-Borne et al., 2015). Cultural humility identifies that this challenge involves active engagement with these systems in a lifelong process.

Cultural humility is defined as reflecting on another individual's perspective and/or culture in order to understand common traits, customs, values, norms, and behavior patterns to improve treatment towards more vulnerable groups (Azzopardi & McNeill, 2016; Danso, 2018a; Yeager & Bauer-Wu, 2013). Professionals use cultural humility to establish professional self-awareness through lifelong learning practices in order to enhance knowledge of their worldview and how it impacts their work when working with other cultural groups (Tervalon & Murray-García, 1998). This practice draws attention to the whole person while identifying differences in

life experiences between individuals, providing services to those accessing services that potentially impact resource needs (Bennett & Gates, 2019).

Cultural competence and cultural humility requires the individual to seek learning opportunities throughout their course of practice in order to grow their comfort when providing care to other individuals of various cultural backgrounds. Currently, many hospitals identify their workers as possessing the minimum requirement to provide competent practice while having limited re-education opportunities on a consistent basis, potentially negatively impacting patient-provider interactions (Rossi & Lopez, 2017). Many of these programs within the Unitest States and Canada have limited or no LGBT related professional training during their entire programs, which potentially impacts health and psychosocial services for those individuals (Bidell & Stepleman, 2017). This lack of training impact the ability to provide continued growth and practice for social workers on an RNF unit in a hospital with LGBT patients and limits the hospital's ability to provide culturally competent care that shows humility toward LGBT individuals (Bidell & Stepleman, 2017; Renn, 2010; Rossi & Lopez, 2017).

This framework was used to explore a medical social worker's perception of competence when working with the LGBT population on an RNF unit within a hospital setting. This research focused on studying the perceptions of the use of cultural competence and cultural humility when working with LGBT patients on an RNF floor in a hospital. I will discuss the nature of this study with hospital social workers in the next section.

Nature of Study

I used a generic qualitative approach in this study, which allowed me to collect data using individual interviews with social workers working on an RNF unit in a hospital setting. For the purposes of this research, social workers interviewed will be those working on a RNF in an

inpatient hospital. The selection of social workers on an RNF is a selective sample in order to help ensure consistency of data gathered that is representative of social work practice on these floors involving various medical populations and not focusing on a specific disease process of a patient or of various units within a hospital that have wide ranging workflows, such as an emergency room.

Using a constructivist paradigm, the research used information provided by participants to guide the direction of interpretation of general themes. This paradigm believes that the reality that an individual experiences and believes are multiple, are socially constructed, and are influenced by their specific history and culture (Avramidis, 1999). My goal was to understand the current experiences by social workers providing services in hospital settings. Through these interactions with participants, findings, and themes were identified through individual interview interactions (Ponterotto, 2005).

A generic qualitative approach is appropriate given the desire to further explore the phenomenon related to perceptions of cultural competence and humility by medical social workers. Additionally, a generic qualitative approach is used to avoid making assumptions about a population (Kahlke, 2014). Using a purposeful convenience sampling approach, this research focused on gathering data from social workers working on RNF floors within hospital settings. This research used purposeful convenience sampling. Individual interview questions were open ended and designed to gather social work impressions on perceptions of cultural competence and cultural humility in practice on an RNF unit in a hospital setting with LGBT individuals.

Definitions

Bio-psycho-social-spiritual assessment: a common hospital social work assessment tool that takes into account the patient's biological (basic needs), psychological (cognition, identity,

and self-concept), social (support system and community), and spiritual (sense of self, purpose, or meaning) factors to formulate a comprehensive clinical impression (Singer, 2007).

Care coordination: a primary role of hospital social workers emphasizing organizing patient care between professionals, including the patient, to facilitate appropriate service delivery and continuity of care (Auerbach & Mason, 2010).

Case management: a collaborative process to plan, seek, advocate for, and monitor services, resources, and supports on behalf of a client. Case management enables a hospital social worker to serve clients who may require the services of various health care providers and facilities, community-based organizations, social services agencies, and other programs.

Culturally appropriate care: interventions and practice methods that consider cultural differences while meeting the specific needs of those served through a lens that focuses on bio-psycho-social-spiritual factors (Given et al., 2008). *Cultural competence:* “the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors [including, but not limited to, sexual orientation; gender, gender expression, and gender identity; and family status] in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each” (Workers, 2016).

Cultural humility: a lifelong evaluation and exploration of self and a commitment to develop an understanding of and respect for diverse communities, groups, and individuals, including the consideration of power and oppression, while working to minimize the power differential between them (Fisher-Borne et al., 2015).

Culture: a set of learned beliefs, traditions, values, behaviors, and customs of a specific group or society (Mehotra & Wagner, 2009).

LGBT or *lesbian, gay, bisexual, and transgender:* terms and acronyms used to define a person's sexual orientation or gender identity (Arthur, 2015).

Medical social worker: social workers working in a medical setting that engage in resource mobilization and material support for patients, providing caregiver support, pre and post treatment emotional support, and psychological support and counseling (Pandya, 2016).

Social worker: an individual who possesses a baccalaureate or master's degree in social work from a school or program accredited by the Council on Social Work Education (CSWE; 2017 NASW Delegate Assembly, 2017).

Assumptions

I assumed that the study participants had been exposed to various clients from multiple cultural backgrounds due to their work in a hospital setting in United States. I also assumed that because most social work educational programs teach some form of cultural competence coursework, all study participants were able to respond to questions related to culturally competent care and cultural humility. To confirm this assumption, I asked study participants about their education and training experiences related to cultural competence and cultural humility. Another assumption I made was that study participants would answer openly and honestly to the questions posed. To promote this, I ensured that participants had a thorough understanding of their consent to take part in the study including the protection of data, confidentiality procedures, and their ability to member check their interview data.

Scope and Delimitations

This study used individual interviews from hospital social workers working in various hospital systems throughout the United States to obtain their perceptions of cultural competence and cultural humility in their practice. Delimitations to this study include obtainment plan of

sample, location of study, individual interview format through Zoom, and efficacy. The study population consisted only of the phenomenon from the perspective of social workers with experiences in a hospital setting, while not exploring the perspective of LGBT individuals receiving hospital care. The reason for choosing this group was due to the specific focus on the perceptions medical social workers have of providing care to LGBT patients related to cultural competence and cultural humility in the health care setting of the social work profession. I explored perceptions of experiences of culturally competent services delivered in hospital settings as opposed to traditional office settings. This setting was selected due to the unique setting and types of work that is specific to social work within a hospital setting. Also, although I aimed to understand how hospital based medical social workers perceive how they are delivering culturally appropriate services to LGBT patients, the results of this study did not reveal efficacy of the practices named.

Limitations

Limitations exist when using qualitative inquiry, and they affect the generalizability of research findings (Atkinson & Delamont, 2010; Kahlke & Hon, 2014). For example, qualitative data inquiry relies on my skills as a researcher, including my ability to manage biases which could influence data interpretation (Anderson, 2010). Furthermore, my presence during the data collection process may have influenced the results of the inquiry (Anderson, 2010). Limitations in this study included measurement tools to gather the data, influence of researcher presence on study participants, and time.

An initial limitation of the study is that it looks only at the perspective of the social worker and their experiences. LGBT patients may have different perspectives regarding the use of cultural humility and cultural competence in their experiences within the hospital. Future

research examining the perceptions and experiences from LGBT individuals in the hospital setting would be needed.

Another limitation of the data analysis. I collected data through the completion of individual interviews only. This means that data gathering and analysis relied on only one method of inquiry. If participants are completing a questionnaire, for example, they may have had time to consider their responses differently than they did during the individual interview. Additionally, my presence in the individual interview presented a potential limitation to the study. The presence of a researcher asking questions has the potential to influence the answers of the participants. To address this concern, I ensured that participants understood the purpose of the research, their ability to withdraw their consent to take part at any time, and the aim of the study. Furthermore, when necessary, I used self-disclosure as a means of addressing the validity of data gathering (Yin, 2011).

Another limitation to this research was time to complete the research adequately. Qualitative inquiry is time consuming (Anderson, 2010). As such, I took measures to ensure that there was no rush to complete the study or data left incomplete. Measures that I used to address time constraints included ensuring that there was an ample allotment of time for the individual interview session so that participants did not feel rushed by the process and carving out time on a weekly basis for data analysis so that processes received the time and attention necessary. This included scheduling the individual interview for a 2-hour Zoom session. Participants of the individual interview were also provided with my contact information if they wished to reach out to me after the conclusion of the individual interview to provide more details to their answers.

An additional limitation included the use of video conferencing techniques for the individual interview. Current restrictions due to the Coronavirus pandemic make in person

individual interviews impractical to conduct. As a result, I was able to hear vocal patterns and see head movements but was unable to observe group dynamics within a work group brought together in a room.

An area of concern included the willingness of social workers to be truthful and forthcoming regarding their perceptions of cultural competence and humility when working with LGBT clients in their workplace out of fear of employer response. Those who volunteered may have had a bias to participate and may not represent the larger population. Additionally, social workers may over report their experiences and levels of cultural competence and humility related to LGBT education and competence, which can impact the credibility of the research results of this study. This study worked to ensure confidentiality of responses from participants in order for them to feel comfortable sharing their experiences truthfully. Further limitations to the study include sample and setting. Because this study only explores the phenomenon of cultural competence and cultural humility of social workers in a hospital setting, and not social workers in a community or agency setting, themes may not transfer to other social work settings or types of practice.

Significance

Currently, the research literature does not discuss the perceptions of cultural competence and cultural humility use with LGBT individuals from medical social workers working in hospital settings. This research may help provide a better understanding to the current use of cultural competence and cultural humility when providing care to LGBT individuals from medical social workers working in RNF units of hospitals. Additional research opportunities may be identified from the research data that may help identify opportunities within hospital settings to ensure continued growth towards cultural competence and humility

with LGBT individuals within professional social work practice. The perceptions of experiences expressed from social workers within this study around cultural competence and humility with LGBT individuals in their practice will help guide future research or practice to improve use of cultural competence and cultural humility in social work practice. Further understanding based on medical social workers perceptions of their own experiences working with LGBT patients within the hospital setting may assist the social work profession and hospital settings to identify potential opportunities for use of cultural competence and cultural humility within hospital practice.

Summary

More LGBT individuals from various cultural backgrounds seek hospital treatment, and this means that social workers must respond in culturally appropriate ways to meet their client's needs (Bidell & Stepleman, 2017; Delavega et al., n.d.; Margolies & Brown, 2019; Rowan & Beyer, 2017a). Without culturally competent delivery of services, LGBT individuals may not access necessary services, may experience less effective therapy treatment outcomes, or may experience an overall disparity of service delivery throughout their hospital stay from admission to discharge. Using a qualitative analysis, guided by the conceptual frameworks of cultural humility and cultural competence, I explored how hospital-based medical social workers are perceiving their experiences of using cultural competence and cultural humility to deliver medical social work services on an RNF unit in a hospital setting to LGBT individuals.

Chapter 2: Literature Review

Introduction

In this chapter, I examine cultural competence and cultural humility within social work practice in a hospital setting. To establish the basis for this study, I examined the literature to review the historical perspectives and current studies related to cultural competence, LGBT cultural competence, cultural humility, and social work practice in health care settings. Also, I examined the literature that researches how to address the problem of potential barriers to access and use for LGBT individuals, education and training for social workers, and the relationship between working with LGBT individuals and perceived cultural competence and cultural humility within practice of service providers. The chapter begins with a description of the search strategy used for this literature review. I then present the historical explanation of culturally competency within social work practice, rationale of culturally competency practice in social work, and applicability of cultural competence and cultural humility as conceptual frameworks. Next, I present an overview of the evolution of social work practice within a hospital setting and how its use and structure continues to change. This section is followed by exploration on the various roles that social workers play within the hospital setting and how those role definitions have led to barriers for social workers to practice effectively within hospital organizations. Finally, the representation of the problem of hospital care for LGBT individuals causing barriers that affect access and continued use of health care services is presented. This chapter ends with a summary of the information presented and the relevance and significance the literature has toward the study.

Search Strategies

I conducted this literature review to support three major domains, specifically related to the variables of the study, social work cultural competence, social work cultural humility, and use of health care services by LGBT individuals. Additional searches contributed to the problem statement, helped identify the gap, and supported the rationale for the methodology and design. I conducted a key word search by requesting peer-reviewed articles through Academic Search Complete, ProQuest Central, EBSCO, Google Scholar, PSYCHIndex, PsychARTICLES, SAGE Premier, and Science Direct using the following terms: *LGBT, LGBT advocacy, LGBT ally, affirmative training/therapy, bisexual, competence, culture, education, diversity, feminist, gay, gender, gender identity, health care providers, heterosexism, lesbian, gay, multicultural, queer, questioning, religion, religiosity, spirituality, social justice, licensed social worker, sexual identity, bisexual, sexual orientation, multiculturalism, integrative, clinical supervisor, social work supervision, heterosexual privilege, self-efficacy, minority, psychotherapy, social work assessments, intersectionality*, and *transgender*.

After retrieving results related to the search terms identified, I conducted additional searches to locate related articles with further narrowing to include results from 2015 or later. I selected other literature for review that contained applicable information such as a working definition, relevant findings, historical and current perspectives on the problem, confirmation of the gap, use and manipulation of variables, and participant population. In addition to verifying whether studies existed outside of the educational databases, I conducted an online search of the key words identified above in the rare event that peer-reviewed articles and other media were published that could inform the study but were not found in the databases selected. Some of the literature that was relevant to the discipline may have been contained in human services, public

policy, nursing, and health care but offered value to the study because the information aligned with disciplines outside of the social work but was relevant in this paradigm. I also reviewed research conducted in other countries, such as Korea, the United Kingdom, and Canada, for comparison of cultural competence and humility in social work practice, perception of social work practice in hospital settings, and whether social worker experiences in other countries were impacting care of LGBT individuals. I considered it prudent to review the literature of these countries in an effort to provide a thorough understanding of the perceptions of issues identified with hospital social work due to the limited literature within the United States on the topic. Also, I gathered information from the CSWE's website to identify codes of ethics and definitions about client diversity, cultural context, and competencies used in social work education practice as well as the National Association of Social Workers (NASW) website for professional social work practice with LGBT client populations.

Sources used included scholarly books, peer-reviewed articles, journals, web pages, reports, and dissertations. The articles I selected were within the scope of subject reference by filtering using key terms and references from online resources. Information from the resources addresses advocacy and providing social work services to the LGBT community within a hospital setting. The journal articles described clinical preparedness and social work competencies and humility for working with LGBT patients.

Conceptual Frameworks

The conceptual framework is created using concepts of cultural competence and cultural humility for hospital social work practice. For this study, I will discuss the overall definition of culture as it relates to social work practice. Then, cultural competence and cultural humility will be discussed. Finally, an overview of medical social work and its evolution will be discussed.

Culture

The literature within social work practice defines culture as having a specific individual label. Labeling other individuals as cultured ignores the possibility of a social worker holding their position in the helping relationship as one of privilege over a minority/unprivileged population (Park, 2005). Many authors have defined culture from various societal perspectives.

Culture as a social work tool varies from individual to individual because it defines its reality based on the specific worldview of the individuals that belong to a specific culture at a specific time (Alvarez-Hernandez & Choi, 2017). An individual's worldview is defined by how the individual perceives relationships to their experiences and view of their world over time, such as their experiences with nature, people, religion, and other institutions (Chi-Ying Chung & Bemark, 2002).

Cultural Competence

This section describes cultural competence research, including the need to include sexual orientation when completing social work development research. Cultural competence consists of the ability of a social worker to integrate skills, knowledge, attitudes, values, and ethics in the practice. Social work practice identifies ethical care as a core practice standard for professional social work practice regardless of an individual's background. The NASW Code of Ethics (2017) defines within its ethical care principles that social workers must seek to assist vulnerable, disadvantaged, oppressed, and marginalized persons. As a part of this practice, social workers should promote policies and practices from agencies and organizations that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that protect the rights of and confirm equity and social justice for all people (NASW, 2017). Ethical standards of

practice for social work include the requirement for social workers to value differences while attempting to advocate for the needs of all individuals regardless of culture (2017 NASW Delegate Assembly, 2017). Fundamentally, cultural competence is a central term for the knowledge, skills, and resources that social workers use to engage clients of various cultural backgrounds (Margolies & Brown, 2019). In social work practice, this involves supporting patients through interventions, respecting patients and their experiences, and affirming patient value systems. Utilizing cultural competence allows social workers to employ cross-cultural skills to work effectively with people from many backgrounds by acting as an advocate, broker, and case manager among other roles.

Limitations of Cultural Competence

Cultural competence has long been viewed as the cornerstone of fostering cross-cultural communication. Opponants of cultural competence state that the concept views its focus as an endpoint where individuals learn a set amount of skills that allow them to effectively practice with individuals (Campinha-Bacote, 2019b). As identified by Fisher-Bone et al. (2015), the major criticisms of cultural competency frameworks include: (a) the focus on comfort with "others" framed as self-awareness; (b) the use of "culture'" as a proxy for minority racial/ethnic group identity; (c) the emphasis on attempting to "know" and become "competent" in understanding another's culture or cultures; and (d) the lack of a transformative social justice agenda that addresses and challenges social inequalities. Many of these cultural competency models lack acknowledgement of the complex history and reality of the present health, economic, and social inequalities that clients may be experiencing. The orientation of cultural competency creates a landscape where the learning of a group's history is sufficient in gaining cultural competence, without the need for advocating for social justice or eliminating that

oppression. Furthermore, competence suggests that the learning of a broad description of multiple group identities can equate to the social worker knowing life experiences of individual clients (Fisher-Borne et al., 2015).

Cultural Humility

Social workers need to understand cultural humility as well as the dynamics of privilege, power, and social justice within their own places of work, while taking responsibility to educate and advance social change within their systems, organizations, and the broader society. Cultural humility has grown in popularity due to the shortcomings presented within the concept of cultural competence. This approach is seen by many as an alternative approach to cultural competence (Danso, 2018b; Hook et al., 2013; Moore-Bembry & Walpole, 2018). The concept of cultural humility views the individual's self-reflection and critique as a lifelong process requiring less emphasis on knowledge, while placing greater commitment on lifelong nurturing of self-evaluation and critique, addressing power imbalances, promotion of sensitivity, and an attitude of openness and ego lessness (Campinha-Bacote, 2019a; Danso, 2018c). Fundamentally, cultural humility involves creating a stronger connection with the individual perspective with consideration for the personal experience by allowing the patient to share their narrative and, through this process, increases the social worker's cultural knowledge base (Davis et al., 2016). In a recent study, Mosher et. al (2017) described cultural humility as involving:

(a) a lifelong motivation to learn from others

(b) critical self-examination of cultural awareness

(c) interpersonal respect

(d) developing mutual partnerships that address power imbalances

(e) other-oriented stance open to new cultural information.

Individuals practicing cultural humility would recognize their own prejudices and misconceptions while developing an attitude that learning happens from the client. This relationship creates a mutually beneficial relationship by reestablishing the power balance to be equal between the health care provider and the individual. Development in an environment that is void of fear and shame is vital to cultivating cultural humility (Mosher et al., 2017). Doing so leads to greater cultural awareness from the worker and reduces implicit cultural biases from the worker during multicultural interactions. As a reflective process that stresses an importance of increased awareness of self, personal biases, and historical experience, cultural humility allows a social worker to build upon their professional knowledge to offer successful and effective practices to patients while recognizing potential imbalances in power or how culture impacts their receiving of medical care.

Cultural humility is the process whereby one moves away from personal conceptualizations of culture, tradition, or racial/ethnic identification and allows for continued learning from the experience of patients (Cleaver et al., 2016). Cultural humility offers multiple dimensions of enhanced cultural awareness, including lifelong learning with a specific focus on critical introspective reflection, recognizing power imbalances between the patient and their environment, and encouraging accountability on the micro-, mezzo-, and macro-levels (Chang, et al., 2012).

Importance of Cultural Humility in Social Work Practice

Approaching cultural awareness in this manner is essential, as it allows an appreciation of one's own culture and fosters acceptance of others. Cultural humility is a relatively new but well-developed concept. A majority of research within the last 4 decades has focused on theoretical tenets that may increase cultural competency only within the profession of social work without a

focus on cultural humility (Sousa, 2016). The current project was designed to understand social worker perceptions of cultural competence and cultural humility when providing services on a RNF in a hospital setting to the LGBT population. Of particular focus within the lens of cultural humility is the aspect of introspection and how such self-reflection impacts care. For example, social workers must be aware of specific cultural nuances, especially at a patient's end of life, as various traditions are culture-specific and can prominently improve the quality of a patient's life during the poignant and challenging period of hospice care (Waldrop, 2011). Instances of culture and diversity are recognizable in all interactions, making the concept of cultural humility vital to embrace those that are different.

Cultural humility advocates for acknowledging our own biases and experiences but also encourages practitioners to be willing to grow professionally by promoting learning about and understanding other cultures in-depth (Romanelli & Hudson, 2017; Rossi & Lopez, 2017). Fundamentally, the concept of cultural humility allows a practitioner to reject the role of expert to develop instead an authentic curiosity for the patient experience recognizing how differences impact end-of-life care.

Ethical Care

As part of the core principles for the social work profession, development and use of cultural competence in direct client practice is guided by the ethics of the profession. In previous iterations of the NASW Code of Ethics (2008), the ethical standard 1.05 was entitled Cultural Competence and Social Diversity, which emphasized developing knowledge in cultural differences, recognizing the role culture plays in social work services and encouraging practitioners to continue education related to cultural development. However, as of the latest revision to the Code in 2017, the NASW has revised the profession's code of ethics, removing

the word “competence” from this standard and replacing it with “awareness.” Further changes to ethical practice as related to culture include the addition of a competency related to awareness of socioeconomic disadvantage and the role it plays in the use of technology.

The NASW Code of Ethics (2017) within its revision identifies the following standard for ethically responsible cultural practice as a social worker to clients:

1.05 Cultural Awareness and Social Diversity

(a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.

(b) Social workers should have a knowledge base of their clients’ cultures and be able to demonstrate competence in the provision of services that are sensitive to clients’ cultures and to differences among people and cultural groups.

(c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability.

(d) Social workers who provide electronic social work services should be aware of cultural and socioeconomic differences among clients and how they may use electronic technology. Social workers should assess cultural, environmental, economic, mental or physical ability, linguistic, and other issues that may affect the delivery or use of these services.

Additionally, the NASW Code of Ethics (2017) emphasizes cultural competence and ethical responsibilities to the broader society:

6.04 Social and Political Action

(a) Social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups.

(b) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally.

(c) Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people.

(d) Social workers should act to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical ability.

Furthermore, the NASW Cultural Standards of Practice (2015) outlines for social workers ten standards of culturally competent practice:

1. Ethics and Values
2. Self-Awareness
3. Cross-Cultural Knowledge
4. Cross- Cultural Skills
5. Service Delivery
6. Empowerment and Advocacy
7. Diverse Workforce

8. Professional Education
9. Language and Communication
10. Leadership to Advance Cultural Competence

The NASW states that the goal of culturally competent social work practice "promotes and supports implementation of cultural and linguistic competence at three intersecting levels: the individual, institutional, and societal. Cultural competence requires social workers to examine their own cultural backgrounds and identities while seeking out the necessary knowledge, skills, and values that can enhance the delivery of services to people with varying cultural experiences associated with their race, ethnicity, gender, class, sexual orientation, religion, age, or disability [or other cultural factors]" (NASW, 2015, p. 65)

These obligations laid out to social workers by the NASW professional code highlight the importance for social workers to recognize cultural differences while maintaining self-awareness. Furthermore, the NASW Code of Ethics highlights the need for social workers to be lifelong learners and be able to recognize difference among cultural groups when in practice. Thus, inferring that cultural humility would be a key part in developing competent practice as a social worker.

Understanding these obligations entrusted to social workers through the NASW professional code is crucial in recognizing the benefit to practice culturally competence and cultural humility within practice, especially for LGBT patients seeking general medical treatment within the hospital setting(Fox, 2019; Gehlert et al., 2019; Harrison et al., 2019; Rowan & Beyer, 2017b). The Code of Ethics stresses awareness of self, continued development of cultural training, and recognition of how difference or disadvantage may impact the social work alliance with a patient (NASW, 2017). Therefore, it can be gathered that the NASW Code of Ethics

supports the continued growth of cultural humility in practice in lieu of other models of competence.

Cultural competence is the foundation of social work practice, though this concept is changing to meet the needs of the diverse population as evidenced by the NASW's Standards for Cultural Competence in Social Work Practice (2015), which places considerable emphasis on the developing concept of cultural humility. Social workers are instructed within the NASW's (2015) standard 4, Cross Cultural Skills to understand and address differences in worldviews between the social worker and client system. This standard states that the social worker should use skills within micro, mezzo, and macro practice that show an understanding and respect for the importance of culture in practice (NASW, 2015).

Professional Training

Social workers are expected to develop culturally appropriate skills as part of foundational practice from the CSWE accreditation standards for social work programs. Per CSWE (2015) competency standard 2:

Competency 2: Engage Diversity and Difference in Practice

- Social workers understand how diversity and difference characterize and shape the human experience and are critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including but not limited to age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion/spirituality, sex, sexual orientation, and tribal sovereign status. Social workers understand that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and

acclaim. Social workers also understand the forms and mechanisms of oppression and discrimination and recognize the extent to which a culture's structures and values, including social, economic, political, and cultural exclusions, may oppress, marginalize, alienate, or create privilege and power.

Social workers:

- apply and communicate understanding of the importance of diversity and difference in shaping life experiences in practice at the micro, mezzo, and macro levels;
- present themselves as learners and engage clients and constituencies as experts of their own experiences; and
- apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies.

Additionally, per CSWE (2015) standard 3, social work programs seeking accreditation for their programs must:

Competency 3: Advance Human Rights and Social, Economic, and Environmental Justice

- Social workers understand that every person regardless of position in society has fundamental human rights such as freedom, safety, privacy, an adequate standard of living, health care, and education. Social workers understand the global interconnections of oppression and human rights violations, and are knowledgeable about theories of human need and social justice and strategies to promote social and economic justice and human rights. Social workers understand strategies designed to eliminate oppressive structural barriers to ensure that social goods, rights, and responsibilities are distributed

equitably and that civil, political, environmental, economic, social, and cultural human rights are protected.

Social workers:

- apply their understanding of social, economic, and environmental justice to advocate for human rights at the individual and system levels; and
- engage in practices that advance social, economic, and environmental justice.

Several researchers have examined efforts of LGBT advocacy by examining how educational institutions address sexual orientation diversity and provide curriculums addressing sexuality within educational training programs (Bidell & Whitman, 2013; Dunn et al., 2006; Rutter et al. 2008; Walker & Prince, 2010). In a cross-sectional research study, McCarty-Caplan (2015) found differences between the levels of LGBT client competencies among social work faculty members compared to those of students in the social work education program. Using a Multidimensional Cultural Competence (MDCC) model, the researchers examined program perceptions of culture attention in the social work programs about their self-perceived LGBT competence. McCarty-Caplan's research population consisted of 34 masters of social work (MSW) programs, 34 directors, 242 faculty members, and 1,109 students. McCarty-Caplan evaluated the academic criteria of 1,109 social work programs and determined high levels of self-perceived organizational LGBT-competence from students among the social work programs. The evaluation also yielded measurements correlating to higher levels of self-perceived LGBT-competence among the students in the social work programs ($b = .04$, $p < .001$) (McCarty-Caplan, 2015). Students who reported feeling more competent to counsel LGBT clients rated their institutional program's overall cultural attention higher than those students who reported feeling less competent to meet LGBT clients counseling needs (McCarty-Caplan, 2015). McCarty-

Caplan (2015) reported students' perceptions of multicultural agendas within the social work program was associated with their level of self-perceived LGBT competence. McCarty-Caplan indicated the lower the level of self-perceived LGBT competence among respondents was a predictor of low perceptions of multicultural attention within the social work program. LGBT students in another study reported experiences of homophobic behaviors, and microaggressions from both students and instructors within the classroom setting (Dentato et al., 2014). As a result, students reported feeling a lack of inclusion and were resistant to disclosing sexual orientation or gender identity within the classroom setting. Likewise, there is a correlation between LGBT students comfort and readiness to practice with increased faculty knowledge and use of assignments focusing on LGBT content (S. L. Craig et al., 2016). Furthermore, in Craig (2014) study of 1000 LGBTQ students comprising of over 126 college programs across the United State and 7 from Canada, he found that 44% reported limited inclusion of LGBTQ content within curriculum content. Currently, no state requires LGBT training as part of the continuing education requirement for social work.

Medical social workers ability to provide culturally appropriate services to the LGBT population is explored through the lens of cultural competence, culturally humility and ethical care. The role of the social worker within health care settings has changed over time along with the areas within the health care setting in which social work provides care and support. The section below will further discuss social work practices within the health care setting.

Social Work Practice in Health Care Settings

The social work profession has a long-lasting role within the health systems. Today, social workers face challenges in providing care to clients. Continuous changes to the financing and delivery of health care along with a shortage of data showing effective outcomes of social

work use has impacted health systems and patients by declining social work staffing within certain health settings (National Association of Social Workers, 2016). Health care settings present an interesting environment for social workers as more are supervised in the health care setting by individuals that do not hold social work degrees. Additionally, tasks provided to social workers previously were conducted by other personnel, such as nurses and volunteers. Additionally, studies related to outcomes with older adults who have post-discharge involvement with a social worker demonstrate a decrease in hospital readmissions (Watkins et al., 2012) as well as an increase in communication with their physicians and follow up with their physicians within 30 days of discharge (Altfeld et al., 2012).

The Affordable Care Act has presented challenges to social work delivery within the health care setting while putting an emphasis on creating care delivery models that improve health outcomes while decreasing overall costs of care. For these models to succeed, social workers skilled in navigating the health care systems while managing mental and behavioral health, chronic disease management, and care coordination will be necessary to assist patients and families through complex discharge needs (National Association of Social Workers, 2016). These changes will lead to an increased expansion of roles for social workers within community health settings to assist patients in navigating those concerns. Some key terms to understand when discussing social work in a health setting:

The NASW Standards for Social Work Practice in Health Care Settings (2015) outline the following principles to be practiced by social workers within health care settings:

- Self-determination: Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals.

- Cultural competency and affirmation of the dignity and worth of all people: Social workers treat each person in a caring and respectful fashion. With skills in cultural awareness and cultural competence, social workers affirm the worth and dignity of people of all cultures.
- Person-in-environment framework: Social workers understand that each individual experiences a mutually influential relationship with her or his physical and social environment and cannot be understood outside of that context. This ecological perspective recognizes that systemic injustice and oppression underlie many challenges faced by clients.
- Strengths perspective: Rather than focus on pathology, social workers elicit, support, and build on the resilience and potential for growth and development inherent in each individual.
- Primacy of the client–social worker relationship: The therapeutic relationship between the social worker and the client is integral to helping the client achieve her or his goals.
- Social justice: At all levels, from local to global, social workers promote and advocate for social, economic, political, and cultural values and institutions that are compatible with the realization of social justice.
- Importance of social work research: Social workers promote the value of research as a means of improving the well-being of individuals, families, and society; strengthening the current workforce; and maintaining the social work profession's role in health care settings.

Some of the common roles and responsibilities for the social worker in a health care setting per NASW (2015) are:

- Understanding of common ethical and legal issues in social work practice in health care settings
- Biopsychosocial–spiritual assessment
- Use of the strengths perspective
- Client and family engagement in all aspects of social work intervention
- Case management/care management/care coordination/health care navigation
- Discharge and transition planning
- Client concordance with and adherence to the plan of care
- Advance care planning
- Palliative care, including pain and symptom management
- Hospice and end-of-life care
- Identification of child/elder/vulnerable adult abuse, trauma, neglect, and exploitation
- Crisis intervention
- Facilitation of benefits and resource acquisition to assist clients and families, including an understanding of related policies, eligibility requirements, and financial and legal issues
- Advocacy with other members of the interdisciplinary team and within the health care institution to promote clients' and families' decision making and quality of life
- Client, family, interdisciplinary, and community education
- Family systems issues, including the impact of health care concerns, illness, and disease on family relationships; life cycles; and caregiving roles and support needs.

Medical Social Work Practice in the Hospital Setting

Medical social workers in the acute care setting participate in various tasks with most hospital settings utilizing the social work professional for discharge planning. Social workers are tasked with assessing individuals' basic needs for discharge which includes the identification of those individuals with low health literacy suggesting that increased participation in aiding patients in taking a more active in their healthcare is essential (Lane et al., 2017). Social workers often relied on other health professionals to ensure patients' understanding of their discharge instructions (Eaton, 2018; Harrison et al., 2019; Sundström et al., 2018). Patients who discharge from the hospital without understanding the multiple facets of their instructions for post discharge care are at increased risk of readmission to the hospital making it crucial that health literacy is assessed (Desai et al., 2016; Sundström et al., 2018).

Discharge instructions include information about an individual's diagnosis, disease process, medication, and follow up appointments (Pilcher & Flanders, 2014). It is imperative that an individual understand the information provided to follow their treatment regimen (Pilcher & Flanders, 2014). Filling prescriptions when someone does not understand what medication they are taking or how to read the instructions is futile and can result in noncompliance to medical treatment (Pilcher & Flanders, 2014). Inadequate explanation of discharge instructions leads to misunderstandings and according to Pitcher and Flanders (2014).

> When people do not understand information or the rationale for health care instructions, they are more likely to miss appointments, not follow through with having medical tests and procedures, make more self-care errors, and have difficulty managing their own care. (p. 151)

Failure to educate effectively can result in negative health outcomes for the patient. Involvement of medical social workers in engaging patients and families to understand discharge instructions could increase a patient's health literacy and decrease negative outcomes.

Evolution of the Hospital Social Worker

The healthcare social worker has experienced an evolution of their role. During the 1990's, hospital social workers experienced many changes in their position, organizational structure, and the delivery of clinical services (Mizrahi & Berger, 2005). Some examples of change in the healthcare environment include the focus on outcomes and throughput with a decreased emphasis on individualized care (Lloyd, et al., 2002). Other healthcare organizational stressors that developed involved lack of funds, staff shortages, and high turnover as well as units working in silos, having to cope with other healthcare professional attitudes, and the bureaucratic work setting (Lloyd et al., 2002).

Additionally, social work has had to adjust to the experience of ethical dilemmas and how best to serve the patients under the current circumstances, as well as operating within a psychosocial model within a medical model setting (Lloyd et al., 2002). Hospitals coped with these changes by reorganizing the hospital environment, often-eliminating middle managers, social work departments or social work directors who provided clinical supervision to their social work staff (Kadushin et al., 2009; Mizrahi & Berger, 2001). Hospital social workers have endured the transition from inpatient primary care to a primarily outpatient model, and consequently, social work administrators either have experienced a loss of administrative duties or endured a significant increase in responsibilities (Mizrahi & Berger, 2001). So much so that it is not uncommon for the medical social worker in a hospital setting to report to a nurse as their manager. The transformation of hospital social work has resulted in some progression (Eaton,

2018; Fantus et al., 2017; Gehlert et al., 2019; Sundström et al., 2018). For example, changes in the healthcare environment have spurred the development of new programs, the focus on preserving the social work discipline, and the increased involvement in the hospital system reorganization with redefined social work roles, and responsibilities (S. L. Craig & Muskat, 2013; Eaton, 2018; Harrison et al., 2019; Sundström et al., 2018).

During the 1990s, social work also experienced regression (Mizrahi & Berger, 2001). Some examples of this deterioration include decreased acknowledgment and value of social work contributions in the hospital setting, increased workload, and increased demands on social work resulting in unreasonable expectations of social workers (Mizrahi & Berger, 2001). Furthermore, social workers experienced a decrease in the quality of social work care offered and endured outside threats such as decreased lengths of stay and department reorganization (Craig & Muskat, 2013; Eaton, 2018; Sundström et al., 2018).

As a result of their inclusive approach around social problems, social workers possess valuable knowledge and skills to address social determinants of health, which has long presented a challenge in health settings (Gehlert et al., 2019). Additionally, these skills make the social worker well positioned to provide valuable leadership to healthcare settings in addressing economic and environmental stressors. Social workers have played a valuable role in care coordination of new models of care integrated as part of the Affordable Care Act, which includes Health Homes in Medicaid and Accountable Care Organizations in Medicaid and Medicare. An example of this has occurred in Mt. Sinai Hospital in New York, where social workers play a key role in the coordination of their Medicaid Health Home model for patients with complex chronic health conditions (Gehlert et al., 2019). Although social workers are leaders in health care

systems, they often find their contributions deeply embedded in the care provided and as a result are not visible.

Hospital social workers are presumed to have less authority and provide less valuable contributions than other direct care professionals such as a nurse or physician (Fantus et al., 2017). As a member of a multidisciplinary team, social workers often are overlooked when making health care decisions. This is despite the makeup within hospital systems where social work plays a vital role when discussing ethical decisions. As a result, social workers in health care per Fantus et al (2017) report feeling less respected, leading to moral distress, and often not considered as a legitimate field of practice within the hospital setting. Social workers working in hospital settings where roles are ambiguous have reported a higher level of moral distress (Craig & Muskat, 2013). This distress can impact the value of supervision received by the social worker within the hospital setting. However, fiscal concerns within the hospital setting has led to decreases in formal supervision for social workers (Fantus et al., 2017; Gehlert et al., 2019; Harrison et al., 2019; Muskat et al., 2017; Silverman, 2016). New social work trainees identified that newer social workers in health care described the need for a strong work ethic, and ability to work under limited supervision due to the pace and various complications that health care work poses (Nicholas et al., 2019). As a result, social workers must have the ability to self-direct but assertive enough to know when to ask for help from other when needed.

Other challenges social workers faced in organizations include role ambiguity due to various overlapping roles with other professions, competing demands, and the inability to fulfill tasks understood as a social work role (Lloyd et al., 2002). Further, social workers have described themselves as feeling as though they are bouncers, janitors, brokers, jugglers, firefighters, and challengers within their work in hospital settings (Craig & Muskat, 2013).

Social workers within health care have needed to navigate gaps in the health care system while being diplomatic when working with multiple disciplines and understanding the power dynamics within other disciplines of the setting in order to advocate for patients and the role that social work plays (Nicholas et al., 2019). Ultimately, this new era of healthcare has had a plethora of negative consequences for social work (Mizrahi & Berger, 2001).

Social workers working on a regular nursing floor within a hospital setting take on various roles throughout the course of caring for a patient. Social workers and the care they provide have suffered due to having less time for patient care, less overall social work staff for the increased volume of caseload, and lack of appreciation for the social work role, as well as competition with the nursing role (Mizrahi & Berger, 2001; Mizrahi & Berger, 2005). Social workers within a health care setting may only have one patient contact during a hospitalization, and that time varies based on the complexity of the issue. The various social work services delivered can include, supportive counseling, structured therapy, education, financial support, assessment, resource allocation, advocacy, transportation assistance, and discharge planning (Craig & Muskat, 2013; Muskat et al., 2017). Social workers report lack of moral sources available to them, which result in an inability to fulfill professional responsibilities as a result of conflictual responsibilities placed on the worker that conflict with their personal values, beliefs, and worldviews (Fantus et al., 2017). An overlap of responsibilities between social work and nursing within the hospital setting can add to the role confusion and distress (Baum et al., 2016; Craig & Muskat, 2013; Fronek et al., 2017; Rowe et al., 2016). Additionally, social workers received significantly less pay as compared to nurses despite holding an advanced degree (Mizrahi & Berger, 2005). Currently social work representation within research hospital settings as academic researchers is minimal (Bryson & Bosma, 2018). Social workers in research roles

may complement current models of university based research as well as help advance social work knowledge to hospital systems (Bryson & Bosma, 2018). Other consequences of the change in the healthcare climate include social work leadership becoming preoccupied with management issues versus clinical operations; hence a disconnection between social work leadership and social work staff is occurring (Mizrahi & Berger, 2005).

Medical Social Work Preparation to Work with LGBT

Fisher-Bourne et al. (2015) explain the education needed for the social work professional in the field of practice is to educate beyond cultural competence to include cultural humility. They argued that cultural humility comprises of abandoning the role of expert and looking to appreciate the other's perspective, engaging the person as an active partner in the process. Cultural competence in health care has grown to become an iterative process where individual patients present with particular health inequalities connected to macro-level concerns (Fisher-Borne et al., 2015). Cultural competency is larger than the social work to client relationship and focuses the importance on the institutional level.

Messinger (2013) concluded that universities and the service provision agencies are designed for the heterosexual person. The current Educational Policy and Accreditation Standards (EPAS in CSWE, 2015) require social work students to receive education on diversity within multiple areas such as gender, gender identity and expression, and sexual orientation, as well as many other dimensions of diversity within social work education (Rowan & Beyer, 2017b). While the civil rights of LGBT persons has been an active movement, there is still discrimination and marginalization seen in social policy, and hiatuses in LGBT civil rights take place in the national, state and local government levels (Dessel & Rodenborg, 2017). As these

systems focus on change, the need to incorporate interpersonal supports, as well as institutional resources that address the needs of the LGBT population remain critical.

Steelman (2018) argues sexual orientation and gender identity are vital to one's identity and development; however, social workers are limited in their education and understanding when caring for LGBT individuals. Therefore, further education and training of social work professionals to on LGBT competency-based care is needed to adequately supply educated, competent practitioners to the field. Fisher-Borne et al. (2015) argue that education and development of social workers is many times a process occurring in a linear manner that proposes it is sufficient to educate about differences, therefore creating a comfortableness rather than an understanding of the influence, bias, and assumptions that the social worker may bring to the professional relationship.

Martin (2016) argues the perception of uniqueness is at the heart of stigmatization and discrimination within the LGBT population, a likely benefactor to health inequalities in the LGBT population. The need for additional research stems from the limited information on the social work professional's experiences and perceptions of working within the hospital setting with LGBT adults. The lack of research on sexuality and sexual health further intensify this growing need. This creates a twofold issue where there is a lack of information, and the lack of knowledgeable social workers for the LGBT community. A vital part of the preparation and training for social work professionals is in the education about the inequality and addressing the marginalization of the older LGBT person on a macro level. The necessity for social work graduates to advocate for LGBT inclusion and policy protection (NASW, 2017) is still needed.

Barriers to Diversity of Care to LGBT Community

Currently there are over 2.7 million adults over the age of 50 that identify as LGBTQ in the United States (Boggs et al., 2017). This number is expected to double by 2060 as more LGBTQ individuals identify their relationships as such. Currently, LGBT older adults live alone to a greater extent than heterosexual adults and are at a greater risk for disability, poverty, homelessness, social isolation, depression, alcohol abuse, financial disparity, issues with housing, and institutionalization (policy institute, 2000; De Vries, 2014; Espinoza, 2011; Fredriksen-Goldsen et al., 2011; Witten, 2014; Zelle & Arms, 2015). LGBT individuals have concerns with discrimination in health care facilities. One study conducted by Johnson, Jackson, Arnette, & Koffman (2005) found that 73% of LGBTQ adults living within the community believed that discrimination existed within assisted living facilities, and as many as 34% reported that they would hide their own sexual orientation if they had to move to a facility.

The LGBT life experience has been characterized in some regards as one of disapproval by biological families, lack of children, and feelings of shame or internalized homophobia from discrimination experiences (Boggs et al., 2017). As a result of these experiences, this group may be in higher need of general medical services, but less likely to access continued medical services as well as lacking the same opportunities to outside support, as a result of anticipated discrimination from providers and family members.

Culturally insensitive care experiences, such as, ridicule, refusal of treatment and stigmatization by care providers pose health consequences to LGBT individuals as they refuse and/or delay needed care (Rowan & Beyer, 2017b). LGBT individuals are less likely to remain active in medical treatment when compared to heterosexuals in addition to experiencing prejudice by medical service workers that may be untrained in LGBT specific issues (Goldbach

et al., 2018). Boggs et. al. (2017) reported in their study that LGBT participants indicated that health care agencies continued to utilize modes of practice that excluded sexual orientation, gender identity, and family context when treating LGBTQ adults. Another study of a local Area Agency on Aging (AAA) by Dunkle, et al. (2019) found that LGBT adults reported a concern that the agency did not have an interest in serving the LGBT population based on a one size fits all approach around diversity of clients. They further expressed a desire that the LGBT community be approached and educated on their services in a more authentic way that expresses understanding to their beliefs and experiences.

LGBT individuals are considered an at-risk population for many physical and mental health concerns such as cardiovascular issues, obesity, and isolation when compared to their heterosexual and cisgender counterparts (Rowan & Beyer, 2017b). LGBT individuals are a vulnerable population due to their susceptibility to coercion and exploitation due to their disadvantages related to social exclusion, lack of social support, low self-esteem, high incidence of physical and mental diseases as well as lack of access to health services (Ekmekci, 2017). LGBT individuals have greater all-cause mortality rates than heterosexual individuals, placing them at higher risk of developing certain cancers (Bristowe et al., 2018). The experiences of LGBT adults may include issues related to sexual or gender minority stress. These experiences can cause LGBT individuals to feel unwelcome in healthcare systems designed for the heterosexual and cisgender populations (Siverskog, 2014). These characteristics of the healthcare delivery model often drive members of the LGBT community to avoid basic preventative care, which can potentially lead to greater health consequences (Fredriksen-Goldsen, 2011).

The need to understand the LGBT identity and the cultural norms they bring to relationships when utilizing hospital care is important to personalizing care. The diversity of the

LGBT identity and the aging population in general, has slowly begun to be recognized in gerontology (Kimmel, 2014). The heterosexual notion is widespread in community service agencies. This idea guides social workers and their delivery of services, thus limiting the language utilized on intake forms, prevents open discussion of crucial relationships, and impedes programing for LGBT persons and their families (Hash & Rodgers, 2013; Kimmel, 2014). Visibly there are questions around aging and the accounts about LGBT aging. The LGBT literature presents experiences of either successful aging (overcoming stigma) or social marginalization, disparity, and loneliness (Hughes, 2018; King, 2016; Simpson, 2014). If the LGBT adults follow the social exclusion, how will social services and social policy be developed and effectively provided? As a result, accurate data is challenging to obtain on this marginalized population (Kimmel, 2014). Mankowski (2017) and Herek (2007) defined stigma as a result of the LGBT adult's experience of disempowerment, disapproval, and feelings of marginalization from another individual. Stigma can be implicit, whereby containing three spheres: anticipated stigma, internalized stigma, and enacted stigma (Whitehead, et al., 2016). These spheres may influence health-related decisions and lower use rates of health care services among LGBT individuals. This stigma may be in direct connection to experiences and expectations of stigma, based on gender identity or sexuality (Bockting, et al., 2013). Moreover, the anticipated stigma of LGBT individuals supports the potential risk of declining to pursue healthcare, due to possible discrimination (Whitehead et al., 2016). Enacted stigma (actual occurrences of experienced discrimination) may create a challenge for LGBT persons to access care.

Anticipated stigma is focused on what will occur if the identity of an individual is found out, the concern that others will think less of, or discriminate against them (Quinn et al., 2014). Individuals that identify as having multiple minority status, interact with others knowing of a

potential stigmatization of identity. However, LGBT individuals may have hidden their identity, not knowing exactly how others would respond if they bared their uniqueness (Emlet, et al., 2015). The historical negative stereotypes associated with identification of LGBT heightens individual awareness of the potential negative perception that will be received by the LGBT individual if they disclose their identity (Klein & Nakhai, 2016; Smith et al., 2019). Quinn et al. (2014) argued that learning negative stereotypes often occurs prior to the exposure to a stigmatizing event and is therefore a perception that can be difficult for individuals to unlearn. Research has shown a connection between anticipated stigma, the devaluing of a group, and the reported decline in psychological, as well as, physical health of that group (Emlet et al., 2015; Quinn et al., 2014). Living with stigma incorporates matters of uniqueness, self-regard, associations, health outcomes, and the cultural context in which one lives (Hughes, 2018).

Some may assume unfair practices by health care workers, which in turn creates a barrier to gaining treatment when timing can be critical to positive outcomes. Internalized stigma is branded by the recognized characteristics and beliefs about one's place in the world (Emlet et al., 2015). Beliefs including guilt, shame, and lack of self-respect may cause LGBT individuals to reinforce the perception that they do not justify having equal access to healthcare (Emlet et al., 2015). In the Bristowe et al. (2017) study, experiences of homophobia or transphobia, both personal and historical, reportedly stayed with the participants. Those experiences would play a role in whether a disclosure of their identity to health care professional would happen. For some the homophobic or transphobic disapproval or discrimination traversed decades, back to a time when same-sex sexual relationships were unlawful and gender norms were enforced (Bristowe et al., 2017; Emlet et al., 2015).

Enacted stigma symbolizes the public tones of bias from others, examples of this are avoidance and social distancing (Emlet, 2016; Emlet et al., 2015). It has been observed that stigma, whether anticipated, internalized, or enacted will impact behavioral, psychological, and health outcomes (Emlet et al., 2015; Quinn et al., 2014). Hughes (2018) maintains this grouping of diverse and multidimensional individuals into one 'LGBT' category has shortcomings, two of which are the superficial fusion of sexuality and gender, and the appearance that the L, G, B, T subgroups are unchanging personages. Jones (2016) argues it is one's life course placement, the sociocultural context, and the generational cohort which determines the attachment to the LGBT label. Further research is needed in all three domains of stigma, anticipated, internalized and enacted stigma in relation to the LGBT community.

Medical Social Workers as LGBT Competent Providers

Social workers roles in health care often involve managing problematic behavior, care planning, crisis intervention, and advocating for patients and families (Craig & Muskat, 2013). When employed in hospital settings, social workers primary roles contribute to health and well-being of individuals by addressing the needs that may go beyond medical needs; thus environmental and contextual impacts of an individual must be taken into consideration (Nicholas et al., 2019). These interactions involve engagement at a personal level with clients, often with an emphasis on knowledge and competence while listening in an empathic and nonjudgmental way. Finally, social workers bring expertise to multidisciplinary teams regarding the health disparities and social factors that may inhibit a successful discharge for an individual (National Association of Social Workers, 2016). Current research on LGBT care within a hospital setting is limited to focusing on mainly medical providers such as nursing and physicians (Margolies & Brown, 2019; McCarty-Caplan, 2018b; Radix et al., 2018; Schweiger-

Whalen et al., 2019). A majority of the studies focused either on health care social workers role within a hospital setting, or the specific identification of culturally competent practice within a specific setting, such as pediatric centers, or cancer centers (Davis et al., 2018; Klein & Nakhai, 2016; Muskat et al., 2017; Singh & Durso, 2017). A majority of studies related to perceptions of experiences of cultural competence and cultural humility focused on physicians, nurses, and social work students only.

The need for this study increased as a result of the literature I found that examined that social workers working within medical social work settings have concerns with providing care to LGBT individuals accessing social work services in a hospital setting (Delavega et al., n.d.; Dessel et al., 2019; Held et al., 2019; Smith et al., 2019). The research notes that continued experience and practice in working with the LGBT population is key to continuing to develop competency (Boskey et al., 2019c). One that recognizes LGBT as a population requiring separate skills and competences for professional practice (Boskey et al., 2019c). The results of this study may assist health care institutions as well as the social work profession to addressing opportunities identified from this research regarding educational and curriculum opportunities within hospital settings to ensure continued growth towards cultural competence and humility in professional practice. Expressed concerns from social workers within this study around cultural competence and humility with LGBT individuals in their practice will help identify gaps in educational trainings and skill practice opportunities within their area of practice that will provide areas of future research or practice to improve cultural competence and humility in social work practice.

Decreased funding has led to increased responsibility placed on social workers regarding discharge planning, limiting the ability for social workers to provide support and brief counseling

services to individuals within the health care setting (Muskat et al., 2017; Nicholas et al., 2019; Silverman, 2016). The pressure of health care settings needing to decrease length of stay has led to social workers having more infrequent contact with patients prior to leaving the health care setting, at times one visit only, while at the same time contributing more to the discharge planning needs for patients in a hospital setting (Gibbons & Plath, 2009).

Summary

The literature review I conducted produced several references to cultural competence and cultural humility with limited studies addressing social work practice within a health care setting. There was a confirmed gap in the literature associated with social worker perception of cultural humility and competence within a healthcare setting with LGBT individuals. Additionally, components that contribute to cultural competence and cultural humility practice, such as ethical practice and education were identified.

After reviewing the literature, I concluded that a qualitative study utilizing a individual interview of hospital social workers working on RNF floors in hospitals would be used to explore perceptions of cultural competence and humility in hospital social work practice with LGBT population. Chapter 3 provides further review of the study's sample size, sampling methods, research questions and overview of the individual interview recruitment and format.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore how social workers described their perceptions of use of cultural competence and cultural humility when providing services on a RNF in a hospital setting to the LGBT population. This research utilized a qualitative approach to gather data via individual interviews with medical social workers working on an RNF within a hospital setting. Responses were gathered and analyzed from social workers on their perceptions of the use of cultural competence and cultural humility when providing care to LGBT individuals.

The following chapter reviews the research method plan for this study. The chapter begins by reviewing the research design and rationale. Next, I will discuss my role as the researcher for this study. Then, a review of the methodology used for this study will be provided, which will include the plan for recruitment, participation, and data collection. Issues of trustworthiness will then be reviewed. Finally, ethical procedures and concerns will be highlighted prior to a summary of this chapter.

Research Design and Rationale

This research utilized a generic qualitative approach which allowed me to collect data utilizing individual interviews with medical social workers working within a hospital setting. For the purposes of this research, social workers who participated in the individual interview were those working on a RNF within an inpatient hospital. The selection of social workers on an RNF was a selective sample utilized in order to help ensure consistency of data gathered that was representative of social work practice on these floors involving various populations and not focusing on a specific disease process of a patient, or of various units within a hospital that have wide ranging workflows, such as an emergency room.

The nature of this study was to focus on how medical social workers described their perceptions of use of cultural competence and cultural humility when providing services on a RNF in a hospital setting to the LGBT population. This approach was utilized to generate new knowledge of medical social workers perceptions regarding cultural humility and culturally competent practice with LGBT individuals within individual interviews. This basic qualitative research study helped provide a better understanding on the perceptions that medical social workers have related to cultural humility and culturally competent practice with LGBT individuals within the hospital setting. This basic qualitative research study provided a better understanding of medical social worker perceptions of use of cultural humility and cultural competence skills that are required for use on an RNF in a healthcare setting. The purpose of this basic qualitative research study was to explore perceptions of use of cultural competence and cultural humility when providing services on an RNF in a hospital setting to the LGBT population. This aligned with the proposed qualitative individual interview methodology by providing an individual environment that fostered the exchange of ideas from professionals.

Qualitative research is used when a researcher wants to gain an understanding of individuals' experiences and perceptions accompanied by the meanings attached to the experiences and perceptions (Korstjens & Moser, 2017). This research study used the qualitative study design with a domain of life experience, the area of inquiry is surrounding the social worker's current experiences in practice, and the focus of the research is on the social worker making sense of their current work environment by providing insightful renderings of subjective experiences related to the topic (Korstjens & Moser, 2017). The selection of the design fit with this study through the recruitment of medical social workers engaged within a hospital setting

through care coordination and discharge planning and the shared group experience of LGBT patients (Moser & Korstjens, 2018).

The use of individual interviews in social science research creates an environment conducive to stimulate an exchange of ideas on a specific topic (Moser & Korstjens, 2018). Individual interviews as a data collection method allows for the examination of varying experiences and perceptions of participants (Moser & Korstjens, 2018). The use of an individual process provides a nonthreatening environment that may stimulate ideas not accessible using alternative research methods increasing the chances of spontaneous responses and yield additional data (Moser & Korstjens, 2018). Basic qualitative research using individual interviews provides a methodology for practice improvement by gathering evidence through critical reflection to implement changes (Koshy, et al., 2011). The individual interviews provide an economical approach to engage multiple participants to gather data in a cohesive environment fostering feelings of safety where there is a likelihood of candid responses that may otherwise be missed (Onwuegbuzie et al., 2009). The individual interview aligns well with this study as it provides for the exploration and assessment of perceptions, experiences, and challenges that provide an environment for eliciting ideas from a social work professional in a one-on-one setting.

Qualitative research using individual interviews provides a non-threatening environment to allow like-minded professionals to gain a better understanding of the individual interviews topic and hopefully improve clinical social work practices (Linhorst, 2002). The answers that were provided helped to establish themes of commonalities that best represented medical social workers within a hospital setting.

A generic qualitative approach was appropriate given the desire to further explore the phenomenon related perceptions of cultural competence and cultural humility when providing services on a RNF in a hospital setting to the LGBT population. Using a purposeful convenience sampling approach, this research focused on gathering data from social workers working on RNF floors in hospital settings. Individual interview questions were open ended and used to gather social work impressions on feelings of humility and competence in culturally competent practice in the workplace with LGBT individuals.

Research Questions

RQ1: How do medical social worker perceive their experiences of utilizing cultural humility to deliver medical social work services in a hospital setting to LGBT individuals?

RQ2: What key characteristics or skills do medical social workers perceive are needed to effectively demonstrate cultural competence and humility with LGBT individuals in a hospital setting?

RQ3: How do medical social workers describe culturally competent practice with LGBT individuals in a hospital setting?

Role of the Researcher

I came to select this topic based on 15 years as a practicing hospital social worker working with patients from various cultural backgrounds on a regular nursing floor within a hospital setting. I acted as an observer and facilitator of the interview in this research project. Acting as an observer and facilitator allowed the opportunity to guide the individual relationship and observe how participants operated within a setting (Kawulich, 2005). Additional roles I took on in this study involved recruiting participants, interviewing of participants during individual interviews, recording data in interviews, and analyzing and interpreting of interview data. At the

completion of the study, I provided an opportunity for participants to review the written transcript of their individual interview to allow an opportunity for the participant to clarify information they presented during their individual interview. I recruited social workers in the United States via social media announcements and posts utilizing LinkedIn and Facebook. While there was some concern with the potential to interview social workers that I held prior relationships with, acting as an observer in this research allowed participants to provide the relevant information based on their experiences. Due to my prior role as a supervisor, I did not recruit current or former supervisees for this research study in order to avoid coercion in the study. My prior experiences with cultural competence and cultural humility in hospital practice allowed me to let the participant be the guide for showing the perceptions of their practice within the hospital setting. Within my practice, individuals were given the opportunity to guide the conversation and provide relevant information based on their experiences, thus allowing me as the social worker the opportunity to learn. Bias was avoided as the interpretation of data was based on the information gathered from participants only.

Methodology

Participant Selection

Inclusion criteria for participation in the individual interviews included participants being a licensed social worker (bachelor or master's level) and having practice experience as a social worker on an RNF unit. Within the United States area, there are multiple hospital systems in various geographic settings serving multiple cultural demographics. I recruited medical social workers via postings on my personal LinkedIn and Facebook profile as well as professional network groups such as NASW, Society for Social Work Leadership in Health Care, Social Work Network, Medical Social Work, and Ohio Medical Social Work groups. A preliminary

recruitment post was provided on these pages asking for interested participants for the individual interview to contact me through direct message or email or by commenting their interest so that I would contact them through direct message to obtain a contact email. Once this was completed, I emailed participants further information about the individual interview. The goal was to conduct seven to 12 individual interviews overall. Saturation of information within qualitative research tends to occur near the sixth collection event (Guest et al., 2020). Additionally, the median sampling sizes for individual interviews is around five to 12 participants for the average research study (Carlsen & Glenton, 2011). Participant responses from this sample produced overall themes which lead to saturation of responses, codes, and themes. Participants were emailed and asked to provide me with multiple days and times they could participate in an individual interview. The number of questions selected per individual interview allowed sufficient time for participant input over the scheduled 2-hour individual interview, along with providing sufficient opportunity for me to observe participants answers. Richness of content was determined via analysis of data in which themes and patterns were established from review of audio recorded individual interview sessions.

Instrumentation

I collected cross-sectional data via demographic information and responses to the individual interview questions. Individual interview questions were open ended to allow participants to describe their experiences. The instrument development for the individual interview guide was created by me. The literature informed the interview design by focusing on the LGBT-DOCSS scale developed by Markus Bidell (2017). Information gathered from this study asked nurses and physicians to rate their perceptions of LGBT competence based on a quantitative scale (Bidell, 2017). I looked at those questions and adapted my own for an open-

ended qualitative research study that asked participants to discuss their perceptions of use of cultural competence and cultural humility. The conceptual framework informed the interview questions of this research by looking at cultural humility and cultural competence in tandem for social work practice in a hospital setting with LGBT individuals instead of as separate frameworks for social work practice. The questions were sufficient to obtain social work perceptions of use of cultural competence and cultural humility in hospital social work practice with LGBT individuals on an RNF unit. Questions were crafted in an open-ended format to allow participants opportunity to provide individualized answers regarding both cultural competence and cultural humility experiences. I utilized the individual interview approach to allow participants to provide perceptions and experiences based on open ended questioning (Appendix 1). Participants provided responses, which were video recorded in order to allow sufficient coding and analysis upon completion of the individual interviews.

Prior to the individual interview, participants were emailed a 5-item demographic questionnaire via a Google Form link to complete. The responses were then accessible for me to establish demographic information. Questions identified their social work degree type, length of experience in the field, age, gender, and sexual orientation. As an example of a question related to their position, participants were asked, “How many years have you practiced as a hospital social worker?” I collected this information to help better establish themes at the conclusion of the individual interview for reporting purposes in this study.

Recruitment

This research included interviews of medical social workers working within hospital settings on regular nursing floors. For this research, participants were medical social workers working in the hospital setting on a regular nursing floor. For the purposes of recruitment, I

utilized LinkedIn and Facebook to recruit participants for the individual interviews. The goal was to conduct a minimum of seven individual interviews overall.

The sample was recruited via a recruitment flyer (Appendix B) on both LinkedIn and Facebook. Recruitment posts were posted on my personal LinkedIn and Facebook profile as well as professional network groups that included NASW, Society for Social Work Leadership in Health Care, Social Work Network, Medical Social Work, and Ohio Medical Social Work groups. Posts provided my email contact information so that participants could contact me to identify their interest. Participants then contacted me via email or direct messaging to inquire about participation in the study. I contacted these potential participants via email or direct messaging within the social media application to inform participants of the purpose of the study, time commitment needed from each participant for the individual interview session (2 hours), consent and confidentiality form to be completed prior to attending the individual interview, and participation procedures. Once participants agreed to continue and signed the informed consent document and completed the demographic Google form and confidentiality statement, I contacted participants via email to seek available days and times to participate in the individual interview.

For this research, individual interviews utilized the Zoom platform to provide a synchronous teleconferencing meeting lasting 2 hours. Use of video teleconferencing provided synchronous interviewing that allowed observation of vocal cues from participants (Opdenakker, 2006). Zoom teleconference options were conducted at a time that was after normal working hours in order to avoid potential conflict for the participants. Once determined, I provided scheduled dates and times for the individual interview of participants. The individual interview was then scheduled, and participants were provided with contact information, web link, and

directions on how to attend the Zoom individual interview meeting. Upon completion of the individual interview, participants were provided with the opportunity to review the audio recording. Audio recordings were edited for accuracy by me via Zoom and audio transcription software to edit out identifiable information such as name and specific identification regarding place of employment to protect confidentiality. Participants were provided with a follow-up email with the link to the audio along with a 2-week time limit to review the video and provide feedback or clarification on information discussed in the individual interview. Additionally, participants were allowed to provide further analysis via email upon reviewing the audio recording once they completed the individual interview.

Data Analysis Plan

Information collected was then codified by me into a single codebook. Zoom's audio recording software was used to transcribe the interview to audio. Additionally, I utilized audio recorder software on my computer to complete a second audio recording of the individual interview in case Zoom audio recording failed. Upon completion of the individual interview, participants were provided with an audio recording to review. They were given two weeks to respond to me with follow-up information if they wish to do so. Email responses from participants after reviewing the recordings were coded by myself. Comparison between the individual interview codes and themes were then be completed and included in the data utilizing the same data analysis process for the individual interview. The analysis of the data started with the coding process which was systematic to increase the trustworthiness of the research (Mangioni & McKerchar, 2013). The coding of the data completed involved organizing the data into codes and themes thereby identifying concepts and patterns while searching for similar and distinctive features within the data (Mangioni & McKerchar, 2013).

The data was then analyzed using a three-step process. The first step was to break down the data into smaller sets of information to encode the data (Onwuegbuzie et al., 2012). Coding occurred first by open coding utilizing descriptive codes that summarized a topic being discussed (Saladana, 2015). Then through assessment of audio recordings and review of written transcripts I split the data into smaller coded segments to identify themes. Splitting the data allowed more detail and codes to be established from certain sections of information (Saladana, 2015). This allowed more descriptive detail to emerge as well as helping secure saturation of themes and patterns. The next step was to place the encoded data into categories (Onwuegbuzie et al., 2012). To encode data into patterns, I reviewed audio recordings again and combined the codes into categories. The third step was to develop themes from the categories (Onwuegbuzie et al., 2012). I utilized selective coding, to focus on the development of themes identified among participant responses as well as emergent patterns discovered through further analysis of the established categories. Lastly, I reviewed codified data and interpreted the central idea, summarized the occurrence of concepts, and conclusions discussed by participants as related to themes that were identified (Maguire & Delahunt, 2017). From these interpretations, data was analyzed, and conclusions were identified to answering the research questions of the project.

Data analysis identified codes, categories, and themes from transcription of interview logs and reviewing of audio recordings. Coding provided identifiers to topic areas, patterns, or themes discovered within the transcript (Ravitch & Carl, 2016). Codes were placed together to form categories. Themes then emerged from the categories established within the study. Themes when established show what the relationship may be between two or more concepts (Ravitch & Carl, 2016). Themes that were identified from the analysis explained why phenomena occurred the way that they did. These results informed the discussion as well as areas for future research

based on the central themes identified throughout the interview process and data collection. Criteria to measure quality in qualitative research was identified by trustworthiness, which directed the question as to whether the findings of the research can be trusted (Korstjens & Moser, 2018).

Issues of Trustworthiness

Trustworthiness within a research study helps to ensure that a study has results that are reliable and valid to their area of focus (Shenton, 2004). Assessing trustworthiness of this research study involves exploring dependability, credibility, transferability, and confirmability. Trustworthiness helped ensure that the study allows for appropriate levels of rigor through assessment of the methodology for the study in those areas. Below I will discuss how trustworthiness was obtained through exploration of dependability, credibility, transferability, and confirmability.

Participants did not report concerns with potential employer retaliation as a result of their participation in the individual interview, so were not selective with the information they shared. Participants were asked to base their answers on their own personal experiences as well as being reinforced that there were no wrong answers to any of the interviewer's questions.

Credibility

Credibility looks at the validity of the information contained within the research and the idea that the research findings be as aligned with reality and as credible as possible (Shenton, 2004). This required that I ensured methods utilized were appropriate to the area studied. In this example, sampling utilized purposeful sampling by seeking participation from social workers working on an RNF floor within a hospital setting. An area of concern included the willingness of social workers to be truthful and forthcoming regarding their perceptions of cultural

competence and humility when working with LGBT clients within their workplace out of fear of employer response. Employees might have been hesitant to share information for fear of information being interpreted as talking negatively about a current employer. Finally, ensuring that I was equipped with knowledge and expertise based on my prior experiences in the required areas as a hospital social worker providing discharge planning on an RNF unit helped ensure credibility.

Transferability

It was important that the results of the study were transferable to other settings and the larger population of medical social workers in hospitals. This focus ensured that correct sampling was utilized that fairly represents the area being studied (Rubin, 2012; Shenton, 2004). I needed to be clear with the boundaries of the study being suitable to draw distinctions on social work on an RNF unit setting only. Doing so helped assure that information shared by social workers applied to their area of work specifically and not to generalist social work practice. Additionally, this included being clear of any bias in selection or recruitment for a study, which will be discussed further in Chapter 4 of this study. The strategy that was used for transferability was to use thick description which entailed adding context to the experiences to increasing meaningfulness to the reader as well as helping the reader determine if the setting was sufficiently similar in order to transfer the findings (Korstjens & Moser, 2018).

Dependability

This area of quality focused on the reliability of the study. The focus of this study was on ensuring that if all of the work of the study was repeated with the exact methods and same participants that the results would be similar (Shenton, 2004a). This focus is similar to credibility; however, the focus was on research design, implementation of research, operational

detail of how data was gathered, and appraisal of project through reflection. The strategy that was used for dependability was to ensure an audit trail via the use of a research journal via Day One journal to track day to day processes to track analysis as well as providing transparency and description of the steps taken during the research process from the start of the project to the reporting of the findings (Korstjens & Moser, 2018). Additionally, many hospital settings have specific work role expectations on a regular nursing floor at a particular hospital that may vary from social workers working on an RNF floor at another hospital, which might have impacted participant perceptions and experience of humility in their responses based on those job expectations. The methods of this study looked at the perceptions of cultural competence and cultural humility within social work practice on the RNF unit. Varying role expectations by social workers only impacted their perceptions of their experiences. This helped add depth to the categories and themes established from the information gathered.

Confirmability

The focus of confirmability was on ensuring that the results of the research were a direct result of experiences and ideas from the participants rather than those from myself as the researcher. It was important in this step for me to be forthcoming with my own pre-conceived thoughts or beliefs on the topic (Shenton, 2004a). Doing so helped determine the impact of investigator bias on the topic area. I additionally alleviated concern with confirmability by being detailed when providing description on the methods utilized when conducting all areas of the research. Record keeping via a research journal and storing of audio sessions helped confirm that experiences were as stated by participants. Per Hughes (2014), use of email offers participants the opportunity to individually explore their feelings on topics and tend to lead to more in-depth analysis and responses. This aligned with the research experience as the participants utilized

email to provide in depth analysis and clarification to the audio that was provided to ensure the message aligned with the arguments they were trying to make to me within the individual interview. Allowing participants the opportunity to review the audio recording provided the opportunity for feedback and clarification on ideas expressed within the individual interview after the completion of the individual interview. This step allowed the participant an opportunity to check their messages sent in an individual interview and give appropriate information that helped confirm their intended messages.

Ethical Procedures

Social science research must follow ethical procedures (Clark, 2009). This study worked to ensure confidentiality of information by limiting access to audio recordings via an email link for two weeks after the completion of the individual interview. Videos that participants will view were accessed via a weblink that expired two weeks after the emailed video link was sent to participants. Informed consent is the bedrock of sound ethical research guidelines (Clark, 2009). Once notified regarding participation in the individual interview, the participants were provided with a consent form for review and when they were ready they replied to the email with “I consent”. The consent form provided a brief description of the study, the purpose of the study, procedures that were completed, and provided sample questions that would be asked in the individual interview. Additionally, the consent form detailed the voluntary nature of the study, the risks and benefits, privacy guidelines, and Walden University’s approval to proceed with research with IRB approval study number. The last section detailed obtaining consent and asking the participant if they had a firm enough understanding to provide consent to participate in the study. This procedure protected the individual to ensure they understood they may stop participation at any time. This study provided participants with confidentiality as it would be

outlined in the privacy section of the consent form. Any identifying or personal information was not be shared. Participants were reminded in the individual interview that experiences shared should be based on personal experiences and that they were encouraged not to share specific information with anyone outside of the individual interview. The data was then stored on my personal password protected computer for five years as required by Walden University. Participants contact list were also to be stored on a separate password protected file for a period of five years. A backup of the data was stored on a password protected external hard drive and will remain stored for five years as required by Walden University. The data will then be destroyed by reformatting the computer hard drive and external hard drive to the manufacturer's original computer formatting. Additionally, the demographic data sheets and transcripts from the individual interviews will be shredded and disposed of. I was the only individual that had access to the data as the single researcher for the study, however participants within individual interviews were given access to the audio recording of the individual interviews including an opportunity to provide clarification via email correspondence within fourteen days following the completion of the individual interview.

Summary

This basic qualitative research study using individual interviews was the most appropriate method to explore hospital social worker perceptions of use of cultural competence and cultural humility when working with LGBT patients in the hospital setting. This research study was designed to answer questions with qualitative research increasing knowledge in a specific context (Joshy et al., 2011). This basic qualitative research study encompassed the use of individual interviews created from members of a medical social workers association through purposive sampling. The purpose of this study was to explore how social workers described their

perceptions of cultural competence and cultural humility when providing services on a regular nursing floor (RNF) in a hospital setting to the LGBT population.

In the next chapter, I will present information related to IRB approval, unforeseen changes to the proposed plan, data collection, data analysis, and study results. Presentation of completed data collection methods will also be discussed. Interpretation of the results of the study, limitations, recommendations, as well as future research and practical implications, will be discussed in Chapter 5.

Chapter 4: Results

Introduction

The purpose of this study was to explore how social workers described their perceptions of utilizing cultural competence and cultural humility when providing services on a RNF in a hospital setting to the LGBT population. Individual interview questions were open ended and used to gather social work perceptions of humility and competence in culturally competent practice with LGBT individuals in the workplace.

RQ1: How do medical social worker perceive their experiences of utilizing cultural humility to deliver medical social work services in a hospital setting to LGBT individuals?

RQ2: What key characteristics or skills do medical social workers perceive are needed to effectively demonstrate cultural competence and humility with LGBT individuals in a hospital setting?

RQ3: How do medical social workers describe culturally competent practice with LGBT individuals in a hospital setting?

In the sections that follow within this chapter, I will present information related to IRB approval. I will discuss unforeseen changes to the setting of the proposed research plan. I will then review the participant demographics of the study. Next, I will discuss data collection for this study. Then, I will describe the data analysis for the study. I will then review evidence of trustworthiness to the study. Finally, I will review the study results.

Demographics

A total of six participants participated in this study. Demographic breakdown of the participants is listed in Table 1 below. Participants were social workers with experience working on an RNF unit in a hospital setting. Participants worked in the state of Ohio only. Participants

worked in multiple hospital settings throughout cities in Ohio such as Cleveland, Akron, Canton, Toledo, and Columbus Ohio (see Table 1). For the purposes of data reporting, Akron and Canton are identified together due to the participant mentioning their work consisting of servicing clients within Akron and Canton, Ohio. These two cities are separated by 24 miles. Of the areas identified, the social work participants for this study had extensive hospital experiences, which included work in an intensive care unit, emergency room, community health floors, regular nursing floors, and experience on an oncology floor. Participant licensure levels were LSW (n=2) and LISW/LISW-S (n=4).

Table 1

Demographic Table

Participant number	Licensure status	Years of experience	Gender	Race	Sexual orientation
1	LISW	5 years or less of experience	Female	Caucasian	Heterosexual
2	LSW	16 or more years of experience	Female	Caucasian	Heterosexual
3	LISW-S	6-15 years of experience	Female	Caucasian	Heterosexual
4	LISW-S	16 or more years of experience	Female	Caucasian	Heterosexual
5	LSW	5 years or less of experience	Female	Caucasian	Heterosexual
6	LISW-S	6 -15 years of experience	Female	Caucasian	Heterosexual

No participants reported working within community practice settings that had a religious affiliation. Participant health care experiences ranged from 5 years of training (n=2) to 21 or more years of training (n=2). All participants (n=6) reported being heterosexual, and all participants for this study identified as women. It should be noted that no male participants agreed to individual interviews for this study. Throughout the process of recruitment, two male

respondents from Ohio reported interest in the study, but upon receiving the informed consent along with further study information, they declined to participate. Recruitment for male participants was ongoing throughout the interviewing and data collection process.

Data Collection

Interviews were conducted between November 2020 and March 2021. The setting for this study was via Zoom teleconference. Due to the conditions surrounding COVID-19 and quarantine conditions, no face-to-face interviews were scheduled. Interviews ranged from 33 minutes to 63 minutes in length. The median time length was 41.8 minutes. All interviews were recorded on my laptop via the Voice Recorder app as well as being recorded and transcribed to text via Zoom recording. At the completion of the recording, I provided individual participants with a web link to review the audio of the interview and provide an email response if they wished to provide any further information to answers they provided. No participants responded.

There were minor changes to the original research design after initial IRB approval was obtained. Changes occurred in the area of mode of data collection. An adjustment was made changing from focus group interviews to individual interviews. At the onset of recruitment, I received interest from multiple participants; however, once I informed them of the desire to have focus groups, they requested individual interviews. This resulted in participants declining to participate. With the IRB's approval, which included revisions to the recruitment flyer and consent form that described the use of individual interviews, the method of data collection was changed to individual interviews. Once this change occurred, I was able to actively recruit and schedule my interviews for this study without reservation from participants.

I posted flyers to various social work professional Facebook groups. Prior to posting the flyers to the groups, I contacted the listed administrators via private Facebook messaging or via a

private email of those groups for permission to recruit via posting flyers, which included a copy of the flyer to be posted. Once approval was received, I posted the flyer to the group page. Examples of Facebook groups that were utilized included Northeast Ohio Social Workers and Counselors, Network of Professional Social Workers (NPSW), Social Work, Social Work and Social Worker, Social Work Community, Society for Social Work Leadership in Health Care, The Social Work Group, Trauma Informed Social Work, Ohio Social Workers, National Association of Social Workers – Ohio Chapter, Social Workers Life, Social Workers in Education, Louisiana Chapter of National Association of Social Workers, Toledo Social Workers, and NASW Houston. Membership to these groups ranged from 300 members to over 19,000 members. Postings to Facebook occurred on five different occasions to each professional networking group listed between October 2020 and February 2021.

The original sample size was seven to 12 participants; however, saturation for this study was reached at five participants. As noted in Chapter 3, saturation can occur at a multitude of ranges, but generally occurs between five and 12 participants (Carlsen & Glenton, 2011). Researchers agree that signs of saturation are reached when no new data, themes, and coding are available (Fusch & Ness, 2015). These signs led to the approach to data saturation to this study. New themes stopped emerging by the fifth interview.

Data Analysis

The data collected from the interviews were stored, analyzed, and coded by me for identification of themes. Information was collected then coded through analysis of themes and patterns established from questions posed to participants during individual interviews. Information collected was then codified by me into a single codebook. Zoom's audio recording software was used to transcribe the interview to audio. Additionally, I utilized audio recorder

software on my computer to complete a second audio recording of the individual interview in case Zoom audio recording failed. Upon completion of the individual interview, participants were provided with an audio recording to review. They were given 2 weeks to respond to me with follow-up information if they wished to do so. None of the participants did. I reviewed all written transcripts and edited their contents for accuracy of text, including removal of names. Upon completion of transcription, I analyzed the data, established codes, and generated themes.

Interview and Transcription Process

Interviews were conducted one on one via Zoom teleconference software using the interview guide to guide the conversation (see Appendix A). As a result of the richness of the data gathered after the initial two interviews along with participant feedback, it was determined that the interview guide was sufficient. The interviews were consistent with the interview guide, using prompts and probing questions as needed to elicit further exploration on the question topic.

Once I reviewed the transcription, I reviewed the audio transcription along with the written transcript four times to establish accuracy and highlight important comments and themes using thematic analysis. This type of analysis allows a multi-step process consisting of six steps: familiarizing oneself with the data, creating initial codes, labeling codes by initial themes, reviewing themes identified, defining and naming of the themes, and finally, conducting analysis through a written report (Maguire & Delahunt, 2017).

Coding was conducted by me through analysis of answers to questions through comparing responses that participants made, with attention paid to written notes completed during the interview, along with reviewing audio recordings and written transcripts for each interview question response to each question. The first round of coding produced over 70 codes. Some of those codes included lack of preparedness, social work educational issues, social work

and hospital training issues, lack of LGBT life experiences, self-awareness, clients as role of teacher, social worker bias, lifelong processes for competence obtainment, and positive LGBT experiences with client interactions. The second round of coding entailed utilizing descriptive coding to group topics to general themes from participants. I reviewed all the themes to ensure cohesion and relevance to the focus of the research questions for this study. This second round of coding produced four general themes for this study. Exploration and further in-depth analysis of individual interview discussions in context to the study as a whole narrowed them down for this study to four themes based on overlap of ideas and participant comments: (a) lack of formal educational opportunity/preparedness, (b) cultural humility as a preferred approach, (c) preference for an inclusive client-centered approach, and (d) continual learning essential to social work practice.

Evidence of Trustworthiness

Below is a review of the final position on evidence of trustworthiness post data collection and analysis. Considerations related to credibility, dependability, and confirmability will be addressed. In addition, attention on transferability will be discussed.

Credibility

Per Patton (2015), credibility requires three elements: rigorous methods, researcher credibility, and belief in the value of qualitative inquiry. This study began as a focus group study; however, in the midst of recruitment, participants when informed of the focus group approach stated they would be more inclined to participate in an individual interview instead of a focus group with social work peers. As a result, the procedure was changed and approved through IRB to utilize individual interviews. Changing to this procedure provided the study with a set of data through one-on-one interviews that may not have occurred within a focus group setting. It should

be stated this study used a homogenous sample that may not represent a larger population. Additionally, the study did not manage to gain participants through the initial focus group approach.

Dependability

Additionally, dependability is a key element of trustworthiness, as it indicates the extent to which a study is repeatable (Patton, 2015). This change in procedure may have provided dependable outcomes as a result of individuals feeling the availability to speak freely without the concern of how others may have interpreted what was said. It should be noted that due to the homogenous sample results provided by participants, this study may be biased and not represent the medical social work community at large. This research study should be able to be reproduced by a researcher by repeating the research design and methods outlined in this study while producing similar results with a similar sample. Dependability is reduced due to the lack of participant participation in the follow-up email provided within the study and high reliance on answers provided within individual interviews only.

Confirmability

Concerning confirmability, one barrier in qualitative research is the uncertainty that researchers, though unintentional, can shape findings according to personal worldview and their own biases (Patton, 2015). Plans to diminish threats to trustworthiness outlined in Chapter 3 were upheld within this study. Reflexive practices, such as journaling and taking field notes during participant interviews, were upheld throughout the data collection process. However, the member checking process was not completed and returned to me by any participant, thus denying an additional opportunity for participants to offer feedback at the conclusion of the

interview. The lack of response from participants after the study may not correlate with an agreement with the answers provided.

Transferability

This study utilized a purposeful convenience sampling method. The findings will not be transferable to the entire social work population. This focus on RNF unit medical social workers did not ensure that correct sampling was utilized nor was it fairly representative of the area being studied (Rubin, 2012; Shenton, 2004). I remained clear with the boundaries of the study being suitable to draw distinctions on social work on an RNF unit setting only. Additionally, equal representation from genders in this study did not occur. The results of this study may be transferable among hospital social workers with similar backgrounds and similar gender makeups to the participants of this study.

Results

In this study, I focused on social worker perceptions of experiences utilizing cultural competence and cultural humility in social work practice with LGBT individuals on a RNF unit of a hospital setting. In order to answer this question, I inquired about social worker definitions of cultural competence versus cultural humility, what characteristics are most significant to offering services that show culturally competence and cultural humility to LGBT patients and how social workers implement aspects of culturally humility and cultural competence within their hospital work setting. In this study, I focused on participant responses—their own definitions, understanding, and comprehension of cultural competence and cultural humility with LGBT individuals. Further, I investigated experiences of prior learning and educational opportunities for social workers on cultural competence and cultural humility.

For research question 1, participants perceived their experiences in utilizing cultural humility to deliver medical social work services within a hospital setting to LGBT individuals as limited and lacking the skill required to provide culturally competent care within the hospital setting. Social work participants preferred a cultural humility approach because it allowed the social worker the ability to learn more about specific cultural topics from LGBT individuals.

The second research question looked at what key characteristics or skills medical social workers perceived as needed to effectively demonstrate cultural competence and humility with LGBT individuals in a hospital setting. Social work participants for this study described the need for self-awareness from the social worker in regard to their own potential biases. Additionally, the ability to be aware of how those biases can impact care given to an LGBT individual. Openness to allowing the LGBT client and family system to guide the discussion and conversation in light of limited life experiences was also viewed as a needed skill from social workers within hospital settings.

Finally, research question three looked at how medical social workers described culturally competent practice with LGBT individuals in a hospital setting. Within this study, social workers described culturally competent practice in terms of a lifelong educational process where the social worker must develop an awareness and understanding that they need to commit to being lifelong learners to continue to develop skills and resources based on LGBT cultural experiences. Social work participants noted that effective culturally competent practice involves both the combination of information learned within textbook readings, classroom work, and real-life experiences over time. All of which the participants noted is a responsibility of the social worker as a part of their professional licensure requirements.

As previously stated, I utilized hand coding to identify initial codes and then through further exploration was able to establish the overall themes for the study. After completing the initial coding, I further analyzed the audio and written transcripts along with the established codes in a second round of coding. From this analysis I identified the three prominent themes of the study.

Themes

Data collection and analysis revealed an initial list of codes introduced by participants, however through several additional reviews of the audio and written transcripts it became clear that many characteristics were interrelated and, therefore, three final themes were identified. These themes all have a direct connection and answered the research questions for this study, and data collected and analyzed from the social work participants supported their desire to work from a cultural humility viewpoint as their preferred focus when working with LGBT individuals in a RNF unit of a hospital.

These themes listed below in Table 2 were central to the participant responses and seemed to build on one another throughout the study:

Table 2

Themes Identified	
Theme 1	Lack of formal educational opportunity/preparedness
Theme 2	Cultural humility as a preferred approach
Theme 3	Continual learning essential to social work practice

The themes are discussed further below, and participant responses are denoted to support the themes identified. All participants were assigned participant numbers to protect confidentiality and privacy yet allow for review of relevant themes to be identified in order to protect the trustworthiness of this study.

Theme 1: Lack of Educational Opportunity/Preparedness

Within this research study, participants noted a lack of preparedness both during their educational pursuits as well as after they received their professional license through their workplace setting. Participants noted that their preparedness was directly related to life experiences they exposed themselves to as well as training opportunities they sought out on their own. All participants agreed that frequency of exposure to experiences with LGBT clients correlated with their preparedness.

All participants verbalized that they received minimal formal education regarding ways to provide LGBT care within a hospital setting. All but one participant (participant 4) reported that they were unable to recall education in their master's-level social work program on LGBT or on cultural humility. The participant that noted having this experience noted that they had completed a group project with a classmate who identified as LGBT and as a result their topic for a social work course was LGBT specific. Participant 5 noted the opposite experience and described an overall lack of educational offerings provided to them:

> I can very confidently say I had very, very little education. I can think of a diversity class, it was probably a chapter, and that was really it. Any learning that I acquired, I had to seek out on my own through CEU's or just doing my own research.

Participant 3 noted that in some experiences regarding LGBT issues were discussed, but that skills were not developed that made them confident in practice:

> I think maybe there was one chapter in my entire educational experience that dealt with various cultural issues which feels horrible to even put under the category and the only time LGBT issues came up in an academic setting was with another student via a group assignment, not from a professor.

Participant 5 noted a similar need for more educational offerings that are LGBT specific:

> I definitely think that it needs to be more than just a chapter in a book one time during your bachelor's and master's level. Because you take those cultural diversity classes and it always seems like it's the same thing, the same populations that you're talking about in them.

All participants noted that this lack of exposure to LGBT learning experiences did not necessarily stop at the conclusion of obtaining their licenses or degrees. All participants noted a lack of required trainings involving LGBT, cultural competence, and/or cultural humility within their professional settings. Participant 2 stated, "You know, I really had to learn on my own, because the organization didn't, and I worked for a nonprofit that did not provide any training."

All participants noted that all trainings and skills acquired were done so on their own. One participant noted doing research on their own on various trainings available. Participant 3 noted how they sought grant funding for her employer so that a training could be conducted.

> I chose to go the administrative route and ended up doing clinical work within a hospital, of course. But I would say I had no experience or training in school. Any experience I've gotten post master's degree was sought out and paid for on my own for continuing education opportunities.

Participant 4 echoed a similar experience and noted that the lack of employer support potentially impacted their ability to provide services and seek out supervisor support.

> I have to do my own research for skill building opportunities outside of normal working hours. I still look for the support of my boss my supervisor, or whoever, I can to make sure that I feel I'm approaching a situation with an LGBT client or family properly and handling it in a proper fashion, but without my own research knowledge I would be lost.

Finally, many participants agreed that mandated trainings at the employer and state level may help social workers feel better equipped with the knowledge to provide care to LGBT clients. Participant 6 even suggested that social work boards begin looking at mandating LGBT specific trainings:

> I would like trainings mandated by the social work state boards, I would like it to be required. I think it should be required that social workers working within systems or in organizations that are exposed to LGBT on a routine basis to be trained properly. Because if the training is not required, it may never happen.

Participants expressed a need for more education focused specifically on cultural needs of the LGBT population. In their own words, participants described needing to provide classes in college undergraduate courses that utilized a cultural humility framework when dealing with various cultural needs of LGBT individuals. Participants also mentioned this same approach might be beneficial as a yearly competency for social workers working within agencies and hospitals.

Theme 2: Cultural Humility as the Preferred Approach

Cultural humility as an approach looks at social work interactions with clients as opportunities to gain insights and expertise through engagement with the client in conversation about their own lived experiences. This approach helps the social worker gain insight to the lived experience of the particular client population as they define it. The approach utilized in this study

entailed asking participants to first discuss their perceptions of utilizing cultural competence in their practice on a RNF unit. Participants were then asked to discuss their experiences using cultural humility within their everyday social work practice on a RNF unit. Finally, participants were asked to discuss their preferred approach based on their already provided responses. All participants in this study stated a preference to cultural humility as a preferred approach when working with LGBT individuals. Furthermore, participants reported having more success and positive experiences with LGBT clients in providing social work services on an RNF unit as well as in planning for discharge for clients when they reported using cultural humility as their approach. All participants while stating a preference for cultural humility as their approach, also stated having a discomfort with saying they were culturally competent to practice with LGBT individuals.

Participants were initially asked in their interview to define cultural competence in this research study. A majority of respondents, when defining cultural competence actually defined the main characteristics of cultural humility. Key terms such as; “open minded”, “self-aware”, “humble”, “client-centered” and “unbiased” were used to define cultural humility. Participants when asked to compare the approaches of cultural competence and cultural humility when working with LGBT individuals, all preferred and suggested cultural humility as the approach that should be utilized with LGBT individuals within a hospital setting. Participants mentioned that cultural humility allowed client to feel less vulnerable within the hospital setting, while at the same time giving them a sense of purpose and control to the therapeutic relationship. Additionally, this approach was preferred by participants because it also allowed the opportunity for social workers to learn cultural traditions and preferences from the client. This practice aligned with participants stating that much of their learning and increased knowledge on LGBT

appropriate care was from interaction with other LGBT individuals in a real life setting outside of the workplace. The participants reported that cultural humility was more comfortable for them because it placed the client in control of educating the social worker on the client situation and cultural situation, while further assisting the social worker in strengthening their own exposure and skill set to work with LGBT individuals. Participant's also felt this approach helped limit the potential for the social worker to make assumptions about the LGBT individual's situation. Participant 2 stated:

> Well, I don't like the word competence. Because it implies that I'm competent in someone else's training, I would define cultural competence it as an awareness and a respect for others by not making assumptions while creating an environment comfortable enough for somebody to be themselves if they so choose.

Participant 5 felt the word competence as an approach to their work did not align with the evolving cultural story of their clients they may come in contact with.

> I don't even know if competence is the right word to use, maybe a better word is familiarity. I'm understanding and familiar of what some of the issues that may be experienced by folks who identify as LGBT but I am not competent.

Additionally, participants mentioned how unnatural cultural competence can feel in practice, while utilizing cultural humility seems more natural to the social work process as working alongside the client. Participant 4 added to this discussion that there is not a finite level where a social worker is competent.

> Cultural competence makes it sounds like you check off a box. Okay, I took six hours of CEU's, so I'm more competent than the person that took a three-hour training, you know,

> and the person that took nine hours of training feels like the more competent implies like there are levels. I don't think there can be levels to it.

Participant 4 further went on to discuss the benefit of an open approach to learning and understanding the client situation based on their own cultural experiences that cultural humility provides. They added, "It just has to be an openness so cultural humility to me implies openness. But with cultural humility, you're open to listening and realizing that the more open, you are, it could impact access to care."

Another participant stated that within their work experiences, self-awareness was the most vital aspect of cultural humility due to its continual relationship with the internal frameworks and growth of social worker practice over the course of their own experiences. Participant 1 further explored the importance of self-awareness when utilizing cultural humility.

> You need to be aware, and be aware of where you are, how you've gotten to be where you are and how does this impact the relationship with another client or family, like transference and counter transference. How are you aware of your bias? Are you aware of how you feel? Are you aware of how you might make someone else feel? And then how that looks behaviorally whether it's nonverbal or verbal communication or posturing?

Participant 5 described the differences between cultural competence and cultural humility as being okay with not having all the answers and realizing that competence never has an end point.

> I think the second word to each of those cultural terms, competence versus humility is important, you're competent if you've passed the test. You've learned what you need to know you get the stamp that you're competent to work with this group or that.

Participant 5 then discussed their preference to cultural humility as an approach based on the feeling that competence may never be fully realized:

> Humility, I kind of like better because it's a good reminder that maybe we're never ever completely competent. We might be comfortable, and we might be here to provide services, but competency to me just really is up you. Whereas I think about humility as not assuming that you know everything but wanting to know more and being available to others to learn more. So, there is not an end of the spectrum like with cultural competence, whereas with cultural humility you kind of grow comfortable with being everything in between.

Being comfortable with not knowing the answer regarding LGBT cultural needs within client situations was a common response that participants described when talking about how they effectively utilize cultural humility with LGBT individuals. Participant 1 noted the need for social workers to be humble and seek out information from the client in order to learn more about the LGBT client experiences:

> Social workers need to feel okay with seeking information, whether that be from the patient themselves the caregiver or the partner, along with being comfortable with doing your own research, making your own effort by going to your own educational programs. Cultural humility is the act of knowing that you don't understand and are willing to accept that just because you learned it somewhere doesn't mean that you act upon it essentially.

Being less concerned about the social worker’s knowledge in the initial stages and more with the needs of the client is a common definition that participants gave when discussing a preference of cultural humility over cultural competence in practice. This approach has helped many participants increase their knowledge base and skill through client and family interactions. Participant 3 added the need for social workers to practice being other oriented as a main component of cultural humility when working with LGBT individuals:

> Being other oriented. I guess it's how I would say humility to me is, it is about concerning yourself with another rather than me or my own ego. So, you have to have the cultural piece right, so you have to have a context of the person that you're dealing with in their culture.

Participant 3 added that combining otherness with self-awareness when working with LGBT individuals produces a positive learning experience for social workers:

> Whether it's an LGBT individual or another culture it's about understanding their culture, but then the humility piece is a self-awareness I bring into it with the ability and the understanding that I don't have all the answers and that this is going to be a beautiful learning experience for me as well.

Based on the information provided from participants, the concept of cultural humility is practiced a majority of the time by social workers within the hospital setting without them necessarily realizing it is occurring. Participants expressed a process of implementing cultural humility when working with LGBT clients as a natural part of the helping process with client systems they are not as familiar with. A few participants noted after completing their interviews that they did not realize they utilized cultural humility as an approach with LGBT individuals. Those participants did discuss using characteristics that closely aligned with cultural humility as their approach with LGBT individuals after now discussing and reviewing the concepts of cultural humility within their interview. Their described experiences in using cultural humility aligned with characteristics described above of being selfless, seeking to have the client as the expert, and showing an interest and genuine interest into the specific client's culture, traditions, and experiences.

A key component within the practice approach that participants noted a higher success rate with involved including the client system or family by working alongside the client or family system to better understand the specific culturally situation as the client or family system described it. Participants noted feeling a high level of vulnerability and concern in their experiences that LGBT clients may not value their referral resources or seek out their help if the social worker did not appear to have all the answers regarding the experiences of the LGBT individual when visiting the client within the hospital. Participants reported more successful experiences and stronger LGBT client interactions when the client or family system was included in all facets of their care plan within the hospital setting.

Participants value the impact that continual learning has made on their obtainment of skills within the hospital setting. Participants within this study when discussing cultural humility and success with utilizing it highlighted the need to be comfortable not knowing all the information needed prior to helping an LGBT client. In fact, many participants stated being open to the idea that a social worker may not know all the information around a culture could help the social worker work alongside the client in a collaborative approach that is seen as more inclusive to the client. Participant 1 noted that inclusion positively impacted the social worker further developing their own cultural competence. They stated, “There are times where I've had patients, teach me things, you know, and, I'll say, wow, I never really knew that, but I appreciate you sharing it with me because now that helps me help other people. “

Participant 3 elaborated on this idea that shared learning through inclusion and openness positively impacted learning as “being open to learning from another, being open to going into the hospital room not believing that you have all the answers.”

Participant 5 elaborated on the same idea that the relationship with LGBT clients can be a mutual one that the client leads as the teacher. They stated, "You just approach every person and that you want them to teach you about their experience."

These perceptions continued from Participant 4 who questioned how a social worker can be client centered in their hospital practice with LGBT individuals without eliciting activities and conversations that provides mutual learning to the client and the social worker.

> I don't know how you can be client centered if you don't know your client. I'm always asking questions because I can't assume to know what anybody means by what they're saying. So, if I have a question and I think engaging in a dialogue comes from a standpoint of what can I learn from you? How can I learn where you are in your world and your experience and how is that experience?

Participant 5 echoed the thoughts that taking cues from clients can be helpful within the hospital setting, stating "it's more about listening and taking your cues from the patient that you happen to be in the room with."

Participant 6 added that being inclusive of the LGBT client better helps the social worker understand the perspective and values of the client as they present to the hospital. They stated, "they [LGBT clients] need to guide the discussion and help me understand what that individual feels, what that means to them based on their own perspectives and their own values."

This approach to the social worker and client relationship increases the social worker feeling that the LGBT individual is on equal footing in an inclusive working relationship within a hospital setting. This approach potentially acknowledges differences between the social worker and the LGBT client but uses those differences in a way to validate the LGBT client's perception of the specific cultural situation and develop a mutual communication plan that enhances mutual

understanding. Participant 2 stressed the importance of openness to LGBT client experiences and perceptions as they report it:

> I can't make assumptions. I think it's really being open to learning where the client is right then and let them guide me to areas within their culture and how their experiences have gotten them to be where they are today because I meet clients, where they are.

Continual learning is a part of social work practice. Social workers within this study voiced their desire for professionals working within the hospital system, when practicing culturally competent care, should engage the client systems by asking questions that elicit learning between the social worker and the client based on their cultural background and their unique client situations. The participants from this study highlighted that this inclusive client centered approach to care has improved social worker relationships in practice with LGBT individuals and has led to stronger mutual professional relationships.

Theme 3: Continual Learning is Essential to Social Work Practice

All participants described their preparedness to provide care as either moderately equipped or not equipped at all to provide care to LGBT individuals. The participants that stated they felt moderately equipped had been working in the field for a minimum of 10 years and also had noted in their interviews that they had sought out learning opportunities through continuing education opportunities on their own. However, it should be noted that all participants within this study were heterosexual Caucasian females so participants may be considered part of a privileged group and lacking real life experiences that other non-privileged groups have been exposed to. Participant 1 stated the desire to find trainings independently to enhance their own comfort and skill with LGBT individuals saying “I feel mild to moderately prepared because I myself have sought out continuing education trainings on my own.”

Participant 2 expressed that in their own experiences there was a concern that many hospitals lack continued programming that allows social workers to continue to build on their skills.

> I mean, again, I don't think that we're really equipped, through specific programs for LGBT individuals and that sometimes we're not given enough opportunities to connect with people in that way to get more competence in that area. So, I don't think that hospital settings do a very good job of providing us with educational opportunities about these topic areas on a continual basis.

Trainings on cultural competence and cultural humility with LGBT individuals might be beneficial to multi-disciplinary teams to help build competence to medical teams, not just specific hospital disciplines. Participant 6 noted that trainings including multiple disciplines in a hospital setting may benefit the overall skill and ability to provide care to LGBT individuals on a hospital floor:

> It would be great for hospitals to have trainings with multiple disciplines in the training themselves and that has never happened [in my experience]. It would be nurses who would get their own training, then doctors would get their own training and then social workers would get their own training. It would be great to have all of them in the same room taking the same cultural competence trainings.

Finally, participants felt trainings and educational opportunities should be infinite due to constantly evolving changes in culture and societal change. Participant 4 noted that training should be viewed as lifelong and never finished:

> I feel equipped to handle the population. But I feel like I'm not done. Like there's more to learn. There's more room to grow. There's more to experience. I feel like I have the

> basics, but the basics are always evolving and I'm always gaining more and more information, both from CEU's, of course, and from my families.

Education and training was described by participant's as a vital piece of the social worker's progression to providing cultural competent practice with LGBT individuals. Participants were quick to acknowledge they routinely sought out programs and educational opportunities outside of their normal work hours due to the lack of adequate experiences geared toward serving the LGBT population. They noted that self-awareness of meaningful areas of practice that require improvement upon was an important aspect of the social worker in this area. They noted that embracing the need to ask questions and find out information is an important aspect of continual learning in social work practice.

Summary

The participants openly discussed their familiarity, understanding, and formal knowledge of cultural humility and cultural competence as a concept. Further, they discussed the relevance of culture, respect, inclusivity and self-awareness in practicing culturally competent care with LGBT individuals on an RNF unit. The three themes that emerged from review of the data collected answered all three research questions for this study. Participants stated a preferred desire to utilize a cultural humility approach when exploring individual client situations as a main driving force to the continual growth of skills and experiences for their own levels of cultural competence with LGBT individuals. The next chapter will explore the interpretation of the findings. I will discuss the limitations of the study. Recommendations for further research grounded in the strengths and limitations of the study will then be discussed. Finally, implications for positive social change will then be discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore social work perceptions of experiences related to the use of cultural competence and cultural humility with LGBT individual on an RNF unit. In this chapter, I reiterate the purpose and nature of the research. I provide an interpretation of the key findings in the study. Additionally, I will discuss the limitations of the study. Then, I will provide recommendations based on the study. Finally, I will discuss implications of the study, including the impact on positive social change. I analyze and interpret the findings in the context of the conceptual frameworks as applicable.

Interpretation of the Findings

The intention of this research study was to contribute to social work knowledge regarding perceptions of cultural competence and cultural humility experiences with hospital social workers on an RNF unit with LGBT individuals. With this contribution, I intend to promote a need for continual educational opportunities within the school setting as well as continual education opportunities provided within the hospital setting, based on the perceptions expressed by the social workers for this study. These social workers when given additional educational opportunities could develop a deeper skill set as well as an opportunity to practice skills associated with cultural competence and cultural humility.

Below, I share the interpretation of the three main themes presented in Chapter 4 along with how the results confirm or contradict the literature. The findings extend beyond previous research by showing that social workers also show concern with offering sufficient competence to provide services to LGBT individuals on an RNF unit. The findings from this research vary in how they related to the information gathered in the literature review. The research questions will

be discussed below intertwined with published literature. The themes from the study will additionally be discussed as they answer the research questions of the study.

Lack of Training Opportunities

Participants expressed that the primary factor that contributed to their preparedness to work with LGBT individuals in a hospital setting was a lack of experience with and exposure to working with LGBT individuals in social work practice. Lack of training opportunities played a major role in participants stating whether they felt comfortable providing care to LGBT individuals. Literature suggests that social work students and faculty members that rate their experiences and educational opportunities high in regard to offering cultural competence practice opportunities tend to also report higher inclusion rates within the classroom setting (McCarty-Caplan, 2015). Furthermore, research literature pinpoints a direct correlation between positive LGBT learning environments in the college setting with reported social work student preparedness and competence to provide effective LGBT services. (Atteberry-Ash, et al., 2019; Craig et al., 2014; McCarty-Caplan, 2018).

Participants in this study highlighted that they did not feel prepared from their undergraduate and undergraduate degree programs. All participants reported needing to utilize outside assistance or resources for cases involving LGBT individuals. Some participants reported their only training that occurred in school was during a field practicum experience. Additionally, participants stated the lack of the availability of training opportunities within their agencies caused most participants to seek learning opportunities independently without employer assistance to pay for these programs that took place outside of normal working hours. Despite this barrier, participants stated that they felt that continued educational opportunities were a vital component for social workers to provide culturally competent care to LGBT individuals. All

participants reported that it may be helpful if state licensing boards of social work consider mandating continuing education programs focusing on LGBT cultural experiences in social work settings.

Cultural Humility Preference

The main research question for this study is: How do medical social workers perceive their experiences of utilizing cultural humility to deliver medical social work services in a hospital setting to LGBT individuals? The participants when working with LGBT clients overwhelmingly preferred the use of cultural humility. Many viewed cultural humility as a key ingredient to the social worker further developing cultural competence.

The literature review confirmed these perceptions and preferences from participants, as it aligned with cultural humility's focus on introspection of self and identification with how the individual experience impacts the care they potentially provide (Waldrop, 2011). Additionally, the acceptance of the social worker as the learner in the client interaction leads to authentic interactions with clients and families as well as more impactful discharges from the RNF setting. This aligns with the newest rendition of NASW Code of Ethics standard 1.05 Cultural Competence that discusses that social workers should recognize clients as experts of their own culture (2021). Additionally, the standard highlights the need for social workers to demonstrate an understanding of culture that helps guide their practice with clients of various cultures. Finally, the literature review aligned with the social worker preference for learning about LGBT culture to be a lifelong activity. Participants in many instances stated a dissatisfaction with the term *cultural competence* due to it inferring that an end point could be reached within the learning of competence of cultures. They instead preferred the approach of cultural humility as a beginning to further develop a stronger sense of cultural competence.

Client Centered Approach Benefitted Participant Skill Obtainment

Participants, when discussing the key factors to providing culturally appropriate care to LGBT individuals in an RNF setting, noted the need for the social worker to be self-aware enough to allow the client to lead the conversation and take their cues from the client, versus directing the conversation as the social worker. Participants overwhelmingly preferred a client-centered approach when working with LGBT clients. This approach allowed the participants to feel vulnerable and ask questions from the client to gain a better understanding of the cultural background of the client and improve their skills to providing effective practice approaches to LGBT individuals. Further, many participants reported that in their experiences where they allowed the client to lead the discussion, it lead to better engagement with clients and more effective outcomes related to release from the hospital for the client. Additionally, participants reported that they felt more competent to provide culturally appropriate services to LGBT individuals over time as a result of these client-centered experiences in their practices. The literature confirmed the preference for a client centered inclusive approach, as the concepts of client self-determination, affirmation of dignity and worth of all people, and person-in environment framework are all a part of the NASW Standards of Practice in Health Care Settings (2015) principles of practice within health care settings. Additionally, research from both social work academic programs and professional social work providers showed a positive regard from social workers to feeling competent to provide social work interventions to LGBT individuals as their exposure and experience with LGBT individuals increased (Inch, 2017; Fantis, et al. 2017; McCarty-Caplan, 2018). The literature review indicated that incongruency of information due to ineffective communication between the social worker and client can impact discharge outcomes in a negative fashion (Pitcher & Flanders, 2014).

Continual Learning Essential to Practice

The participants of this research study expressed a strong desire to improve readiness of social workers working in an RNF setting to provide culturally appropriate care to LGBT individuals. Some of the participants stated they felt moderately equipped to work with LGBT individuals on an RNF. However, all of the participants stated that a majority of their training acquired to provide culturally appropriate care was gained outside of an educational and hospital work setting. The participants stated a need to improve cross discipline educational opportunities that allowed social workers to have trainings alongside other disciplines such as nursing and other medical professionals would be beneficial to improving hospital care team's ability to work collaboratively in a way that acknowledges the cultural differences in their clients on an RNF unit. The research aligns with this finding that competence levels associated with providing care to LGBT individuals increases the more that individuals are exposed to experiences and learning opportunities (Bosekey et al., 2019; Atterberry-Ash et al. 2019; Mosher et al., 2017). Furthermore, competence within the healthcare field has been depicted as a static entity without any variance (Baker & Beagan, 2014). One of the primary concerns of competent social work practice with LGBT individuals is the need for social workers to have continued experiences with LGBT individuals and continued skill building opportunities for specific disciplines as well as with others (Boskey et al., 2019). Finally, as Fisher-Bourne et al. (2015) stated, the need for social work within a practice setting is to educate beyond just cultural competence and include cultural humility based on its approach to having the worker remove themselves from the role of expert and instead embrace the role of learner.

Limitations of the Study

Limitations of the study included having a small sample size. Additionally, participants that agreed to participate in the study resided in Ohio only. Also, I was not able to successfully recruit any male participants for this study within the United States. This included ongoing recruitment during the completion of the six participant interviews, at which time saturation for white heterosexual female participants was reached.

This study utilized a homogenous sample with representation from various age ranges, hospital experiences, and amount of time spent on RNFs in the hospital setting. Due to the participants being form Ohio only, this study is not representative of all social workers working with the hospital setting within the United States. Most participants expressed having limited exposure to learning about LGBT cultural experiences in a school and hospital setting. While this information adds to the argument that limited education impacted the social worker experience, the limited exposure also led to social workers seeking their own learning opportunities to develop competence to practice both during their educational experiences and during their careers. McCarty-Caplan (2018) suggested that social work educational programs centering around LGBT competence need to due to following:

1. Include attention to LGBT issues in all courses of social work curriculum.
2. Utilize faculty that are LGBT competent.
3. Include policies that are inclusive to LGBT individuals and provide a safe learning environment for students
4. Have LGBT competent faculty that foster a safe and welcoming learning environment.
5. Produce students that feel prepared to work with LGBT people.

These suggestions align with the participants expressing stronger confidence in providing LGBT care when their own experiences of exposure to LGBT individuals during their educational experiences, life experiences, and professional experiences were plentiful. This aligned with the observed association between participants expressing comfort with LGBT individuals because of their frequency of experiences working with LGBT individuals in life experiences. These experiences lead to social workers reporting higher feelings of cultural competence even when they reported having a lack of educational or professional experiences with LGBT individuals. This self-learning may have impacted participant perceptions of preparedness to practice with LGBT individuals within a hospital setting, as it was closely related to their own self-obtained educational and life experiences.

Given the small sample size and the lack of diversity of the sample, the findings are transferable only to similar areas within a similar population composition. The participants were based in Ohio only, and comprised of a population that is predominantly heterosexual Caucasian female social workers. The sample size included social workers working within urban, city, and suburban hospital settings. Therefore, information from this study may be compared to similar areas in other states or areas that have a similar demographic composition. However, these results may not necessarily be transferable to areas that are more diverse racial/ethnic composition and experiences, as stressors, acceptance, and available resources may be inherently different. Finally, it is unknown if LGBT individuals perceived the social workers as showing cultural humility or not as this study examined the perceptions of social workers only.

Recommendations

I conducted this study to fill the gap in information related to social worker perceptions and experiences in cultural humility and cultural competence in an RNF setting when working

with LGBT individuals. Future research may benefit from exploration of social work experiences with social workers working within hospital settings across multiple states in the United States.

Future researchers could add to this research by looking closer at the use of cultural humility in all professional settings within a hospital setting. This research could be used to identify training opportunities within hospital programs to disciplines including social work. Future researchers could add to this research by looking at the perceptions and experiences as stated by LGBT clients and families of how social workers in hospital settings utilize cultural humility. Researchers would be able to use these results to identify future approaches to LGBT clients in hospital settings that may differ from current practices.

Implications for Social Change

When considering one of the key components of social work practice being to support diverse, vulnerable populations while respecting and upholding an individual's own diverse background they bring into a situation, advocacy for social change is a focus that must be undertaken (NASW, 2016). As a profession, social must view change on the individual, organizational, and political levels. Based on the findings from this research study, micro, mezzo, and macro system efforts lead to addressing issues associated with cultural humility and cultural competence within social work practice.

Individual

Positive social change at the individual level involves looking at the roles and responsibilities of social workers working within RNF units of hospitals. This includes considering the interactions that occur between the social worker, other hospital employees, and individual clients. Social workers could advocate for continued training opportunities for themselves that include LGBT as well as other diverse backgrounds. The NASW Standards for

Cultural Competency and Social Diversity discuss that a social worker should have a strong knowledge base for a client's culture, but also, possess the ability to provide culturally sensitive services (NASW, 2016). Understanding how the social worker can contribute to the successful outcomes as it relates to respect and understanding of LGBT individuals has the potential to lead to social workers reporting higher levels of competence and lead to a greater understanding and purpose to the social worker role within the hospital setting.

Organizational

As professional social workers, the participants stated a potential positive effect to social change, would be for organizations to seek out educational opportunities for employees to provide further skills that would eliminate potential client perceived bias while aiding their own social work practice within a hospital setting. One positive social change would include advocacy, on behalf of organizational leaders, that continued LGBT based education on cultural humility and cultural competence is beneficial to social workers being tasked with providing services to LGBT individuals as well as benefiting the overall outcomes for LGBT individuals during their hospital stay.

Policy

On the policy level, participants stated the need to raise awareness of the need to continue providing educational opportunities to social workers on the organizational and/or state licensure board level through required trainings that specifically target LGBT as a topic of discussion. Current literature supported the potential for positive social change by increasing awareness of the needs for LGBT individuals within a hospital setting (Nolan, et al., 2019; Baker, K. Beagan, B, 2014; Dunkle, J. 2018). It would benefit social workers working with RNF settings if agents

explained the laws and responsibilities associated with LGBT rights, as well as explaining penalties for noncompliance when providing care in an RNF.

Conclusion

I conducted this qualitative, general research study utilizing the conceptual frameworks of cultural humility and cultural competence. Through these frameworks I assessed social worker perceptions of experiences in utilizing cultural competence and cultural humility with LGBT individuals on an RNF unit. Six social workers with various experiences working with LGBT individuals on a RNF unit participated in individual interviews which provided valuable information for the study. Three themes emerged: lack of educational opportunity and preparedness, cultural humility as the preferred approach, and continual learning is essential to practice. The use of individual interviews allowed the participants to add to the current literature on cultural humility and cultural competence as practice approaches with LGBT individuals in an RNF setting. It is important for social workers working with LGBT individuals within an RNF setting to understand the differences between cultural humility and cultural competence while at the same time understanding that effective use of cultural humility can assist the social worker to developing a stronger understanding of cultural factors related to LGBT client experiences while further developing their own cultural competence to practice with LGBT individuals within RNF practice settings.

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Appendix A: Interview Guide

1. What are some of your experiences working with the LGBT population as a medical social worker?
2. What did you learn in your BSW or MSW programs about working with the LGBT population?
3. What types of training have your received about serving the LGBT population since obtaining your licenses?
4. In what ways did your social work education and training prepare or not prepare you to work with the LGBT population as a medical social worker?
5. How would you describe cultural competence practice with LGBT individuals in a hospital setting?
    a. How do you demonstrate cultural competence with LGBT individuals?
6. What characteristics or skills do you think are needed to provide culturally competent practice to an LGBT individual in the hospital setting?
7. How do you define the concept of cultural humility?
    a. How is this similar or different than cultural competence?
8. Based on your experiences, how do you demonstrate cultural humility with LGBT individuals in a hospital setting?
9. Do you feel characteristics or skills to practice cultural humility are the same or different than cultural competence? How so?

    What barriers, if any, do you experience in being able to provide culturally appropriate services?

Appendix B: Recruitment Flyer

Hospital Social Workers Needed for Individual Interview Study

There is a new study called *"Social Worker Perceptions of LGBT Cultural Competent Practice within Hospitals"* that could provide a better understanding of cultural competence and cultural humility in practice with LGBT patients. For this study, you are invited to describe your perceptions of cultural competence and cultural humility with LGBT patients within the hospital setting.

This individual interview is part of the doctoral study for Ronald Davis, a Ph.D. student at Walden University.

About the study:

- One 2 hour zoom individual interview
- Demographic information will be stored via password protection by the researcher only.
- Participants will be given the opportunity to review their audio session recording and submit any follow-up information via email to the researcher within two weeks immediately following the individual interview.

Volunteers must meet these requirements:

- 18 years old or older
- Licensed Social Worker in any state (either at BSW or MSW level)
- Currently working in a hospital on a regular nursing floor

To volunteer click the link to schedule your session or contact the researcher below:

Zoom YouCanBookMe Link

Ronald Davis, MSW, Primary Researcher

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Phone: xxx-xxx-xxxx

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