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## Addressing Physical Health in Social Work Practice

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## Addressing Physical Health in Social Work Practice

by

Kristin K. Huskamp, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial Fulfillment of the Requirements for the Degree of

Master of Social Work

### Committee Members

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

## Abstract

The current base of literature highlights the importance of physical health and its impact on an individual's mental health and overall well-being. The purpose of this research is to examine how often social workers target physical health in practice with clients and if there is an underutilization of the research regarding the impact of physical health on psychological health in practice with clients. The research specifically examines how physical health is incorporated into assessment, diagnosis, and over the course of treatment in clinical social work practice. This study used qualitative research, which includes data collection, data analysis, and using grounded theory to develop themes that arise from the data. Nine clinical social workers from a variety of practice settings were interviewed to gather data about the inclusion of physical health in social work practice. Themes found include the provision of psychoeducation about physical health into treatment, informal inclusion of physical health into treatment as the social worker and client see fit, and the impact of exercise, sleep, and dietary habits on an individual's mental health. The current research findings have many similarities and contradictions with the various findings from the literature review. The present research project had many strengths and limitations alike. The results of the current research project indicate how clinical social workers are presently incorporating physical health into assessment, diagnosis, and treatment. Future research is needed that focuses on how physical health can be formally addressed and measured in clinical social work practice.

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### Addressing Physical Health in Social Work Practice

The importance of the impact of physical health on psychological health has been a focal point of research in social work, as well as several other disciplines. One area of physical health that has been a primary focus is obesity, which is an example of how physical health can directly impact an individual. Obesity is a troubling epidemic in the U.S., with 35.7% of adults and 16.9% of U.S. children and adolescents considered obese (Center for Disease Control and Prevention, 2012). The Center for Disease Control and Prevention (CDC, 2012) also notes an inequality in obesity across races with the rate of obesity at 59.5% for non-Hispanic blacks, while the rate of obesity for non-Hispanic whites is at 34.3%. Obesity increases an individual's risk for many diseases and chronic conditions, such as hypertension, osteoarthritis, dyslipidemia, type 2 diabetes, heart disease, stroke, gallbladder disease, sleep apnea and respiratory issues, as well as certain types of cancers (U.S. Department of Health and Human Services, 2001). The CDC (2008) reported that "medical costs associated with obesity were estimated at \$147 billion... and the medical costs for people who are obese were \$1,429 higher than those of normal weight" (Para. 1). Obesity is a prevalent and expensive problem in the U.S. indicating that intervention is necessary. While obesity is a troubling issue in the U.S., physical health has shown to impact much more than just one's weight.

Research indicates that an individual's dietary choices and exercise regime impact not only one's physical health, but also their mental health (Harper, 2010; Hassmen et al., 2000; Riba et al., 2012). Individuals who maintain unhealthy diets generally have higher rates of depression, Seasonal Affectiveness Disorder (SAD), anxiety, and suicide (McGrath-Hanna, Green, Tavernier, & Bult-Ito, 2003). Regular physical exercise is

associated with positive psychological well-being (Hassmen, Koivula, & Uutela, 2000). Exercise has also been shown to be effective in the treatment of clinical depression (Fox, 1999). These results suggest that targeting physical health could be effective in alleviating symptoms of depression and anxiety, indicating a possible area of intervention for therapists in practice with clients.

Food insufficiency has also been shown to impact one's mental health indicating another area of research regarding physical health's role on mental health. The United States Department of Agriculture (2012) found that "14.9 percent (17.9 million) of U.S. households were food insecure at some time during 2011" (para. 2). Food insufficiency is associated with negative outcomes including problems with mental health, namely anxiety and depression (Attar-Schwartz, 2007; Hadley & Patil, 2006; Heflin, Corcoran, & Siefert, 2007; Heflin, Siefert, & Williams, 2005; and Heflin & Ziliak, 2008). While food is only one of several factors analyzed for the subjects in these studies, the research indicates a strong correlation between food insufficiency and mental health issues. This finding highlights opportunities to explore intervention strategies in future research.

While most practitioners understand the importance of physical health on one's overall well-being, professionals often underutilize this information in practice with clients, or are unaware of the impact that physical health can have on psychological health. The purpose of this research paper is to address the experiences of clinical social workers in practice with the phenomena of physical health in assessment, treatment, and diagnosis. The research question being posed is: How often do social workers target physical health in practice with clients and is there an underutilization of the research regarding the impact of physical health on psychological health in practice with clients?

A literature review and a summary of data gathered qualitatively through personal interviews. The research data was assessed using grounded theory and content analysis.

### **Literature Review**

#### **Barriers to Healthy Eating**

The literature review suggests that there are several barriers to healthy eating for adults and children alike. Story, Neumark-Sztainer, and French (2002) organized these barriers into four different categories: intrapersonal influences, interpersonal influences, physical environment, and societal influences. Drawing on the astute observations from these researchers, this paper discusses the barriers to healthy eating, as identified throughout the review of available literature, in a similar fashion.

**Intrapersonal Influences.** Intrapersonal influences to one's eating behaviors are those factors that relate directly to the individual. Examples include, but are not limited to, food preferences and taste and lifestyle factors (Birch, 1999; Story et. al, 2002, Goh et. al, 2008, Kaufman & Karpati, 2007, French, Story, & Jeffry, 2001, & Shepherd et al., 2006).

**Individual Preferences.** People have their own predilections for food, which are shaped through past experiences with food and biology (Birch, 1999). Food preferences are shaped from birth into adulthood and are a determining factor in decisions about one's diet. Story et al. (2002) investigated the individual and environmental influences on the diet of adolescents. The results indicated that preferences for food, as reported by the subjects, were the strongest predictor of what an individual will choose to eat. Similarly, the same study determined taste of the food as an important indicator of dietary choices. Age appears to be a factor in food choices in that adolescents are more likely to

focus on the immediate gratification of an unhealthy snack than the potential long-term benefits of healthy snacks and overall diet (Story et al., 2002).

Adolescents were more likely to choose unhealthy vending machine selections if they rated their first priority for their selection as taste or sensory perception of the food (Story et al., 2002). Preferences for food taste have also shown to be a major contributing factor to an individual's decision to eat fast food over healthier food choices (Shepherd et al., 2006). Story, et al. (2002) discovered that junk food was associated with pleasure, guilt, and being with friends; healthy eating was "linked with family, meals, and being at home". Similarly, Goh et al. (2008) examined possible intervention strategies to address the barriers to healthy eating through community-based participatory research. Results indicated that the perceived poor taste of school food was a major factor in why adolescents chose unhealthy snacks or fast food over generally more nutritious school lunches. Additionally, students chose soda or other unhealthy drink choices due to their expressed distaste over the school's drinking water options (Goh et al., 2008). In general, individual diet preferences and sensory perceptions regarding food have a strong influence on dietary choices.

***Lifestyle factors.*** While food preferences play an important role in diet choices, several lifestyle factors severely impact what an individual chooses for food and what they are actually able to include in their diet. Time and convenience were found to be primary factors in how an individual determines which foods to consume with a perceived lack of time being an obstacle to healthy eating choices (Story et al., 2002). Kaufman and Karpati (2007) studied a Latino neighborhood in Brooklyn, New York and found that convenience was a factor in choosing healthier food options because more

fast food than healthy restaurants existed near their home area. Fast food is often chosen over healthier food alternatives for its inherent ease of accessibility and overall convenience (French, Story, & Jeffry, 2001, Shepherd et al., 2006). In relation, Palmeri, Auld, Taylor, Kendall, and Anderson (1998) investigated the barriers to healthy eating for low-income Hispanics. The results indicated that convenience was a primary factor in choosing foods for family meals. Prepackaged meals or fast food were often chosen over healthier meal alternatives because of a lack of time due to the long hours worked by family members. Convenience was shown to be an important factor in decisions regarding food choices for adolescents and adults alike and represents a major barrier to healthy eating.

While convenience is an important influence for people choosing unhealthy foods, cost is also a major factor in these food decisions. Research demonstrates that many individuals choose fast food or similar unhealthy food choices because they believe eating healthy costs too much (French, Story, and Jeffry, 2001; Shepherd et al., 2006). Lopez-Class and Hosler (2010) investigated diet and nutrition in a small Latino neighborhood in New York. Research demonstrated that cost was an important factor in eating choices due to the high price of nutritious foods, such as high-fiber bread and fresh fruits and vegetables, in their neighborhood. Likewise, cost played a role in dietary choices in Kaufman and Karpati's (2007) investigation of diet practices among Latino families. Towards the end of the month, participants were often short on money and received credit at smaller supermarkets with fewer healthy food options. Also towards the end of the month, many families practiced the custom of food sharing among extended family members, friends, and other neighbors. While this practice of food

sharing was necessary and helpful for survival, it limited the food options available to various family members and likely contributed to unbalanced diets. While Story et al. (2002) demonstrated that taste was the most important factor in food choices in their particular study; cost was the second most influential factor in food selection.

**Interpersonal Influences.** Interpersonal influences on an individual's dietary choices are those factors that relate to the person's social environment, including the impact of family and peer groups, which particularly influence adolescents (Story et al., 2002).

**Family.** It is common knowledge that one's family decisions regarding household meal and snack options impact the formulation of an individual's dietary choices in adolescence and into adulthood. Story et al. (2002) demonstrated that dinner is often the primary meal that families eat together and the meal that adolescents report eating most often. Due to many factors, such as busy schedules or familial conflict, dinners at home are irregular for most families. Research has shown that the more often a family eats dinner together, the healthier the diet of the individual (Story et al., 2002). This particular study also indicated that demographic characteristics of the family influence eating habits. For instance, families with two parents who worked, or those with only one head of household, had less time to spend preparing meals. As noted previously, convenience was identified as a barrier to healthy eating. One can reasonably assume that households that have less time to devote to meal preparation generally have less healthy diets. Eating out has become a more common practice than in the past, with many families choosing the unhealthier option of going out to eat or bringing home fast food instead of cooking a more nutritious meal at home (French et al., 2001). In addition,

the researchers pointed out that portion sizes today are often much larger than necessary, which is a possible barrier to healthy eating habits for individuals who are unaware of what was an accurate portion of food.

The research indicates that there are several other barriers to healthy eating related to family life besides dinnertime meals. Story et al. (2002) found that socioeconomic status is correlated with the amount of fruits and vegetables that an adolescent consumes, with those adolescents in families of lower socioeconomic status consuming less fruits and vegetables. Lack of cooking skills and ignorance of healthy eating habits were two barriers to healthy eating relating to the family life identified by Palmeri et al. (1998), indicating potential avenues for change to promote healthier eating habits. Barriers to healthy eating at the family level are also influenced by the cultural makeup of the family unit. Kaufman and Karpati (2007) discovered that overweight children in the Latino families that participated in the study were viewed as more acceptable than thin children. This was because overweight children fit into families that had overweight members; these families tended to view thin children as “fragile”. In addition, the research determined that a second barrier to healthy eating related to family structure. Fathers who lived outside of the household in these Latino families tended to provide unhealthy meals and/or snacks for their children as a way to make their children happy instead of focusing on the nutritional value of the food (Kaufman & Karpati, 2007). In summary, barriers to healthy eating at the family level are more complex than meal provision where culture and knowledge play equally important roles in dietary choices and overall nutrition for the family members.

**Peers.** Another barrier to healthy eating on the community level involves peers. Peers can be quite influential on adolescent school choices, suggesting that utilizing peer groups can be useful for interventions regarding general health and preventing obesity (Goh et al., 2008). Peer groups commonly exert a considerable amount of influence on the lives of many individuals, especially those in adolescence. While there were no conclusive generalizations about peer influence on adolescent eating behavior in the research completed by Story et al. (2002), the researchers did find that peers had the most influence over snack food choices. With the considerable amount of time that adolescents spend with their peers, it is important to consider the influence of friends when assessing potential barriers to healthy eating.

**Community Influences.** Community influences are those environmental factors that act as potential barriers to healthy eating patterns. Examples include schools, workplaces, prepackaged snacks and meals available through the increasing number of vending machines and convenience stores, and numerous fast food options (Story et al., 2002).

**Availability of Fast Foods.** Fast food restaurants and convenience foods act as possible barriers to healthy eating in both adolescents and adults. Fast food restaurants and prepackaged snacks and meals are increasingly abundant and are an integral part of the diet of some individuals (French et al., 2001). Kaufman and Karpati (2007) found that those foods available in a low-income Latino neighborhood were primarily “high-fat, high-carbohydrate, processed foods”, including numerous fast food options and convenience stores. Individuals have few healthy options to choose from in their immediate neighborhoods or communities. Story et al. (2002) found that fast food

consumption appears to account for nearly one third of meals that juveniles consume outside of their homes. The researchers noted that teens utilize vending machines for 3% of their total food intake and nearly 5% of their intake comes from convenience stores. In addition, teens often hold part-time jobs, many of which are fast-food restaurants where employees frequently get discounts for food, as well as receive free beverages (Story et al., 2002).

**Schools.** Story et al. (2002) report that 35-40% of an adolescent's diet includes school lunches or foods bought at school. These findings indicated that school lunch programs have a large impact on their nutritional choices, not always in a healthy direction. High-fat and high-sugar options are abundant in most school settings, including those coming from a la carte lunch options and vending machines. Goh et al. (2008) discovered that while some schools have difficulty complying with federal or state nutritional standards in their school lunch programs, some students and their families held inaccurate beliefs about the nutritional content of school lunches. The availability of unhealthy food choices within school grounds, along with the belief that much of this food is healthy, contributes negatively to youth's overall diet and overall health.

**Societal Influences.** Societal, or macrosystem, barriers to healthy eating include large-scale elements within a society such as "media, cultural normal, social norms, food production and distribution systems, and food accessibility and availability" (Story et al., 2002, p. S47).

**Media.** Adolescents are increasingly exposed to multiple forms of media that are often considered violent or tragic. This exposure can impact an adolescents' perception of their world, their relationships, and can increase certain high-risk behaviors (Villani,

2001). In addition, through mediums such as television viewing and Internet usage, teens today are increasingly exposed to advertising that influences their beliefs about themselves and the world. (Story et al., 2002). McCabe and Ricciardelli (2012) explored how media impacted body size, weight change, and muscle size in youths. Adolescents from several different high schools in Melbourne, Australia completed several related questionnaires. (McCabe & Ricciardelli, 2012). Media was found to be an important influence in body size changes or anxiety over one's body for subjects in this study. Females were more likely to be dissatisfied with their weight and engage in attempts to lose weight, while the males in this study engaged in attempts to increase weight and muscle size. In general, the media has the potential to greatly influence an individual's dietary choices and physical health.

***Culture and Society.*** Research indicates that culture and society have an impact specifically on an individual's dietary choices and physical health (Palmeri et al., 1998; Kaufman & Karpati, 2007). Changes in family structure, such as the increasing number of women who work and single-person headed households, contribute to less time available for meal preparation. These changes in family structure can act as a barrier to the healthy eating of not only one person, but to an entire family (French et al., 2001). Secondly, family customs and habits for purchased snacks and meal preparation significantly influenced the diet of the family members. (Palmeri et al., 1998; Kaufman & Karpati, 2007).

### **Nutrition and Mental Health**

The dietary choices of individuals not only affect their physical health, but also their mental health and psychological well-being (Harper, 2010; McGrath-Hanna et al.,

2003; Weaver & Hadley, 2009). Harper (2010) examined the impact of the Westernized diet on the mental health of American Indian clients. The researcher noted the decline in physical and mental health among these clients after switching to a Western diet. Results indicate that these changes in diet were correlated with an increase in occurrences of depression, alcoholism, and diabetes among these American Indian populations (Harper, 2010). McGrath-Hanna et al. (2003) analyzed the effect that diet has on mental health in circumpolar peoples. These diets were also rapidly influenced by Western society. Changes in diet led to several physical health problems, along with a decline in psychological well-being, which led to a higher incidence of depression, Seasonal Affective Disorder, anxiety, and suicide.

**Food Insufficiency and Food Insecurity.** Globally, many children and families deal with poverty, hunger, and malnutrition in their daily lives. Food insecurity is associated with common mental disorders, such as anxiety and depression (Weaver & Hadley, 2009; Hadley & Patel, 2007). Hadley and Patil (2007) researched rural populations in Western Tanzania and found that food insecurity was a strong indicator of anxiety and depression. In addition, seasonal changes that affected the severity of the food insufficiency in a household also changed the severity of anxiety and depressive symptoms. Food insufficiency and food insecurity have been associated with a number of factors surrounding an individual's psychological well-being (Attar-Schwartz, 2007; Heflin et al., 2007; Heflin & Ziliak, 2008). For example, mental illness influences an individual's ability to maintain and obtain employment and decreases annual income by a significant amount indicating vocational and financial difficulties for those with a mental illness (Heflin & Ziliak, 2008). In addition, the research indicated that mental illness,

poverty, and food insufficiencies are correlated. Heflin et al. (2007) investigated the reasons why some individuals on welfare in Michigan experienced food insecurity during the transition from welfare to work and other individuals did not. For these individuals, having one or more mental health problems were strongly correlated with food insufficiency. A similar study examined food insufficiency and mental health among those who participated in the Food Stamp Program and produced interesting results. Food-insufficient individuals who participated in the Food Stamp program experienced a higher degree of emotional distress than did food-insufficient people who were not participating in the Food Stamp program. In addition, individuals who received a higher level of benefits under the Food Stamp program also suffered more emotional distress than those who received lower levels of Food Stamp benefits (Heflin & Ziliak, 2008). These results indicate that elements of participating in food assistance programs increase emotional distress due to the rigorous standards and policies of the Food Stamp program.

*Children and Families.* Food insufficiency and food insecurity also impact the psychological well-being of children and families. Attar-Schwartz (2007) examined the factors that influence emotional, behavioral, and social problems in Israeli adolescents who were in residential care. Results indicated that children in residential care settings who were exposed to proper quantities and varieties of food had better emotional, behavioral, and social outcomes than those children who experienced food insufficiency in their residential care setting. These results denote that food insufficiency is associated with more negative outcomes for adolescents in residential care settings (Attar-Schwartz, 2007). Furthermore, food insecurity was predictive of domestic violence within the family and increased rates of behavioral issues in the children of these families (Melchior

et al, 2009). Similarly, Jyoti, Frongillo, and Jones (2005) researched the impact that food insecurity has on adolescents' academic performance, weight gain, and social skills. Results showed that food insecurity was a strong predictor of poor developmental outcomes in children, especially food insecurity during the early elementary years. Food insecurity was also related with social skill proficiency in kindergarten through third grade females, but not their male counterparts. Hernandez, Montana, and Clarke (2010) stated the following:

Unabated stress due to impoverished conditions can interrupt child neural activity and brain development, compromising a child's health and mental health, learning abilities, and adult health outcomes. Poverty and economic insecurity can also affect the mental health of parents, producing psychological distress, anxiety, and depression. These conditions can negatively affect the interactions and relationships between parents and their children (p.1).

In sum, food insecurity has a profound effect on the psychological well-being of children and their families, as demonstrated in the research.

***Women's Mental Health.*** Food insecurity is often related to maternal mental health problems, commonly depression and anxiety (Melchior et al., 2009; Hadley & Patil, 2006; Heflin et al., 2005; Siefert et al., 2001). Problems with maternal mental health were associated with food insecurity in a sample of European and U.S. families (Melchior et al., 2009). Similarly, a study conducted in rural Tanzania also found an association between food insecurity and maternal anxiety and depression (Hadley & Patil, 2006). Heflin et al. (2005) researched the link between food insufficiency and the mental health of women on welfare. The researchers appraised a population of women who

were welfare recipients in an urban Michigan county for a period of three years. The results indicated that food insecurity was strongly associated with depression for these women. Siefert et al. (2001) also surveyed low-income women who participated in the welfare program. These results also lend credence to the idea that the physical and mental health of women is impacted by the larger societal factors surrounding them, namely food insecurity.

### **Physical Exercise, Depression, and Psychological Well-Being**

Harper (2010) investigated the relationship between physical and mental health through a review of literature that focused on American Indian and Alaskan Native populations. Results indicated that physical health and mental health were correlated (Harper, 2010). Hassmen, Koivula, and Uutela (2000) investigated the relationship between regular physical exercise and positive mental health characteristics by using a sample of participants from a 1992 research project, the Finnish Cardiovascular Risk Factor Survey. Participants were randomly selected from this sample and completed various questionnaires to assess their physical and mental health. Results indicated that the more times an individual exercised per week, the better psychological outcomes were for that individual. Fox (1999) found that exercise is an effective treatment for clinical depression and that “exercise has a moderate reducing effect on state and trait anxiety and can improve physical self-perceptions and in some cases global self esteem”. In patients who had recently suffered a cardiac event, depression commonly occurred following the cardiac event. When care providers utilized exercised-based treatments for the cardiac events, both physical health and depressive symptoms improved (Riba, Wulsin, Rubenfire, & Ravindranath, 2012). In addition, exercise was found to be effective in

controlling depressive symptoms for individuals when compared to those who received no treatment or the mental health intervention (Riba et al., 2012). Another study also found minimal support for exercise as a treatment for clinical depression. Krogh, Nordentoft, Sterne, and Lawlor (2011) investigated the differences in depressive symptoms following individuals who either participated in an exercise regimen or did not participate in a structured exercise routine. The researchers found that the exercise group had better outcomes for their depression, but the results were small. In summary, physical health and mental health appear to be closely related and exercise could possibly be utilized as an effective treatment for depression and anxiety.

## **Conclusion**

This literature review addresses the impact that one's nutrition and physical health has on their mental health. An individual's dietary choices are impacted by various intrapersonal, interpersonal, community, and societal influences, which can act as barriers to healthy eating (Story et al., 2002). Diet and physical health can influence one's psychological well-being (Harper, 2010; McGrath-Hanna et al., 2003; Weaver & Hadley, 2009), indicating a connection between physical health and mental health. In addition, individuals who experience food insecurity often also experience mental health issues. Depression and anxiety are commonly found in individuals who experience food insecurity (Weaver & Hadley, 2009; Hadley & Patil, 2007). Adolescents who face food insecurity often have poorer outcomes than children who do not experience food insecurity (Attar-Schwartz, 2007). Lastly, research indicates that physical health and exercise are correlated with depression (Harper, 2010; Hassmen et al., 2000; Riba et al.,

2012). In conclusion, the aforementioned research indicates a correlation between an individual's nutrition and their physical health and mental health.

### **Conceptual Framework**

This applied research project requires students to use grounded theory and content analysis to formulate a theory directly from the data gathered during the research phase of this project. For the purposes of this paper, I will utilize the conceptual frameworks of the person-in-environment (PIE) perspective of the social work paradigm, holism, and the bio-psychosocial perspective to understand the data. These frameworks best take into account the effect that nutrition, diet, and physical health has on an individual's mental health.

The PIE perspective focuses specifically on the interactions an individual has with their environment and the impact these interactions have on human behavior. Clinicians who use the PIE perspective in their practice do not view clients as abnormal, but focus instead on the environmental interactions that are causing dysfunction within the client. In assessment, the PIE system looks at an individual's functioning, social environment, mental health, and physical health and addresses client problems in each of the four areas. One disadvantage of the PIE perspective is that it does not directly address client strengths or resources in any of the aforementioned four areas (Hutchinson, 2011). For purposes of this research project, the PIE perspective is an effective framework because it addresses environmental factors that impact client welfare, such as the role of physical health on an individual's well-being, instead of focusing solely on the client's presenting problems. By addressing the contextual elements of an individual's life, a clinician is able to assess client functioning on a broader scale and address possible cultural issues

that a client has with their environment that might not be addressed within a different framework.

Holism is a second framework that can be used to understand the impact that diet, nutrition, and physical health has on an individual. The holistic framework assumes that the individual and the environment are completely interrelated. The individual and their environment are considered an indivisible unit. The central tenant of holistic theory is that the whole is always greater than the sum of its parts. The idea is that an individual can only be completely understood when one assesses their relationships between that individual and their physical and social environment (Forte, 2007). This perspective would consider the relationship the client has with their diet and physical health as pertinent information for a clinician to have to fully understand the client.

A third framework utilized in this research project is the bio-psychosocial perspective that emphasizes the mind-body connection. This framework considers human behavior to be the result of the interactions between biology, psychology, and social systems (Hutchinson, 2011). The current medical model emphasizes deficits and biology; while the bio-psychosocial perspective posits that biology, psychology, and social systems are inseparable from one another, and are all necessary to fully understand an individual. More recently, spirituality has been added as an additional dimension necessary for fully understanding an individual. This approach is beginning to be used in a variety of settings by clinical social workers, neurobiologists, neuroscientists, and nurses, to name a few (Hutchinson, 2011). For this research project, the bio-psychosocial perspective is important to utilize because it specifically addresses the impact that physical health has on an individual, including the impact on one's mental health.

In conclusion, the person-in-environment perspective, holism, and the bio-psychosocial approach are useful frameworks to help understand the connection between one's overall diet and physical health in relationship to their psychological well-being. These three theories provide a clinical framework for a social worker, or other clinician, to use collaboratively with their clients during assessment, treatment, and diagnosis in order to provide a broad, complex, and more complete picture of the individual in context with their physical and social environment.

### **Methods**

This research study will utilize qualitative research methods to explore the impact of food, diet, and physical exercise on an individual's psychological well-being.

### **Research Design**

Qualitative research answers the why and how questions of research and is more explorative and descriptive than quantitative research. This research method allows for more in-depth information to be gathered to answer the research questions of this study and to reach a hypothesis about the subject matter. The steps of qualitative research include data collection, data analysis and coding, and drawing conclusions from the raw data. The data for this research project was gathered through observation in the form of semi-structured interviews with relevant professionals. Semi-structured interviews offer the possibility to gather a broader scope of information because of their inherent flexibility. This qualitative research study aims to gain a deeper understanding of how food, diet, and physical exercise impact one's mental health by gathering data that is rich and diverse.

### **Sample**

The researcher conducted nine semi-structured interviews with various clinical social workers involved in mental health, nutrition, or physical health. Subjects were recruited using snowball sampling, which identifies key members in the community related to the research topic. Snowball sampling is a non-probability sampling technique where the existing pool of readily available subjects and key members in the community related to the research topic are used to then gather more subjects through personal connections (Monette, Sullivan, & DeJong, 2008). Identified subjects were given an information sheet about the study for themselves and copies to distribute (see Appendix A). The researcher interviewed a variety of clinical social workers to gather a diverse set of data to analyze and formulate a hypothesis based on the gathered data. The information sheet described the purpose of this study and described the research question as follows: to explore the experience of social workers in practice with the phenomena of nutrition and physical health in assessment, diagnosis, and treatment. Subjects were asked to engage in an audio-recorded interview that lasted less than one hour in time. Interviews were conducted in private rooms, with closed doors, at locations most convenient for the subjects. The information sheet described the type of questions that were asked, the voluntary nature of the research study, and confidentiality. The participant's anonymity was maintained and all data and audio files will be destroyed prior to completion of the research project.

When the subjects called the researcher after receiving the information sheet, the researcher responded with a pre-prepared phone script (see Appendix B). Once the call was received from a potential research subject, the study was explained in further detail and any additional questions were answered. The participant was then reminded that the

audio of the interview was digitally recorded and that the researcher kept any identifying data anonymous and confidential throughout the research process. When an individual agreed to participate in the research, the interview time and location were then arranged.

### **Protection of Human Subjects**

In order to protect the human subjects that were interviewed for purposes of this research project, client confidentiality was addressed in several ways. Prior to the interviews, the subjects were required to read and sign a consent form in order to participate in the research. The consent forms were kept in a locked filing cabinet in the researcher's home (see Appendix C). The audio files were kept on the researcher's private computer, which was password protected and kept in the researcher's home. Only the researcher and the research assistant had access to the audio files for purposes of data analysis, and the researcher digitally erased the audio files after the completion of this research project.

### **Data Collection**

The semi-structured interviews were audio recorded on the researcher's personal computer. Participants were able to have access to a copy of the interview questions (see Appendix D) prior to the interview, if they desired. As previously stated, the audio files were kept on the researcher's password protected personal computer. Interviews were audio recorded for the purposes of data analysis, specifically data transcription and coding. These interviews were conducted in a private room with a closed door, either at a location picked by the subject or in a private group room at the library on University of St. Thomas campus, depending on the individual preference of each research subject.

The interview questions explored the practice experience of the subject and their experience with nutrition and physical health in social work practice.

### **Data Analysis**

The researcher used grounded theory and content analysis to analyze the data gathered from the semi-structured interviews. Grounded theory uses the data to develop a hypothesis instead of framing the data collection from a pre-determined hypothesis (Monette et al., 2008). Content analysis involves transcribing the interviews and discovering themes or codes that emerge from the data (Monette et al., 2008). The researcher transcribed the data, which was kept on the researcher's password protected computer in her locked home office. In addition, the researcher recruited a research assistant, who signed a confidentiality agreement prior to participating in this research project (see Appendix E). Each interview was analyzed to find similarities and differences in the data gathered from each subject. Then the researcher was able to identify major themes that appeared across the research data (Monette et al., 2008). These themes correlated to each of the specific questions asked during the semi-structured interview, including how physical health was addressed in assessment, diagnosis, and throughout the course of treatment. The researcher conducted a reliability check to verify that the conclusions reached based on the data were accurate and not because of researcher bias. The research assistant conducted the reliability checks through careful analysis of the researcher's codes and a review of the transcript to match with the coding (Berg, 2012).

**Strengths**

There is little research on how clinical social workers and other professionals utilize nutrition and physical health in practice. This study provides valuable information to social work practitioners about the importance of applying a more holistic approach to their practice. Social workers can utilize the results of this study to determine how food, diet, and exercise could be incorporated into assessment, treatment, and diagnosis. The use of qualitative research and semi-structured interviews allow for an exploratory view of the research questions to gather rich and diverse data. The semi-structured interview approach allows the researcher to ask questions that are not on the interview question list (see Appendix D) and gather varied data due to the flexible nature of semi-structured interviews.

**Limitations**

Qualitative research is exploratory in nature so the results of this research study are unable to be generalized to other populations. The sample for this study was gathered using snowball sampling, which could have limited the diversity of subjects and collected data. Due to time constraints, the study only utilized eight questions during the semi-structured interviews and only nine subjects participated in this research study, which limits the amount of data gathered and impacts the ability to generalize results. In addition, all research subjects were female, clinical social workers residing in the state of Minnesota, which also limits the researcher's ability to generalize findings to other populations. Finally, the researcher conducted all steps of data collection and analysis, and researcher bias could have existed that influenced the data that was collected and the

analysis of that data. Future research will be needed to more completely address the role of nutrition and physical health in assessment, diagnosis, and treatment.

### **Findings**

The purpose of these interviews was to further understand how clinical social workers incorporate their client's physical health into assessment, diagnosis, and treatment. Findings include demographic characteristics of the participants for this research study, themes arising from how physical health is incorporated into assessment, diagnosis, and treatment with clients, the role of food and nutrition in clinical work practice, and the relationship that clinical social workers observe between physical health and depression. The participants provided a variety of responses, each relating to a particular theme discovered during data coding and analysis. The nine participants of this research study will be referred to numerically as Participant 1-9 in groupings based on practice settings to protect the anonymity of the research subjects.

### **Demographics**

Research participants included nine clinical social workers licensed in the state of Minnesota who also reside in Minnesota. The nine participants in this research project were generally middle-aged females who were over the age of 18. Participants 1-3 engaged in private practice, participants 4 and 5 practiced in medical social work settings, participants 6-8 were school social workers, and participant 9 worked in behavioral health case management. Participant 8 worked primarily as a school social worker, but also practices at an inpatient rehabilitation facility during the summer. All of the participants described using an eclectic approach in their social work practice. Many described formatting their therapeutic approach to meet the needs of each specific client

and using a variety of therapeutic techniques with each client based on to the client's needs, strengths, and symptoms.

### **The Role of Physical Health in Assessment**

Participants were asked the question "What is your experience incorporating physical health into assessment?" A variety of responses were given to this question. There were five prominent themes that emerged in answer to this question. These themes included (a) physical health assessment questions on intake forms, (b) the social worker's personal assessment of a client's physical health, (c) current medications and their side effects, (d) not responsible for assessment, and (e) client's personal goals in therapy regarding their physical health.

**Intake form questions.** When asked how physical health was incorporated into assessment, two of the participants (participant 1 and participant 2) responded that they had questions on their intake forms that specifically dealt with the client's physical health.

Participant 1 responded, "It's on my intake forms," indicating that physical health questions appear on the intake forms that each new client must fill out before beginning treatment with this specific social worker.

Participant 2 responded, "There is a spot on my assessment where I specifically ask their (the client's) history of physical issues."

Participant 9 reported that there were no specific intake forms in her work in behavioral case management and states that:

By the time they (mandated clients) get to us, they've already been through the intake process and have been assigned to us. When I did CATI waivers, clients

were asked to rate their physical health as excellent, good, fair, or poor. Then they are asked why they feel those certain ways regarding their physical health. If you are fair or good, why are you feeling certain ways.

**Worker's Personal Assessment of Physical Health.** Respondents were asked how physical health was incorporated into assessment in their practice and six of the nine participants responded that they personally assessed the client's physical health, but did not follow a specific intake form regarding physical health at the assessment phase.

Participant 1 responded that she did have questions on her intake forms specifically surrounding physical health, but that she also assessed physical health informally without the aid of intake forms. She stated:

It's on my intake forms. I talk about it with all my clients. I ask about any medical conditions they have. I assess lifestyle issues that affect physical health – we talk about exercise, diet, nutrition, sleep, and medications, a kind of life history of their body as well as their spirit. Smoking and substance abuse are definitely on there, too (questions that the social worker will ask).

Participant 2 also had places on their assessment forms that assessed the client's physical health, but she also conducted a more thorough examination of a client's physical health through informal questions asked during the assessment phase of practice with new clients. She responded:

There is a spot on my assessment where I specifically ask their history of physical issues. If they are on medication, if so, for what? Even if they had early childhood illness, all the way back to what the conditions were like when they were born. Just to see if there is a history of trauma as early as being in the womb

or a traumatic birth. I cover a wide range of years from birth to current just to see if there are any physical issues.

Participant 3, who practices both in private practice and as an independent contractor working primarily with children and adolescents, and some adults, describes an informal approach to assessing a new client's physical health:

I ask them about their eating, their sleeping, their food intake related to body image, especially with teenagers, their social networks, sleep, diet, nutrition, the client's social life, and the amount of exercise that they engage in.

Participant 4 is a clinical social worker practicing in a medical setting, specifically an inpatient rehabilitation facility. Being in a medical setting, there are medical professionals, such as doctors, physical therapists, and dieticians, who are specifically in charge of some aspect of the client's physical health. As a social worker, her role focuses on working with patients, usually with a traumatic brain injury (TBI) or after a stroke, and is in charge of counseling, hooking the client up with community resources, and assisting clients in the process of discharging from the rehabilitation facility. She incorporates physical health into assessment informally, with special emphasis on lifestyle prior to injury, activity level, and the type of job the client has or has previously held. She states:

We (herself and other social workers/colleagues practicing at this specific inpatient rehabilitation facility) have to ask everyone what his or her lifestyle was prior to coming in because they've all sustained some kind of injury. So, we get into a little bit in the initial assessment, such as what did you do before? Not so much diet, but if they were active, what their hobbies are, what their work was.

Their lives have been turned upside down. Someone comes in with a stroke and he or she used to walk three miles a day and now they can't walk three feet. It's more of a general question than specifics. I leave things open-ended for them to share whatever they feel is pertinent.

Participant 5 is also a medical social worker, but she works specifically in hospice. She described assessment with clients in hospice as focused on providing comfort and symptom management for the client at the end of their life, and not so much focused on promoting positive physical health skills for the client. Participant 5 described how the body begins to shut down towards the end of life and many people lose the desire to eat or drink. Instead of focusing on the quality of the client's diet, the clients are encouraged to eat or drink whatever they want or nothing at all, if that is what they wish. Later in our interview, she described meeting a client in their home who was drinking a beer at 10 a.m. This man's body systems were shutting down and he had lost most of his appetite and thirst. At this point, participant 5 reiterated that she allowed individuals to eat and drink whatever they want because nutrition does not matter much at that point towards the end of life.

Participant 5 states:

If it is anything health-related, it would be looking at symptom management and focusing on helping to look at or assess the client's pain. Helping to be that extra set of eyes and ears for their overall care for where they are at whether that's at home or a nursing home, or in an assisted living facility. To be sure that they are

being cared for in a good way. At that point nutrition doesn't matter. We say the hospice philosophy is let them eat and drink what they want. If they don't want to eat, they don't have to. If they don't want to drink, they don't have to.

Participant 8 is a school social worker who works as a medical social worker in an inpatient rehabilitation setting during the summers when school is on break. She described assessment as not her primary responsibility, but stated:

Now, do I use it in my clinical practice with kids? If I see a kid individually or I'm doing groups... in my girl's groups we always address it (physical health). In my individual work, I always address it (physical health). When I'm working with parents, I always address it (physical health). It's more in a couple of arenas. One is nutrition. I usually have a bit of a conversation with the kids. Often times, they come to see me and say how tired they are. I'll ask them what they had for breakfast and they'll say nothing, or a frozen White Castle hamburger, or leftovers. Typically, it's nothing. Often times, I have granola and almonds if they want a snack. We talk about nutrition in the individual work. And sleep is another area I talk to parents about and how I tie that in is... what's in their bedroom? That's one of my assessment questions that I always ask. A lot of these kids have TV's and computers in their bedrooms...fully functioning electronics. When they isolate themselves in their rooms, everything they want to be on is in there. It kind of ties in.

Participant 9 works in behavioral case management with adults with mental illness and/or chemical dependency who are on commitment. In her social work

practice with clients, the assessment primarily focuses on the client's diet and nutrition.

She states:

Most of the clients that I work with have been diagnosed with a mental illness.

They always have side effects with whatever medications they are taking. That's

(physical health) always a huge part of it (assessment) – diet and nutrition. If you

are drowsy, a lot of times they are drinking pop all day to stay awake. They are

going from doctor's appointment, to therapy, to the dentist, to whatever. They

have all these problems like repercussions from the bad eating. I do actually work

with a lot of clients and talk about how nutrition will help them feel better. They

don't want to take medication. You can take medication, but also eat well to help

your symptoms.

Participant 9 evaluates client's physical health in assessment and over the course of treatment, although her clients usually are assigned to her after going through intake processes. Previously, she started the conversation about physical health with clients based on their response to their personal physical health rating on the CATI waiver that clients were asked to fill out prior to the beginning of treatment.

**Current medications and their side effects.** One theme that emerged from the data was that many social workers ask specifically about what medications their clients are on and the potential side effects of these medications. While social workers do not prescribe medications, they often make referrals or work in conjunction with psychiatrists and medical professionals. Additionally, many medications have side effects that impact one's physical health, as well as interfering in their daily lives.

Participant 1 asks about what medications her clients are on during the assessment phase of therapy with new clients.

Participant 2 also asks new clients during assessment if they are on any medications and what these medications are for.

Participant 3 states, “I always want to know what medications they (the clients) are on”.

Participant 9 asks about medications during assessment and describes how many medications have side effects, and it important for her to know prior to beginning treatment what medications each client is currently taking. She also describes that if a client does not want to take any medications, she will provide psychoeducation about how diet and nutrition can be an effective substitute for medication in alleviating mental health symptoms and improving one’s mood.

**Social Worker not responsible for assessment.** During the data collection, it became apparent that many social workers were not the ones doing an assessment with a client, especially those working in medical settings and/or those who collaborate on an interdisciplinary team. In these situations, there are other medical professionals, such as doctors, dieticians, nutritionists, and physical therapists, who conduct assessments with clients and are specifically in charge of addressing physical health.

Participant 6 is a school social worker who works 70% of her time in special education and 30% in “regular” education. She describes her work as “I do evaluations, setting goals and objectives, and I see them (children in special education settings) two or three times a week, and see regular education kids once a week in groups”.

Regarding assessment, she states, “I don’t assess the kids. I do a lot of the parent interviews and forms to see if they qualify”.

Participant 7 is a school social worker practicing at a local high school.

Regarding assessment, she states:

The assessments I’m involved with are special education services. If kids haven’t been doing well in their gym classes previously, or there is a physical disability, which is much more rare in my building with kids, then they are assessed with what’s called ADPE services.... Adaptive Physical Education services. That’s the only physical thing I can think of when we assess kids for special education.

Participant 8 is a school social worker practicing at a middle school that has a large number of students. She described her client population as primarily 6<sup>th</sup>, 7<sup>th</sup>, and 8<sup>th</sup> graders. Regarding assessment, she states:

Here, I’m not involved in any assessment of physical health. If we have any concerns about fine motor skills or gross motor skills, we’ll put the adapted physical education professional on the team and she’s the one who really assess the gross motor skills and fine motor skills. In my role as a social worker, I don’t really do any assessment of physical health.

Participant 8 also works in an inpatient rehabilitation facility during the summers when school is not in session. With her work as a medical social worker in this inpatient rehabilitation facility, she is also not specifically in charge of assessing the physical health of clients, as there are medical professionals, specifically dietitians, nutritionists, doctors, and physical therapists, who are in charge of assessing the client’s physical health.

Participant 9 works in behavioral case management with mandated clients who participate in the intake process and then are assigned to a social worker, so she is not specifically involved in the assessment or intake process, but does conduct an informal assessment with clients at the beginning and over the course of treatment.

**Client's personal goals for therapy regarding their physical health.** During many of the interviews with these nine participants, it was continually addressed that while there might be physical health concerns in the client's life, a social worker can only "start where the client is at", which is one of the guiding social work philosophies. Social workers can bring up concerns and provide psychoeducation about the impact of physical health on the client, but if the client is not ready or willing to work on these concerns, there is not much the Social Worker can do. Instead, physical health is addressed when it is part of the treatment plan for therapy devised by the social worker and their clients and/or is a specific goal of the clients.

Participant 9 states:

I'll ask those questions (about physical health), not in the initial intake, but it's something you work on with your clients as part of a treatment plan. How is your physical health? Is that a goal of yours to make your physical health better? Or is it a goal of yours to eat healthy or exercise more? Right now when we are working on individual treatment plans, what is your goal? It can be whatever they want it to be. For some people it is (physical health), for some, it's not.

### **The Role of Physical Health in Diagnosis**

Participants were asked the question of "What is your experience incorporating physical health into diagnosis?" and a variety of responses were given to this question.

There were five prominent themes that emerged from the data collection phase of this research project. These five themes were (a) social worker not responsible for diagnosing clients - Interdisciplinary collaboration, (b) the necessity to gather the client's complete medical and mental health history, (c) rule-out underlying medical conditions, (d) address the client's diagnosis and any barriers to healthy living, and (e) assessing the client's mobility and safety.

**Social Worker not responsible for diagnosing – Interdisciplinary collaboration.** Previously, data showed that many social workers were not responsible for the assessment phase of work with new clients. Additionally, the data indicated that several social workers were also not responsible for diagnosing clients. Often, an interdisciplinary team collaborated to provide treatment for each client and each person has their own specific responsibilities regarding client care.

Participant 4 described how she was not specifically involved in diagnosis, but a whole interdisciplinary team collaborated on each client:

I am not involved in diagnosis. I don't do much diagnosis at all. But it's collaboration between the whole team – the doctors, therapists, psychologist, the nursing staff, and myself. It gets addressed at team meetings, which are done on every single patient. What their premorbid physical health was like. Frankly, it shows in their outcomes usually. Someone who was more physically fit will do better in rehabilitation than someone who was not. Family usually shares this information with us if the patient isn't able to.

Participant 5 described how other professionals are responsible for addressing physical health in diagnoses and stated, “That’s more nursing that will do that. Sometimes we kind of collaborate”.

Participant 7 stated, “I can’t diagnose in the schools. I’m a LICW, but diagnostic stuff is not my role here”.

Participant 8 was also not responsible for diagnosing clients as a school social worker in a middle school setting. Instead, “it would be through adaptive physical education and it’s diagnosed if they qualify for specialized services in the area of adaptive education. Most of the special education kids do qualify for adaptive services”.

Participant 9 stated: “I’m not diagnosing. I do the case management part. Usually they have a therapist or a psychologist. They already come with a diagnosis and everything”.

**Medical and mental health history.** Many of the participants described the importance of getting a full medical and mental health history prior to diagnosing a client with a mental disorder. In order to rule-out any underlying medical conditions that might contribute to the client’s symptomology, the social worker needed to gather as much medical and mental health history on their client as possible.

Participant 2 described collecting a medical and mental health history before diagnosing a client. She stated, “If there’s an assessment or some sort of report from a doctor, I will make sure to look at that”.

Participant 3 described how she collected the medical and mental health history of each of the clients that she works with and stated:

Many of my clients come to me because they have a chronic or life threatening illness. It becomes part of what we do. I like to get a medical history. In children and adolescents, I actually have a form that parents complete. I know if the child has had surgery, is on any medications, or has any medical diagnoses. Like kids with asthma often take two or three medications and I like to know that. If they have ADHD, are they on or off medications. If they've been treated for depression or anxiety before, I'd like to know that. I like to know the family medical history...the family mental health history in terms of depression, anxiety, and any other mental health issues, (such as) addiction or alcohol use.

Participant 6 described how physical health was addressed in diagnosis as a school social worker:

We always look at hearing and vision before we assess. We try to get any kind of medical reports. I try to get the health history from the parents to see if there was anything that might skew the assessment or give more information for why the behaviors are happening.

**Rule-out underlying medical conditions.** Two participants specifically addressed the importance of ruling-out any underlying medical conditions that could contribute to their symptomology before giving that client a mental health diagnosis. Previously, many social workers highlighted the importance of collecting medical and mental health histories about their clients prior to determining an official mental health diagnosis for the client.

Participant 2 stated:

It's good to rule-out things when you are making a diagnosis because physical

health and mental health are so interrelated. If there's an assessment or some sort of report from a doctor, I will make sure to look at that. So just keeping it in mind and making sure what you see, when you put a name or diagnosis to it, that there isn't more going on with their physical health or their mental health.

Participant 6 described gathering medical and mental health history about the children that she worked with to "see if there was anything that might skew the assessment or give more information for why the behaviors are occurring".

**Address diagnosis and barriers to healthy living.** Respondents highlighted the importance of addressing an individual's diagnosis and assessing their barriers to healthy living. In addition, these social workers also addressed the client's negative and positive coping mechanisms and lifestyle issues that were getting in the way of healthy living.

Participant 1 describes how she addressed a client's diagnosis and personal barriers to healthy living:

Well, if a person is coming in for depression or anxiety, which are the most common reasons for coming in, (I ask) how the person is dealing with their physical body. Are they getting enough sleep? Are they drinking caffeine? Do they have an exercise routine? Those are critical lifestyle factors that tell me if they have already tried some healthy coping strategies to deal with it or not. We have to understand that and the obstacles. If they just hate exercise and don't do it, we have to understand what's getting in the way of them doing that. If they have any substance abuse issues, then that may be self-medicating. All of that has to be addressed. What are the client's negative and positive coping strategies, and assessing whether they are open to working on lifestyle issues. Some are eager to

do that and there are others that are very resistant.

Participant 3 described how she incorporated a client's history, current functioning, and physical health into diagnosis:

So once I know all of that (their medical and mental health history) and what their condition is, then we talk about the specifics of their condition and what might be the barrier in their healthy functioning. It might be pain. It might be depression. It might be a life-threatening illness causing anxiety. It might be needing to learn a specific skill, like learning how to swallow a pill because they are newly diagnosed with X, Y, or Z. I'm a certified yoga teacher, although I don't teach yoga, I utilize it in my practice. I might introduce some concept around breath work for relaxation or producing more comfort. I am very biologically oriented. I also always talk about the mind-body connection with clients.

**Client's mobility and safety.** Especially in medical settings, participants responded that addressing the client's mobility and any safety concerns which are pertinent in regards to physical health and diagnosis.

Participant 5 described that during diagnosis:

It all depends on the person... I think physical health would be safety, which would be the biggest thing. Looking at the person... some people think they can continue to walk without assistance or without a device like a wheelchair or walker or a cane even. Some people get pretty stubborn about that because they don't want to believe that they have declined. So, sometimes it's helping them to understand this is going to keep them home if they use this and fall. Fall risk is huge. We are always looking at that.

### **Physical Health over the Course of Treatment**

Participants were asked the question: “What is your experience addressing physical health over the course of treatment for clients in your practice?” and a variety of responses were provided. There were four prominent themes that emerged from the data collection phase. These four primary themes were (a) starting where the client is at, (b) a weekly check-in about physical health that addresses many areas of a client’s physical health, (c) providing psychoeducation about the impact physical health has on an individual, with an emphasis on exercise as a natural “mood-booster”, and (d) incorporating movement as part of therapy.

**Starting where the client is at.** Many of the clinical social workers that were interviewed highlighted the importance of “starting where the client is at”. In regards to physical health, this means that a social worker can only work with a client on their physical health concerns if the client is willing or able to address these concerns. If clients are willing or able to address these physical health problems, many social workers incorporate physical health into the treatment plan and/or specific physical health concerns; lack of exercise or poor nutrition, are particular goals of the client over the course of treatment. Also, a social worker will address grave physical health issues with their clients over the course of treatment as deemed necessary for an individual client.

Participant 1 described her style of addressing physical health as being tailored to each specific client and their concerns and needs. She stated that she addressed physical health over the course of treatment depending “if the physical health issues are critical. For example, I have two clients with cancer- so their ongoing self-care is a big “S” – I talk a lot about self-care.” She described incorporating weekly check-ins with each client

surrounding their physical health concerns as determined to be critical or as the client wished to have as one of their goals for treatment. Additionally, she described determining a client's barriers to physical health and understanding why a client was resistant to a certain aspect of physical health, such as increasing exercise to treat depression.

Participants 4 and 5 both work at inpatient rehabilitation facilities where physical health is usually the primary concern as the clients are usually in the hospital to recover from some sort of accident or disease. In these settings, it is often necessary to address physical health concerns, especially those regarding mobility and safety, as the individuals are only in the hospital for a short period of time and are there to recover from some sort of physical concern. Due to this, social workers and other medical professionals address physical health concerns in the immediate and offer resources and referrals for these individuals for after they leave the hospital.

Participant 7 described incorporating physical health into treatment with school-aged children on an as-need basis so that each client received individualized treatment, specifically regarding their physical health concerns. She stated:

When I'm working with kids, we talk a lot about sleep. We talk a lot about exercise. We talk a lot about nutrition. Most of the kids I work with are very poor for all of those. It's addressed in my work with them, but I don't necessarily come up with a treatment plan for kids, but mine is more on an as needed basis with kids.

Participant 9 described how physical health is addressed in her practice with clients only if the client was willing or able to address those concerns. She stated:

Really, the only way it's discussed in case management is if it's a specific goal of the clients. I can give you a case example. I had a client who was in a chemical dependency treatment program and had a mental health diagnosis. He was trying to learn coping mechanisms for when he feels like using. What his counselor and he came up with at the treatment center was how he could go run or use the bike, or use the elliptical, or whatever thing is accessible to you at the time and that's what he was doing. So one of his goals with me and with his treatment team was to get healthy. So that was one of his coping mechanisms. If I feel like using, I'm going to go for a run or bike or whatever it was.

**Weekly check-in regarding client's physical health.** As previously mentioned, many social workers incorporate physical health into the treatment process only if the client is willing or able to address these physical health concerns. If so, many social workers incorporate weekly check-ins regarding many facets of the client's physical health, such as sleep, diet, nutrition, and self-care.

Participant 1 addressed critical physical health issues with clients over the course of treatment, stating:

I talk a lot about self-care. That just becomes woven into a weekly check-in. It might be part of their homework assignment. They decide they want to eliminate sugar because it makes them wound up and stressed, so I check in on that. It becomes....with some people more than others, depending on problem areas, it can be an ongoing touchstone or recommendation I have. If they are opposed to

medication for depression, then exercise is on the top of the list. Or understanding why they can't do it or why they are resistant.

Participant 2 highlighted the importance of addressing physical health with an emphasis on developing positive coping skills to replace negative coping mechanisms that the client might be using. She stated:

I do really take it (physical health) into consideration and I think it's important. Often with adults, especially those suffering from depression, anxiety, or experiencing a lot of stress, one of the first things that can go is self-care. Within self-care, there might not be motivation to exercise or even motivation to get out of bed. There are people who are emotional eaters and they are eating more excessively and not being mindful of the types of food that they are eating, their nutrition, or they are not eating enough. I do also have clients with body image issues and eating disorders. I try to work with those kinds of people on just looking at and practicing and reincorporating positive coping skills into their daily life, which often includes taking better care of yourself – exercising, eating better. Weight loss may come along with that, but it might not be the target of treatment.

Participant 3 stated:

“I often check in with people's exercise because their mood shifts if they don't exercise. So I notice that and check in on their exercise. And many clients come in with sleep disruptions and sleep disturbances so I always check on that (sleep) and get updates on that (their sleep). Some of them are on medications...Ambien and what not. Some are even on Ativan to help them sleep. So I always check on that. I always check on how they are managing their medications and who is

supervising it and making sure that there is oversight. We don't prescribe, but I do know what the medications are and I like to make sure their physician or psychiatrist is on top of things.

Participant 5 works in hospice and has weekly check-ins that are a bit different from the weekly check-ins of social workers in different settings. Her focus with each meeting with a client is to alleviate any discomfort that the client might be facing at the end of their life. She described:

Every time there is a visit through nursing, or by ourselves, or anyone that sees them, they are assessing the client's physical health. Pain issues and any symptoms that are coming up, like shortness of breath, that kind of thing may need to be brought back to the case manager because something isn't begin managed. Somebody shouldn't have to live with shortness of breath. There's medication that can be given. Somebody shouldn't have to live with pain. There's medication that can be given to help relieve those symptoms.

Participant 6 described collaborating with other professionals over the course of treatment about the physical health of their client in a school setting. She stated:

We stay in contact with the physician if we need to. Or we talk with the school nurse about things like asthma or any other physical needs. We don't have a lot of kids with disabilities because we don't have that program so we don't have any extensive health needs. We have 80% free and reduced lunch. We make sure they do get breakfast and lunch. Nutrition is hugely important. In my practice, I will have snacks if I can because I know they don't have enough to eat at home.

Participant 8 described her continual assessment of physical health concerns over the course of treatment with middle-school children. She explained continually checking-in with the children about their sleeping habits, exercise and movement during their day, and their dietary habits.

Participant 9 described that when clients set goals around their physical health concerns, she will incorporate these goals into treatment and check in on their progress towards these goals each time they meet.

***Regular check-ins about sleep.*** Many of the research participants emphasized the importance of sleep for an individual's overall physical and mental health.

Participant 1 described the importance of addressing sleep with the clients that she works with. She stated:

Often people will come in and they will do really well with exercise, but their lives are so crowded and they are so overextended that they aren't sleeping. They have two young children, they work full-time, and/or they have a partner that works eighty hours a week. Sometimes the lifestyle issues are so predominant, even though there is a glaring need to talk about sleep, you just have to weave it in and understand that even though you can see there is something really obvious that is having a cascading effect on their well-being, their mental health, and their physical health. Sometimes people are unwilling or unable to work on these things.

Participant 4, another medical social worker, described checking-in regularly with her clients about sleep, because it is often difficult for clients to get good sleep while in the hospital. She stated:

Unfortunately, we are in a hospital and it's the worst place to get sleep and we tell the patients that. Nurses have to go in throughout the night and check on patients and it wakes them up. If we find a patient who isn't sleeping well, there are different things we can do to promote sleep. Things like signs on the door and grouping nursing care at night. We talk about those things with the patients and family members who see a patient struggling to stay awake during the day or is complaining that they can't sleep at night for one reason or another. We do try to promote sleep as much as we can in this environment knowing that it is very difficult to do. It is definitely addressed throughout their stay here.

Participant 6 described checking in on the children she works with as a school social worker about their sleep. She specifically wanted to find out if they are really going to sleep and getting adequate amounts of sleep at night. She stated:

Last year, we had a Kindergarten student whose behavior was disregulated. After talking to the family, we found out he wasn't getting enough sleep at night. So sleep is a huge thing for kids because they are in elementary school. Making sure they get enough sleep. It changed his behavior when he got 8-10 hours of sleep. Also figuring out are they watching TV or playing video games at night? Are they really going to sleep and getting adequate amounts of sleep at night?

Participant 8 regularly checked in about the sleeping habits of the middle school children that she worked with over the course of treatment. She stated:

I would have conversations with the kids about what's in their bedroom, how many hours a day are they on screens, what are they doing right before they go to sleep, and how much sleep are they getting.

**Psychoeducation about the impact of physical health.** Many of the participants in this research project provide psychoeducation to their clients about the impact of specific areas of physical health on one's mental health and overall well-being.

Participant 3 described providing psychoeducation about how physical health impacted mental health and overall well-being over the course of treatment. She stated:

I would do diet and exercise education – you know, psychoeducation about it. You know, Henry Emmons has written wonderful books, *The Chemistry of Joy* and *The Chemistry of Calm*. I kind of use that model. Although I do it intuitively or intrinsically because I've been trained in mostly a medical setting to look at what is happening to their bodies. I pay a lot of attention to non-verbal's, to facial expressions, to the ways in which they are sitting, and the ways in which they are holding their tension.

Participant 3 also described:

And that of course relates to sleeping, how much one is sleeping, and if the person is getting enough rest. If you aren't getting enough rest, what do we need to do to help you get more rest? It's all intrinsically connected from my perspective.

Participant 4 described how she provided psychoeducation over the course of treatment to address the client's physical health and general well-being. She stated:

Given that we (practice in a) physical rehabilitation (setting), we do a lot of education. Not only are the therapists working with them on their physical health, we as social workers, are giving them information about community resources for physical health, such as adaptive Tai Chi programs for people who have had strokes or community groups they can attend for physical education for folks with

a disability. They are provided with quite a bit of information after they leave here (physical rehabilitation facility) because they are only here for a short period of time. We can address things while they are here, but life is after the hospital. It's important for them to know how to stay physically fit. We can give them information and resources on things they can purchase for their own homes if they are able to do so to help stay physically fit.

Participant 5 described providing psychoeducation to clients in hospice and to their friends and family. She said:

We do a lot of education about the physical decline in people when the body starts to let go and shut down. It starts by not wanting to eat. It starts by taking in less liquids and fluids and stuff. It's really just ending its life. We explain that to people. For the most part, people can see that and know that so they aren't fearful when this starts happening to their loved ones. We are there to support them.

Participant 7, who worked in a school-based setting, provided psychoeducation to the students that she worked with and with their families, if deemed necessary.

Participant 8 provided psychoeducation to students and their families about what constitutes healthy sleeping patterns and things that children and their families could do to help their child get adequate and consistent sleep each night.

*Exercise as a natural "mood-booster"*. Participants indicated that participating in some sort of movement or exercise could naturally increase positive mood through the body's hormones and responses to movement.

Participant 1 described exercise as an effective treatment for depression, especially if a client was resistant to taking medication. She also addresses motivation

behind exercise and other areas of physical health to better understand the world of the individual client.

Participant 3 described the importance of targeting exercise and movement with clients who were depressed as a natural treatment for the depression and suggested reading materials related to the impact of exercise on depression and overall well-being.

Participant 9 described a case example where an individual utilized exercise when he felt like using. She described the positive effects of exercise on mood, which was helpful for this individual. In addition, participant 9 described another example where she was working with an individual whose goal was nutrition and personal hygiene. She met with this client in her home during the course of treatment, and this particular instance occurred around breakfast time. She stated:

She goes and gets a triple-decker sandwich and a bowl of pudding. This actually happened. I asked her if nutrition was one of the goals that she still wanted to work on. She replied, 'Oh, I am, but this is what I always eat for breakfast'. It was a really good teachable moment. You don't usually get that in the office. I would never see that and it wouldn't come up. I wouldn't be like, 'What did you have for breakfast today?' Being in the community, you get to see things like that. They are in their own environment where they are comfortable versus just an office space where it's more uncomfortable in a way.

**Movement as part of therapy.** Previously, respondents addressed the importance of movement and exercise on one's physical health and their mental health. If the client was willing or able, many social workers incorporated movement into their practice with clients.

Participant 3 described how she incorporates movement and breathing exercises into treatment. She stated:

I'm a certified yoga teacher, although I don't teach yoga, I utilize it in my practice. I might introduce some concept around breath work for relaxation or producing more comfort. I am very biologically oriented. I also always talk about the mind-body connection with clients.

Participant 8 specifically addressed how she would incorporate movement into her work with middle-school children. She stated:

I have a medicine ball, a five-pound really heavy ball. I use that a lot with kids to get their body moving. We'll play catch or I'll have them do the alphabet with it. Sometimes I'll even use movement or exercise in my time. I had one kid I worked with last year who was very obese and didn't have any form of exercise when he left school. He would go home and play video games. Rarely went outside. Whenever I see him in the spring and fall, if it's a nice day, we walk and do therapy. So sometimes I'll incorporate it in terms of walking during my sessions or if they are real fidgety and have attention deficit issues, and they need that deep movement, we'll do some things with the medicine ball in our sessions.

Participant 9 described how she will often attempt to incorporate movement into her practice with clients, which often occurs in the community. With community-based practice, it was easier for her to include physical movement over the course of treatment. She described attempting to include a variety of movement into each meeting with the client and encouraged clients to exercise outside of therapy. Movement can include just going outside for a short walk or more extended types of movement.

### **Relationship Between Physical Health and Depression**

Participants were asked the question “In your practice experience, what is the relationship between physical health and depression?” and a variety of responses were given to this question. There were three prominent themes that emerged from the data collection phase of this research project. These three themes are (a) providing psychoeducation about how exercise impacts the physical and emotional body and its role in mood regulation, (b) exercise can act as a natural mood lifter and decrease a client’s experience of depression, and (c) utilizing exercise as a positive coping skill to replace negative coping skills and having exercise as part of the client’s treatment plan.

**Exercise and movement can decrease the experience of depression.** In many respondents’ practice experience, exercise and movement can decrease their client’s experience of depression and contribute to feelings of a positive mood.

Participant 4 described how exercise and mood were closely related, especially in her work with individuals in an inpatient rehabilitation facility:

I would say there is a huge relationship between the two (physical health and depression). In somebody who was able to get off the chair and get their mail, for example – they had the physical ability to do so. Aside from the fact that maybe they went to the gym every day. Now they can’t do a minor thing like go to the bathroom by themselves. So many people unfortunately experience depression after an event that brings them into the hospital with us like a spinal cord injury, a brain injury, a stroke, or even a surgery that debilitates them even temporarily. Many of our patients experience some form of depression.

Participant 5 described the relationship between physical health and depression, stating that:

They certainly can be closely related. I think we see this a lot, sometimes with people as they've aged, they aren't active, or if they aren't active or if they've lived alone and are not getting out anymore, and weight has come on or there is some physical change – maybe there is diabetes or there or some other symptoms that are starting to show up. I think that people, because they haven't taken care of their physical health, develop this depression about themselves, because they are physically sick and physically hurting. People with physical health issues, I've seen a lot of them depressed.

Participant 5 also described her experience in work with clients regarding physical health and depression. She noticed that movement can promote positive mood in a depressed client, specifically when she did Animal-Assisted Therapy (AAT) with individuals. She said:

Some of the agencies that I go to have regular exercise programs for the people. Just those little bits of movement from a chair that our seniors can do and the movement they can do. You see it in their eyes, they just kind of brighten and they feel so much better even if they have some health issues. They just feel better mentally.

Participant 6 described the correlation between physical health and depression in her practice experience:

You see major differences, but it's hard to get that motivation to get out and do it. The hard thing is that a lot of schools take away recess, which is the one time you

can actually get exercise during the school day. That's a punishment. It doesn't help kids who are depressed. It makes it worse. You need to get outside, get that fresh air. There's a huge correlation.

Participant 8 described the relationship between physical health and depression in her clinical social work practice in a school setting as:

I really believe in movement and depression. I really think it's key that people move if they are depressed. Whether that's exercise or walking or going out to socialize with friends... Something that gets them out and feeling good about moving and doing something well.

**Psychoeducation about exercise and depression.** Many of the respondents provided their clients with psychoeducation about how exercise can impact one's depression and overall mood.

Participant 1 described providing psychoeducation to her clients in her private practice about how exercise can impact one's mood:

Exercise is the natural normal lifestyle way that people increase serotonin, endorphins, norepinephrine, dopamine, and all those.... I have articles that I give out that talk about how to support it (exercise to increase experiences of positive mood for the client). I give examples. I use my own life as an example.

Participant 2 stated:

Oftentimes people lose motivation when they are depressed. Even when they know it would be helpful to get up and just exercise, get some fresh air or eat right... that would make them feel better. They lack the skills to even do that. I think they are really related. I kind of relate the sweating of a good work out to a

good cry. It can get rid of some of that pent up negative energy. You hear a lot of times, people are like, I am so stressed; I need a good work out or a good run.

Also releasing endorphins can be a natural mood lifter. I firmly believe in it.

Participant 3 provided psychoeducation to her clients about how exercise could impact one's mood. She also provided books and other reading materials to help the clients further understand the impact of exercise on one's overall well-being. She stated:

We know that exercise boosts a lot of the hormones. It increases your breathing. It produces...depending on how long you exercise, it produces a more deepened focus so that you are maybe not thinking so much and are less worried. It produces some relation, the high, and the endorphins. The happy chemicals kick in and give you some respite from your depressive thinking.

Participant 7 described her view of how exercise impacted an individual's mental health:

I think it's huge. I think that... what I tell kids that I work with here, taking an anti-depressant or seeing a therapist is just as important as getting enough sleep, eating the right foods, and moving your body. Those are the three things we talk about all of the time.

**Exercise as part of treatment.** Many respondents used exercise as part of the treatment plan, as long as the clients were willing and/or able. Also, exercise could be used as a positive coping skill to replace a negative coping skill that the client might be using.

Participant 1 described that exercise naturally boosts hormones to increase positive mood. She stated:

If people come in and they've already discovered that they feel better and it helps them think more clearly or sleep better, that's great. If they haven't it's harder getting somebody without any life experience with that... We set specific goals around these things (exercise). If someone says I'm not interested in exercise, I won't do it, that's all you can do.

Participant 2 described how she provided psychoeducation to clients about how exercise can be a natural mood lifter and can be helpful to those suffering from depression. She stated: "Starting out small with clients and getting them to work in some kind of routine. They often feel better about themselves and even their self-image can improve".

Participant 3 described how she incorporates exercise and physical movement into her work with clients in private practice. She stated:

Exercise is an integral part of being healthy. It's an important part of the therapy. If people come in with pain and can't move certain ways, it's like what can you do? Maybe they go to a gentle yoga class or incorporate something at home that they can do. They will do walking instead of running, even if it's just 20 minutes a day. Then you get the overweight people who really know that they need to change the way they eat, stop drinking so much alcohol, and exercise and don't because they are depressed.

Participant 5, a medical social worker who works in hospice, also uses AAT in her work with the hospice patients. She stated:

I see it (link between the amount of exercise and depression) in (the clients) petting the dogs. When I do pet therapy, there is a movement there. It's the

physical movement of the body that changes the energy and causes the endorphins to kick in. You watch their eyes and they start getting brighter.

Participant 6 described the relationship between exercise and depression according to her practice experience:

It plays a huge role. We've had several kids who have been severely depressed. If we can get them out to recess, working out, or just walking around the school a few times, it can make a big, big difference. Or just stimulating their brain by playing or something can be very helpful.

Participant 8 did not directly address physical health over the course of treatment in her work at an inpatient rehabilitation facility, but did relate that there are other medical professionals in charge of addressing a client's physical health over the course of treatment. In her work in a school setting, she addressed movement and socialization in the groups she does with the middle school adolescents. She says "That's (movement) part of our curriculum in our depression group. We talk a little bit about social and success activities where they develop some mastery. Sometimes that gets them out and feeling good about moving and doing something well".

Participant 9 described an individual who used exercise and movement as positive coping skills that he when he felt like using substances. The client described feeling more depressed in treatment due to the lack of activity and movement:

When you are in treatment, you go to group, then you nap, you go to group, then you nap. You're kind of moping around. There's not much else to do. When he started working out and being healthier, he was really excited. He was excited

about the future. He was really looking forward to the next thing and getting a job.

### **Role of Food and Nutrition in Social Work Practice**

Participants were asked the question “What role do food and nutrition play in your practice?” and a variety of responses were given to this question. There were two prominent themes that emerged from the data collection phase of this research project. These two themes were (a) provision of psychoeducation about food and nutrition and (b) utilizing food as medicine and incorporating it into the treatment process.

**Psychoeducation about food and nutrition.** The majority of participants provided psychoeducation to their clients about the importance of a nutritional and balanced diet in combating mental illness, especially anxiety and depression.

Participant 1 described how she provided her clients psychoeducation about the role of food and nutrition over the course of treatment:

People will come in and talk about anxiety and we have to understand caffeine levels, sugar levels. In the last five years, I've gotten more explicit about talking about gluten and different things... Whether there might be an allergy or sensitivity to certain dietary things. If someone is obese, but if not talking about their obesity, we might talk about nutrition and how it might weave its way into their goals, as would exercise and drinking.

Participant 2 provided psychoeducation to the clients that she works with about nutrition and dietary choices and stated:

There are foods that give us more energy. Sometimes I educate clients on that regarding their overall nutrition. Some can weigh us down and be empty calories.

Some can be helpful for ADHD. If parents are really resistant to medication, often times they will try a change in diet first.

Participant 3 described how she provided psychoeducation in two separate case examples:

It's like yesterday; I was working with a 13 year old. She doesn't eat breakfast, then she doesn't eat lunch until 12:30 p.m., and she has gym midmorning. So, what snack do you have? None. I had to talk to her about glucose in her brain and helping her to stay focused because, of course, one of her complaints was that she loses focus and gets distracted and... so forth and so on. I have one client who has serious and persistent anxiety and depression. She was treated for anorexia as a teenager. She eats the same food every day. We have to talk about reminding her to make sure that she is getting enough protein.

Participant 4 described her experience with individuals surrounding food and nutrition and that there are other members of her interdisciplinary team that are there to specifically address food and nutrition:

We have dieticians and nutritionists who talk to patients about diet. They can talk to patients and their families about grocery shopping if they are newly diagnosed with diabetes. It's really helpful. They are scared out of their gourd. I don't address it specifically other than to give them the information and talk about their feelings about their new diagnosis.

Participant 7 described using a cognitive-behavioral approach to assessing food and sleep by having a student keep a food and sleep diary so she could start to recognize

her eating and sleeping patterns. After recognizing some of these patterns, she began to realize how certain foods and sleep affect her alertness and mood.

Participant 8 described utilizing psychoeducation about food and nutrition with the middle school students that she works with:

The kid's diets are just horrible. Lunch they'll have two energy drinks and a bag of candy. It's ongoing conversations with them. I use the 'in' when we talk in a session and they put their head down because they are so tired. It's a great time to say how much sleep did you get last night, when did you get up, and what did you have for breakfast? Then talk a little bit about protein and I'll give them a handful of almonds. That's where we talk about nutrition.

**Food as medicine and as part the treatment process.** A few of the participants described how they used food as medicine if the client was unwilling or unable to take psychotropic medications. Also, diet and nutrition could be incorporated into the treatment plan and/or as treatment goals for the client.

In addition to providing psychoeducation about diet and nutrition, Participant 2 also stated:

I just encourage healthy choices. In the past, if healthy choices haven't been made, how has that negatively impacted the client? Even if we need some help, we can recognize or learn from our mistakes. Or on the flip side, in the past if they have done that, what have been the benefits. And it would be good to start working on incorporating good nutrition again.

Participant 3 described her practice experience related specifically to food and nutrition:

I see everything from kids who won't swallow certain kinds of foods, young adults with anorexia, young adults with bingeing and purging, and people with food sensitivities. So I always want to know what they eat and when they eat. It's all intrinsically connected from my perspective.

While participant 4 was not in charge of specifically addressing food and nutrition with her clients, as there are nutritionists and dieticians who are in charge of that arena, she did touch on the subject of food and nutrition in her brief work with patients of an inpatient rehabilitation facility. She said:

In my interactions with patients, I talk about the importance of nutrition for their physical being and getting healthy. I can talk about their feelings about being diagnosed, but then I can assure them that they are going to get the information and education to feel confident about going into the world and living as a diabetic. I don't address it specifically other than to give them the information and talk about their feelings about their new diagnosis.

Participant 5, who worked in hospice, did not specially address food and nutrition, but focused on the client's level of comfort as they prepare for the end of their lives. She stated:

We are talking about people preparing for the end of life, so nutrition and diet is not important anymore in their care plan. The philosophy is, let someone eat and drink whatever they want. I was at a man's house the other morning and his wife had poured him a beer at 10:00 a.m. because that's what he wanted. I went 'that's fine.' A lot of times people have been taking all these multi-vitamins and all these extra things to help make them healthy or make them feel healthy, or whatever.

Those are typically discontinued because the person doesn't really want to keep swallowing all those pills anymore when they aren't taking in food and drink so much and it upsets their stomach. Their system is shutting down. It doesn't want that stuff and so nursing will typically discontinue that stuff and they aren't on anything except for comfort medications, like morphine or Ativan, or some of the other things that they get.

Participant 6 described the role of food and nutrition in her work with school-aged children:

Food and nutrition is always huge. I focus on it more because of the poverty aspect. So just understanding if they are getting their basic needs met with food and nutrition. What are you eating? Are you able to get food? Do they need to get linked up to food? Resources. What types of food are their kids eating? In clinical practice, if you see a kid with ADHD and the parent's don't want to medicate, what options do you have? Are you taking the steps to change the diet? You have to look at the whole kid.

Participant 7 described a case example where food and nutrition were a specific focal point over the course of treatment for a student. She said:

Last year, I did a food diary with a student who was really very bright. She liked keeping track of things and researching things. She was really struggling with depression and she didn't want to see anybody and didn't want to go on medication. I had her keep a food diary for me for a week. She also had really horrible sleeping patterns and wouldn't fall asleep until two or three in the morning. It was a food/sleep diary. I think she found some of the gaps that she

had during the day where she wasn't eating or eating really poor things in the morning and how it made her really tired in the afternoon.

Participant 8 described continually checking-in with students about the food that they are eating and its overall nutritional quality. She used examples in the moment during sessions to help the students further understand the connection between their physical health, specifically food and nutrition, and the impact it has on their mood and body.

### **Conclusion**

In general, there were many interesting findings from the current research project. Overall, social workers appear to be incorporating physical health informally into their practice as they see fit and as the client is willing to address in treatment. There appears to be few formal measures addressing the client's sleep, exercise, and dietary habits available to clinical social workers to utilize during assessment, diagnoses, and over the course of treatment. Many social workers understand the importance of an individual's diet on their energy level and overall mood, but it can be difficult to incorporate into practice with limited time and when a client is not ready to address these areas. Most of the participants provide their clients with psychoeducation about the impact of poor physical health on one's mental health. The participants display an understanding of how exercise and movement can naturally treat depression and have begun to informally incorporate movement into actual sessions or as part of the treatment plan for an individual client. Overall, physical health is addressed uniquely by each of the participants in a variety of settings, but there was a lack of streamlined measures utilized by the social workers in each setting.

### **Discussion**

This research project poses the question: “How often do social workers target physical health in practice with clients and is there an underutilization of the research regarding the impact of physical health on psychological health in practice with clients?” Following a review of the literature applicable to this research project, my research findings indicate similar and contradictory results.

#### **Barriers to Healthy Eating for Adolescents**

The literature review highlighted several barriers to healthy eating and these barriers are discussed in light of the current research. This research project finds points of similarity and differences between prior research and current research. This section will focus primarily on adolescents as described by the three school social workers that were interviewed for purposes of this current research project.

**Taste Preference.** Story et al. (2002) found that age significantly influenced an individual’s choice of food. Adolescents were found to be more likely to focus on the immediate gratification of an unhealthy snack rather than the potential long-term benefits of nutritious food choices. Also, adolescents were more likely to choose meals and snacks according to their taste or sensory perception of the food and often made choices about food dependent on sensory pleasure, guilt, and being with friends (Story et al., 2002; Sheperd et al., 2006, & Goh et al., 2008). Participant 7 described how many students she worked with often made poor choices regarding the nutritional quality of the food that they eat. Often times, students were unaware of the impact of poor nutrition on an individual’s mood and energy level. Participant 7 provided students with psychoeducation about the effects of nutrition on one’s overall well-being. As

homework for one of the students that Participant 7 worked with, she had the student keep a food and sleep diary over the course of treatment after she provided the student with psychoeducation about nutrition. This cognitive-behavioral approach helped the student realize which foods made her feel tired or sad, and which foods increased her energy level and her personal experience of a positive mood. In addition, Participant 8 described how many students that she works with chose things like energy drinks and candy for lunch and often felt poorly afterwards. She also provides students with psychoeducation about nutrition and offered snacks, such as almonds, for her students to snack on during their sessions.

**Economic barriers.** Cost is a major factor in dietary choices for families in poverty. Economic barriers impact what foods are purchased and consumed in the family's household, which is partially influenced by the belief that eating healthy costs too much for a family in poverty to afford (French, Story, and Jeffrey, 2001 & Sheperd et al., 2006). Often families and caregivers shape the beliefs that adolescents have about food and the choices they make regarding the nutritional quality of the food that they ingest (Goh et al., 2008, Story et al., 2002, & Birch, 1999). In addition, Goh et al. (2008) found that many students and families have inaccurate beliefs about the nutritional content of school lunches.

The findings of this research project also identify how economic barriers impact physical health and beliefs about nutrition in the various participant's social work experience. Participant 6 focused on food and nutrition with the adolescents that she works with due to the high incidences of poverty in her school. She often had snacks available for the with because she has knew that these children often had poor and

inadequate nutrition at home due to poverty and lack of education about nutrition.

Participant 8 also provided psychoeducation about nutrition and healthy snack options for the students that she works with as many of them live in poverty and/or make poor food choices.

**Inconsistencies with the literature review.** While there were many similarities to the literature review, there were results found in the literature review that were inconsistent or not mentioned during the interviews. Results from the literature view indicate that culture can influence dietary choices and perception of what it means to be overweight. Kaufman and Karpati (2007) found that overweight children in Latino families were viewed as more acceptable than thin children. In their research, the Latino culture was found to view thin children as being ‘fragile.’ In this research project, there was no correlation mentioned in the semi-structured interviews about the relationship between culture and an adolescent’s weight.

Fast food, increasingly larger portion sizes, and eating out were cited as causes for poor nutrition for many families, especially those with limited incomes (Story et al., 2002 & French et al., 2001). Participants 6 and 8 addressed in their interviews that poverty was a concerning factor regarding nutrition, but the gathered data from the current research project did not directly address fast food, eating out, or increasingly larger portion sizes for food.

Additionally, food insecurity and food insufficiency are associated with anxiety and depression (Weaver & Hadley, 2009 & Hadley & Patel, 2007). Research also indicated that mental illness, poverty, and food insufficiencies were all correlated (Heflin & Ziliak, 2008). While the research gathered suggested that poverty could impact the

nutritional quality of food purchased for the household, there was no direct link mentioned between food insufficiency and mental illness. Several participants did mention that fatigue was correlated with poor nutritional quality of adolescent food choices in many of the clients that they worked with in their social work practice.

### **Nutrition and Mental Health**

Diet and nutrition have been shown to influence an individual's mental health and overall psychological well-being (Harper, 2010; McGrath-Hanna et al., 2003; & Weaver & Hadley, 2009). The findings from the current research project generally support these findings from the literature review. Many of the respondents stated in the interviews that they provided psychoeducation to their clients about the impact of poor nutrition on one's physical and mental health and what constitutes a well-balanced diet. Participant 1 recognized the importance in her social work practice of the impact that foods with poor nutritional content have on the physical body and that certain foods can exacerbate mental health symptoms, such as the experience of depression or anxiety. An example is a social worker recognizing that something like excessive caffeine consumption can be problematic for an individual who suffers from anxiety. Participant 2 recognized that certain foods could help with energy level, which is important for all individuals, but especially for those who suffered from depression and lack of energy/motivation. Participants 6-8, who are school social workers, described how the inadequate nutritional content of the student's diet generally lead to an individual's experience of a decreased energy level and diminished experiences of positive mood. Participant 9 realized that there was a correlation between a poor diet and depression in her social work practice experience and often addresses her observations with her clients throughout the therapy

process. Overall, the literature review and current research findings both indicate that there is a correlation between nutrition and mental health and that it is important to address this over the course of treatment.

### **Physical Exercise, Depression, and Psychological Well-Being**

The majority of participants in the current research study indicated in their interviews that exercise and depression were often correlated, a fact supported by the findings in the literature review. For example, regular exercise correlates with a decrease in depressive symptoms and an increase in psychological well-being (Hassmen, Koivula, & Uutela, 2000 & Harper, 2010). Also, exercise has shown to be an effective treatment for clinical depression (Fox, 1999, Riba, Wulsin, Rubenfire, & Ravindranath, 2012, & Krogh, Nordentoft, Sterne, & Lawlor, 2011).

Participants 1, 2, and 3 acknowledged regular physical exercise naturally boosted hormones that have been shown to correlate with an individual's mood. Often these respondents provided psychoeducation to their clients about the impact of exercise, but especially when clients were suffering from depression. Participant 2 described her observations that clients often felt better about themselves once they started some sort of exercise regime and used that exercise as a positive coping skill. Participant 3 also noticed that exercise boosted hormones related to the experience of a positive mood. In addition, she perceived that exercise can provide an individual with a deepened focus and a sense of relaxation, all components of mindfulness. Participant 4 has clinically assessed and diagnosed depression in many of her patients who have recently experienced an accident or disease that limited their mobility. Participant 5, who works in hospice, described how the littlest bit of movement could increase their energy level

and boost endorphins. She practices Animal-Assisted Therapy with her clients and noticed how individuals with decreased mobility often smile and their eyes brighten when they are able to move in small ways, such as petting the therapy dogs that she works with. Participants 6 and 8, who work with adolescents, described how regular movement, especially including recess breaks, can actually boost the student's mood. In addition, participant 7 shared her observations of exercise being just as or more effective than psychotropic medications in her social work practice, which is in accordance with the conclusions drawn in the literature review about the short term and long term effectiveness of exercise in treating depression .

### **Future Research**

The current research project produced similar findings to the literature review and has highlighted several areas that could be considered for future research. Through the gathered data, the researcher noticed the emphasis on regular and quality sleep for an individual to promote psychological well-being. While sleep was not directly covered in the literature review, future research should evaluate the impact of sleep on an individual's physical and mental health alike. The current research further highlighted the importance of balanced nutrition and physical exercise on an individual's energy level and emotion regulation. Future research should include a deeper assessment of how social workers can continue to incorporate nutrition and movement even further in their work with clients. Some of the social workers who participated in this research study tried to incorporate movement into their work with clients, when applicable to the client and if the client was willing or able to. Some of the clinical social workers interviewed, especially those practicing social work in a school setting, provided healthy snacks and

meals for students who might not have access to these items in their household due to poverty or lack of education about proper nutrition. The inclusion of healthy options and psychoeducation about nutrition were consistently incorporated into their social work practice with students.

Additionally, the current research findings indicated that there were very few formal assessment tools readily available to social work in agencies and private settings that specifically measured the client's physical health, including the amount and quality of sleep, the nutritional value of their diet, and how the client is currently incorporating exercise or movement in their daily lives. Due to the lack of physical health items on formal assessment tools, future research could examine how to formally include an assessment of physical health on intake forms. Future research should continue to investigate how social workers can further incorporate physical health into assessment, diagnosis, and over the course of treatment.

### **Conclusion**

Food, diet, and nutrition have been shown to play an important role in mental health, energy level, and psychological well-being in both the gathered data and in the literature review. Depression and exercise are correlated and regular exercise can be an effective tool that naturally treats an individual's depressive symptoms. In addition, participants in this research project were asked how they incorporated physical health into assessment, diagnosis, and over the course of treatment. The majority of participants readily recognized the importance of physical health in working with clients. They continually provide psychoeducation to their clients about the impact of physical health on overall mood and energy level. The results of this current research study indicate that

most social workers have few tools and measurements to formally assess physical health during assessment, diagnosis, and over the course of treatment. Future research should explore how physical health can be measured formally during assessment and on intake forms and how social workers can continue to incorporate physical health into practice.

### **Strengths**

There is little research on how clinical social workers and other professionals currently and formally utilize nutrition and physical health as part of the treatment process, but there is an abundance of literature focusing on the importance of physical health and its impact on an individual's mental health. The current research supports the conclusions drawn in the literature review and also acknowledges areas for future research. This study provides pertinent information to social work practitioners' regarding the value of a holistic and integrative approach to their social work practice through the greater inclusion of physical health in the treatment process.

The current research findings capture a more complete assessment of how social workers practicing in a variety of settings address the physical health of a client during assessment, diagnosis, and over the course of treatment. Results from this study can also help guide future social work research, education, and training opportunities for clinical social workers through having a more holistic focus on an individual with the inclusion of their physical health over the course of treatment. Social workers can utilize the results of this study to determine how food, diet, and exercise could be further incorporated into assessment, treatment, and diagnosis in their individual social work practice. The inherent exploratory nature of qualitative research and semi-structured interviews allowed the researcher to gather more rich and diverse data. The semi-structured

interview approach allowed the researcher to ask questions that are not on the interview question list (see Appendix D) and gather varied data due to the flexible nature of semi-structured interviews. Although the sample size was too small to generalize to the larger population, the participants were from a variety of practice settings. This contributes to a wider berth of knowledge due to the varied practice settings of the clinical social workers interviewed.

### **Limitations**

Qualitative research is exploratory in nature, so the results of this research study are unable to be generalized to other populations or the population at large. The sample for this study was gathered using snowball sampling, a non-random sampling technique, which could limit the diversity of subjects and of the collected data. Due to time constraints, the study only utilizes eight primary questions for the semi-structured interviews. Also, with a small sample of nine participants, the results can not be generalized. All nine participants were middle-aged females licensed as clinical social workers, with only one outlying participant who was younger than the rest of the participants. The participants were all licensed in the state of Minnesota, which limits the diversity of the data. These participants practiced as clinical social workers in a variety of settings, which could have limited the data collected. Future research could focus on how clinical social workers in specific settings are incorporating physical health instead of a general overview of how clinical social workers are incorporating physical health into social work practice in a variety of practice settings. In addition, the findings are only truly applicable to members of this specific population of middle-aged female clinical social workers practicing in the state of Minnesota and these findings are unable

to be generalized to other populations. All of the participants were also Caucasian, which again limits the diversity of the data collected for this research project. Also, the researcher conducted all steps of data collection and analysis, and a researcher bias could exist that influenced the collected data and the analysis of that data. Future research will be needed to more completely address the role of nutrition and physical health in assessment, diagnosis, and treatment in social work practice.

### **Conclusion**

While the data gathered for this research project is valuable and has many strengths, there are definite limits to its generalizability and application to other population groups or the population at large. The participants come from a variety of practice settings, which helps create more diverse and all-encompassing data across the various social work practice settings. A larger randomized sample would be necessary in order for the researcher to be able to generalize findings to the population at large or specific subsets of that population. Overall, more research is needed to further assess how social workers incorporate their client's physical health into assessment, diagnosis, and over the course of treatment and the benefits of including physical health into social work practice.

### **Implications for Social Work**

The literature review clearly demonstrates the importance of physical health on an individual's mood and overall well-being. The findings of the current research project have many implications for social work policy, research, and practice. The current research identifies areas where physical health is currently incorporated into clinical social work practice and areas where there is a glaring need for physical health to be

addressed. Future research could focus on formal measures of physical health that social workers can use during assessment. In addition, future research could investigate the ways that the field of social work can continue to incorporate physical health into diagnosis, assessment, and over the course of treatment.

### **Policy**

The research indicated that there were few formal tools or measurements available to clinical social workers to assess the physical health of the client during assessment, diagnosis, and treatment in clinical social work practice. For example, most of the participants interviewed did not have any, or few, formal scaling measure or question assessing physical health on their various intake forms. Perhaps an increased awareness of the implications of poor physical health on one's mental health will lead to the development of more to help get an accurate picture of a client's physical health at the beginning of treatment. Many of the participants identified that it was important to eliminate any possible medical conditions that would contribute to a client's symptoms before making an official diagnosis, but many of the social workers that worked independently or within the school system do not have direct access to a doctor or the option to collaborate with an interdisciplinary team including medical professionals. Lastly, there was no specific structured way that the clinical social workers interviewed incorporated physical health into treatment. In general, a focus on physical health was incorporated over the course of treatment as the social worker saw fit and as the client was willing or able to address. The interviewed clinical social workers reported having a good understanding of the importance of physical health on an individual's general well-being. The participants also recognized the implications of poor physical health on the treatment process and have done well incorporating physical health as needed into

treatment. Further research is needed to determine if there are empirically-supported ways to incorporate physical health into treatment and provide a more streamlined approach to the inclusion of physical health into practice to help all social workers, especially those new to the field of social work.

### **Research**

The literature review and the data gathered from participants in this research study highlight the importance of a balanced diet in supporting an individual's overall physical health and well-being. Many participants provided their clients with psychoeducation about the effect of poor nutrition on one's energy level, anxiety, mood, and overall well-being. A few of the participants used food as medicine with certain clients if they were resistant to taking psychotropic medications. Many of the school social workers interviewed struggled in their social work practice with children who received inadequate nutrition in their home lives due to many factors such as poverty. They have often offered snacks with good nutritional quality to the students that they worked with. Many social workers saw their clients once a week for less than an hour, which did not always give an accurate snapshot of the client's lifestyle and dietary choices. Future research is needed on how social workers practicing in outpatient mental health can further incorporate diet and exercise into practice, other than the inclusion of psychoeducation into their social work practice.

### **Practice**

The current research findings support the literature review, in that most of the participants interviewed acknowledged how movement and exercise can increase one's experience of a positive mood and naturally combat depression. Several were aware of

the effectiveness of exercise in treating depression, even when compared with anti-depressants. While many clients were unaware of the impact of exercise and movement on their mood and overall well-being, many social workers helped combat this ignorance by providing psychoeducation about physical health to their clients as needed. A few of the participants incorporated movement into their actual sessions with clients, which is a creative way to help a client naturally treat their depressive systems within the session without necessarily resorting to psychotropic medications. Future research is needed on how clinical social workers can continue to provide their clients with psychoeducation about the impact of physical health, including ways to help increase motivation in their clients to help foster the development of a regular exercise regime in their daily lives.

### **Conclusion**

In conclusion, this research has many implications for future social work practice and research through further assessment and inclusion of a client's diet, exercise, and sleep habits into the treatment process. Future research should focus on how social workers can strategically address the client's physical health as part of the social work treatment process. The research further allows social workers to understand how other social workers have begun to incorporate physical health into treatment and where holes exist in the inclusion of physical health into clinical social work practice.

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## Appendix A

### INFORMATION SHEET FOR THE STUDY

My name is Kristin K. Huskamp and I am a graduate student in the MSW program under the direction of Catherine L. Marrs Fuchsel, PhD, LICSW in the School of Social Work, St. Catherine University and the University of St. Thomas. I am conducting a research study to explore the experiences of social workers in practice with the phenomena of nutrition and physical health in assessment, treatment, and diagnosis. I am interested in learning how nutrition and physical health are incorporated into social work practice. I hope that what I learn from this study will help social workers and service providers to understand the impact that nutrition and physical health have on mental health and psychological well-being. I would like to interview social workers about their experience with one's dietary choices and physical health in practice with clients in various agencies.

I am inviting social workers to engage in one interview with the researcher. This interview will last under one hour and will be audio recorded. The interview will be conducted at either a private room of your choosing with a closed door or at a room with a closed door rented from St. Catherine University and the University of St. Thomas' library. I will set up the time and day for the interview depending on what is best for you. If you agree to participate, I will ask you on tape if you understand the information letter, if you have any questions and if you agree to take part in the interview. This study is voluntary and you may choose to stop participating at any time. You may also choose not to answer any question.

In the interview, I will ask you about your past and present experience in the field of social work. I will ask about your experience in practice with nutrition and physical health during assessment, treatment, and diagnosis.

There is no direct benefit to you for participating in this research project. This study may help other social workers in practice by exploring the impact that nutrition and physical health has on one's mental health. The information from this study will be published online through St. Catherine University. Your name will not be used to identify you and information will be recorded anonymously.

The interviews will be tape-recorded and they will not be recorded without your permission. You will have the right to ask for the recording to be stopped. The audiotapes will be kept on the researcher's private computer. This computer is password protected and kept in the researcher's home office, which is kept locked when not in use. Only the researcher will have access to the confidential information. The data will be destroyed after the public presentation of research findings in May, 2013. The tapes will be destroyed and discarded immediately after the tapes have been transcribed.

**Contact information:**

**Kristin K. Huskamp**

**Cell phone: XXX-XXX-XXXX**

**E-mail: XXXXXX@XXXXXXXX.XXX**

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact John Schmitt, PhD, and Chair of the St. Catherine University's Institutional Review Board, at (651) 690-7739.

## **Appendix B**

### **Telephone Script**

Hello! Thank you for contacting me! As you know, my name is Kristin Huskamp and I am a MSW student at St. Catherine University and the University of St. Thomas. For our final year, we are required to complete an applied research project, complete with a research paper and public presentation in May. My topic explores the experience of clinical social workers in practice with the phenomena of nutrition and physical health in assessment, treatment, and diagnosis. Based on reading the information sheet, I was wondering if you would agree to participate in my research? Participation includes engaging in a live interview that is audio taped in a private room with a closed door, either at your office or agency, if you are able, or at a private room with a closed door rented through the St. Catherine University or University of St. Thomas library systems in advance. At the start of the interview, you will be asked to read and sign a consent form. Participation in this research project is voluntary and a participant can decide not to participate at anytime throughout the research process. The information collected during research will remain confidential. Data will be kept on my personal computer, which is password protected. This computer remains at my home in my locked office when it is not in use. After completion of this research project, any identifying electronic data will be permanently deleted and physical data will be shredded and destroyed.

## Appendix C

### Nutrition and Physical Health in Practice RESEARCH INFORMATION AND CONSENT FORM

#### **Introduction:**

You are invited to participate in a research study investigating the experience that social workers have in practice with the phenomena of food, diet, and physical health during assessment, diagnosis, and treatment. Kristin K. Huskamp, a student in the MSW Program at St. Catherine University and the University of St. Thomas, is conducting this study under the supervision of Catherine L. Marrs Fuchsel, PhD, LICSW in the School of Social Work. You were selected as a possible participant in this research because of your experiences as a social worker in practice in relation to the research topic. Please read this form and ask questions before you decide whether to participate in the study.

#### **Background Information:**

The purpose of this study is to investigate how nutrition and physical health are being addressed in social work practice. Approximately eight people are expected to participate in this research.

#### **Procedures:**

If you decide to participate, you will be asked to participate in an individual interview with the researcher either in a private office of your choosing or in a rented room at the University of St. Thomas library. The interview will last about half an hour to one hour for one session and will be audio recorded for data analysis purposes.

#### **Risks and Benefits:**

The study has minimal to no risk.

There are no direct benefits to you for participating in this research.

#### **Confidentiality:**

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

I will keep the research results in a password protected computer and locked file cabinet in the researcher's home office and only I and my advisor will have access to the records while we work on this project. I will finish analyzing the data by May 20<sup>th</sup>, 2012. I will then destroy all original reports and identifying information that can be linked back to you. The audio recordings will only be accessible to the researcher and erased upon completion of the research project by May 20<sup>th</sup>, 2012.

#### **Voluntary nature of the study:**

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or the University of St. Thomas in any way. Participants can refuse to answer any question

asked during the interview. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

**New Information:**

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

**Contacts and questions:**

If you have any questions, please feel free to contact me, Kristin K. Huskamp at (XXX) XXX-XXXX or by email at XXXX@XXXXXX.XXX. You may ask questions now, or if you have any additional questions later, the faculty advisor, Catherine L. Marrs Fuchsel, at (651) 690-6146, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact John Schmitt, PhD, Chair of the St. Catherine University’s Institutional Review Board, at (651) 690-7739.

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

**Statement of Consent:**

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

\_\_\_\_\_

I consent to participate in the study and I agree to be audio recorded.

\_\_\_\_\_  
Signature of Participant Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian, or Witness Date  
(if applicable, otherwise delete this line)

\_\_\_\_\_  
Signature of Researcher Date

**APPENDIX D****Interview Question List**

1. Describe your current practice and position within your agency.
2. Describe your theoretical framework in practice.
3. What is the experience you have incorporating physical health in assessment with clients?
4. Describe how physical health is addressed specifically in diagnosis in your practice?
5. How is physical health addressed over the course of treatment for clients in your practice experience?
6. In your experience, what is the relationship between physical health and depression?
7. What role do food and nutrition play in your clinical social work practice?

## APPENDIX E

### **Transcriber Confidentiality Agreement Addressing Physical and Psychological Health in Social Work Practice**

I am conducting a study to address the experiences of clinical social workers in practice with the phenomena of physical health in assessment, treatment, and diagnosis.

This study is being conducted by: Kristin K. Huskamp under the advisement of my chair, Catherine L. Marrs Fuchsel, Ph.D., LICSW, St. Catherine's University and University of St. Thomas.

#### **Confidentiality:**

Confidential information includes all data, materials, products, technology, audiotapes, computer programs and electronic versions of files saved to portable storage devices. One-time audio recorded interviews lasting no longer than 45 minutes will be conducted by the researcher. The completed audio recordings will be hand delivered to you by the researcher for transcription. No personally identifying information will be attached to the audio recordings. Any transcriptions or electronic files produced by you will not include information that will make it possible to personally identify participants in any way. All audio recordings and transcriptions are to be kept in a locked file. No one else will have access to the records. No one else will have access to the computer on which transcriptions and electronic files will be prepared. All audio recordings, transcripts and electronically formatted transcripts will be returned in their entirety to the researcher. Once transcriptions have been completed and an electronic file compiled, you will contact the researcher who will then personally pick them up. Any and all electronic versions of transcripts will be deleted from your files upon delivery of records to the researcher.

#### **Contacts and Questions**

My name is Kristin K. Huskamp. If you have questions, you may contact me at (XXX) XXX-XXXX or my research chair, Catherine L. Marrs Fuchsel, Ph.D., LICSW, at 651-690-6146. You may also contact the St. Catherine's University Institutional Review Board at 651-690-7739 with any questions or concerns.

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

#### **Statement of Agreement of Confidentiality:**

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