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# Bridging the Silos: The Effects of Including Social Workers in Integrated Healthcare Teams in the Treatment of Chronic Pain

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RUNNING HEAD: Bridging the Silos

**Bridging the Silos: The Effects of Including Social Workers in Integrated  
Healthcare Teams in the Treatment of Chronic Pain**

by

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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  
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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**

An exploratory study of how the inclusion of social workers on integrated treatment teams affects the satisfaction of chronic pain patients. This study utilizes a mixed methods approach: interviews with social workers currently working in integrated healthcare teams as well as anonymous survey data collected from people who identified as having experienced chronic pain in order to provide as much initial data as possible. A content analysis reveals qualitative themes including patient advocacy, the power of integrated healthcare, and the importance of the mind/body connection in integrated healthcare. Qualitative and quantitative both find evidence of a lack of social worker visibility in medical settings which impedes the availability of data regarding social worker effect on chronic pain patient satisfaction. Implications for social work practice and future research are discussed.

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## Introduction

According to the American Academy of Pain Medicine (2011), roughly 100 million Americans currently indicate they feel some level of pain that affects their quality of life on a near-daily to daily basis, which is more than diabetes (28.5 million), heart disease (16.3 million), and cancer (11.9 million) combined. According to a National Institute of Health (NIH) Statistics survey, the four most common types of pain are back (27%), migraine or severe headache (15%), neck pain (15%), and facial ache or pain (4%). Attributable to many causes including sedentary lifestyle, (America's Health Rankings, 2012) and stress, chronic pain is a vast, complicated, and growing problem.

As this population grows, so does the need for the medical field to provide adequate, appropriate care: along with pain itself, many members of the chronic pain cohort also suffer from traumatic emotional histories, chemical dependencies, and difficulty navigating the complicated medical world. Chronic pain patients demonstrate complex medical, emotional, financial, and spiritual needs for which our traditional medical care structure is ill-equipped to provide support. Many chronic pain sufferers spend years moving from one specialty to another: primary care provider to podiatrist to neurologist and often back again, without finding the relief and help managing their needs that they seek. This journey all too often garners increased emotional and physical symptoms along the way, further complicating their patient profiles and adding to distress.

One way the medical community is adapting to better care for chronic pain patients is through the development of the integrated care team. In these settings, doctors of multiple specialties partner with each other, nurses, and other pertinent providers to

offer more comprehensive care. While these teams look and operate differently in different settings, the common thread is increased care-team communication and reduced onus on the patient to coordinate their multiple, often disparate sources of care. Should social workers be included on these care teams? There are differing schools of thought regarding this: many medical providers agree that the inclusion of social workers is beneficial in theory but how social workers are to operate in the team atmosphere, and what they bring to the table that cannot be adequately provided by nurses and other providers is often poorly understood. Further obscuring this issue is the dearth of research on particular needs and considerations for working with chronic pain patients in any setting.

The purpose of this study is to examine the ways in which the inclusion of social workers on integrated care teams affect patient satisfaction among chronic pain patients. This study will be informed by a review of pertinent literature analyzing several major assumptions regarding social workers in the medical setting, including: social work has a positive effect on client satisfaction across multiple populations, chronic pain has biopsychosocial dimensions which social workers are uniquely trained to understand, and social work involvement is generally undervalued in the medical community. Due to the rarity of research speaking to the needs of the chronic pain patient in integrated healthcare settings, many articles on chronic pain in general, or integrated care in general, or the role of social workers in medical settings as a whole will be utilized. Connections will be drawn by the researcher in order to gather a more complete picture of the above assumptions with regard to chronic pain patients.

## Literature Review

### Discussion of integrated healthcare:

According to the Agency for Healthcare Research and Quality, in partnership with the United States Department of Health and Human Services, collaborative care is defined as an “overarching term describing ongoing relationships between clinicians over time,” (AHRQ 2011). Simply put, integrated healthcare is any system in which more than one provider has input in the treatment of a patient. Differing health systems define and carry out integrated care in a myriad of ways depending on their main populations and placement in society; synonyms include collaborative care, healthcare homes, and integrated primary care, among others. For example, a treatment team specializing in the treatment of the elderly would be sure to have an occupational therapist on staff in order to assist patients who have had strokes or other physical and/or neurological setbacks. Versions of this model are becoming especially common in behavioral healthcare, which addresses a patient’s “behavioral issues bearing on health [not only mental illnesses] via clinicians such as psychiatrists, psychologists, social workers, psychiatric nurse practitioners, marriage & family counselors, professional clinical counselors, licensed drug/alcohol abuse counselors & other MH professionals,” (McGraw-Hill Concise Dictionary of Modern Medicine 2002, p. 27).

As of 2013, New York State Office of Mental Health is implementing medical homes, another version of integrated healthcare, as a way to “improve access to health and well-oriented services, redesign managed care programs to improve engagement and retention of high-need individuals, and raise the bar on quality while lowering costs,” (Smith, Erlich, & Sederer, 2013, p. 828). According to Smith and colleagues, New York State’s decision to integrate healthcare will lower patient complications due to chronic



diseases such as diabetes and heart disease through consistent assessments and referrals: ideally this system will limit the number of people who do not seek medical or behavioral treatment until a crisis point is reached, therefore limiting reliance on emergency treatment which generally comes at a much higher price point. When patients receive regular care from providers who know them and who are working together for the sake of shared patients, dependence on emergency departments, and the tax dollars that often fund these, goes down.

**Social work involvement is undervalued in the medical community:**

In a study focused on integrating social workers into elder care treatment teams, Keefe, Geron, and Enguinados (2008), noted that a key challenge facing the future of healthcare will be “creating interdisciplinary team-based models of care ... in the changing settings in which care is provided (p. 580).” As noted above, these interdisciplinary teams become especially important when dealing with special populations such as those with chronic pain, or the elderly because of the complicated nature of these patient profiles. Not only is there the original physical cause for a patient seeking treatment, but in the elderly and those disabled by chronic pain, financial and role loss also become key issues. According to McGuire, Bikson, and Blue-Howells (2005), up to “50-70% of all primary care medical visits among older adults are related to psychological factors (p. 310).” In this study, McGuire and colleagues noted that some physicians have come to believe that patients may make appointments simply in order to gain a relational outlet and some human communication. A recent study of patients in inpatient psychiatric and medical settings found that “the severity of psychosocial issues, especially social role problems, was a more powerful predictor of length of stay than the

Diagnostic Related Groups (van Hook 2004, p. 65).” According to Bikson et al. (2009), one-third of patients dealing with “stressful life events and stressors did not mention them to their primary care physician, (p. 737).”

Although research indicates that integrating healthcare is beneficial to both providers and patients, the actual integration process is fraught with complications, especially as social workers and other behavioral health professionals attempt to integrate into existing medical systems whose may balk at the addition of team-mates or at the changing of structures that are already perceived by clinicians to be working just fine. According to Egan and Kadushin (1995), one reason for the difficulty with integration is confusion regarding clinician understanding of the scope of social work versus nursing practice. This study, which interviewed rural nurses, primary care physicians and social workers regarding professional role understanding, found that beyond discharge planning, many nurses and primary care physicians are undereducated on how social workers can be effective in psychosocial patient care. This lack of education can affect the desirability of including social workers in treatment teams. Professional role confusion was found elsewhere in the literature as well. A study of patient and provider perceptions of psychosocial problems by Bikson, McGuire, Blue-Howells, and Selden-Sommer (2009) found that physicians often provide referrals to social workers for needs related to case management, but less often when patients describe feelings of personal stress. This study also noted that nurses are more likely to make referrals to social workers than doctors, but unlikely to refer out when patients exhibit problems with “home healthcare, activities of daily living, problem drinking or drug use, and shopping (p. 744).” This article indicates that doctors and other clinicians may be undereducated

about social worker scope of practice, and the broad range of services social workers can provide.

Keefe, et al. (2009) did not find role confusion to be among concerns of primary care providers and nurses regarding integration of social workers. Their study, utilizing focus groups of doctors and nurses, indicates that physicians are concerned about the amount of additional consultation time that adding a social worker to the treatment team would require. Keefe and colleagues concluded that many nurses and primary care physicians are supportive of incorporating social workers into existing treatment teams. However, barriers still exist as clinicians are under pressure to generate as much money as possible, and often have 15-minute patient appointments to contend with. Continuing education, as well as some advance planning would need to take place in order for doctors and nurses to fully understand how to integrate social workers into their treatment teams.

Ultimately, even when a patient has a therapist or other mental health provider, research indicates many patients would benefit from social worker involvement in their medical care (Bikson et al., 2009). Although the authors of this study were unsure specifically why this would be the case, it should be considered that patients may not see their therapists, to whom they go for emotional support, as resources for financial or other relational care. As noted above, it is common for social workers in integrated care settings to provide this case management and referrals, as well as psychological support when needed.

**Social work has a positive effect on patient satisfaction:**

One issue that commonly arises in the discussion of social workers in medical settings is debate regarding whether their inclusion actually produces quantifiably positive results. As hospitals and clinics have routinely weathered funding cuts, administrators have often seen social workers as expendable (Barth 2003). Indeed, according to Auerbach, Mason, and LaPorte (2007), “social work education and the profession’s basic values, which emphasize treating clients within environments, client advocacy, and empowerment can run counter to a hospital’s priority of discharging patients quickly (p. 19).” On one hand, social workers are able to advocate for patient needs, on the other hand social worker services are usually the first to be cut as the facility considers its financial viability. In these cases, nurses often shoulder the role of discharge planning and other tasks traditionally under the social worker purview. This shift of responsibility to the nurse role serves to further cloud understanding regarding the value of social workers.

A review of the literature indicates that social workers are especially valuable when working with patients’ emotional and spiritual needs. A study of social workers and bereaved clients at a large Australian hospital noted a strong match between client and social worker perceptions of specific interventions, and reported an 88% satisfaction rating of social workers by their clients (Lord & Pockett 1998). This study also contained four client suggestions: that social workers “be present when the doctor breaks bad news; that additional support be provided in how to talk to doctors; that social workers be involved from the point of admission of the patients; and that a primary social worker remains with the family throughout the hospital stay (p. 63).” The value of including social workers in healthcare teams is inherent in these patient suggestions: physicians

may not have the time or training to fully appreciate the emotional needs of their patients and their families. In another study of client satisfaction with regard to social workers (Crighton, Creighton, & Drummond 2005), this time at an outpatient family practice, 68% of respondents rated their experience “very good,” and to the statement “services helped me deal with my situation,” 85% of respondents agreed or strongly agreed (p. 727-728). These recommendations strongly indicate the value of social workers in client satisfaction. Satisfied clients tend to remain with their current providers; their medical payments do as well.

**Chronic pain has biopsychosocial dimensions which social workers are uniquely trained to understand:**

As noted above, chronic pain sufferers outnumber people suffering from cancer, heart problems, and diabetes combined (American Academy of Pain Medicine 2011). While the problem of chronic pain is increasingly pervasive, its etiology can be extremely complicated. Research indicates that in addition to motor vehicle accidents, posture, and other basic physical causes, chronic pain may also be comorbid with a number of psychosocial factors including low socioeconomic status (Lacey, Belcher, & Croft 2012), traumatic brain injury (Rosenfeld, McFarlane, Bragge, Rocco, Grimes, & Ling 2013), quality of patient-provider relationship (Farin, Gramm, & Schmidt 2013), sexual or physical abuse in childhood (Sachs-Ericsson, Kendall-Tackett, Hernandez 2007), among others. Chronic pain patients who are prescribed opiates for long-term pain management are also at serious risk of developing chemical dependency issues (Eriksen 2001). Further complicating chronic pain treatment is the fact that these variables often work in tandem: a chronic pain patient experiencing negative effects of poverty may also be obese, have suffered traumatic brain injury, and have difficulty connecting with his primary care

physician. All of these factors may be affecting each other, significantly impacting the level and quality of care needed to effectively treat chronic pain patients. Mizrahi and Abramson (2000) found in their analysis on matched shared cases between social workers and physicians that social workers were significantly more likely to identify psychosocial problems than physicians.

Research indicates that doctors often find chronic pain patients, with their complicated medical and psychosocial histories, a challenging population to treat. A quote from one primary care physician illustrates this common perspective: “a lot of [chronic pain patients] have depression that shows up as psychosomatic problems. We will take care of one thing and then they show up with something else,” (Keefe et al. 2009, p. 586). One cause of this ambivalence may be insufficiency of psychosocial education and training in medical school (Astin, Goddard, Forsys 2005).

A main reason that social workers are so beneficial to integrated healthcare teams is their wide scope of practice. According to van Hook (2004), social workers possess a broad range of skills found to be beneficial in medical settings, including mental health screenings, individual, couples, and family counseling, helping patients understand their physical health situations, teaching skills needed for coping in life, chemical dependency counseling, connecting to community resources, grief counseling, and many other tasks necessary for well-rounded patient care. Social workers are trained to evaluate systems, and to seek understanding of how various elements of a patient’s profile may be affecting each other. This focus on person-in-environment is instilled in social work students from day one. According to Kondrat (2002), a person is ‘in’ their environment not as a smaller box is contained in a larger box, but “rather the way dancers are in a ballet or a football

team is in a game. The dancers and the players co-constitute the dance and the game (p. 435).” It is this understanding that social workers bring to the medical field: whereas medical school trains doctors to categorize, prioritize, and treat, social workers are trained to take the whole person into account, to learn about their inner and outer lives, and to co-create a healthier life with their patients.

### **Conceptual Framework**

The aim of this research is to better understand the role of the social worker in integrated healthcare teams treating patients with chronic pain. It is exploratory in nature given that little research on integrated care has focused specifically on efficacy in chronic pain patient care and therefore aims to shed light on both patient and social worker function within the integrated healthcare setting. As discussed above, any integrated medical setting by definition operates as a system, with different elements (nurses, social workers, physicians) functioning both within their own professional framework as well as within the larger clinic environment. Each chronic pain patient’s presentation is also comprised of interwoven causations and correlations, and as noted above, the medical profession has found that simply treating the physical aspect of these patients is ineffective and unfulfilling for both patient and clinician. In effect, successful treatment of a chronic pain patient within an integrated healthcare setting means understanding and treating the patient’s internal system within the medical setting’s external system. The conceptual basis for this study, then, will focus on structural functionalism as well as the multidimensional framework in order to fully illustrate an ecosystemic philosophy. In essence, the multidimensional framework with all of its intricacies and interactions is

affected and acted upon by the integrated care team within the medical system, best explained using structural functionalism.

### **Structural Functionalism**

Structural functionalism, developed by Talcott Parsons, is a sociological version of general systems theory; defined as a, “logico-mathematic field, the subject matter of which is the formulation and derivation of those principles which hold for systems in general,” (von Bertalanffy 1952, p. 199). According to Forte (2007) this theoretical framework “examines how a social system is characterized by structure and function,” where structure refers to “patterns of action” and “provides an order and predictability to system processes and functioning (p. 165).” Structural functionalism can also examine the interrelationship of major systems: personality, social, and cultural (Forte, 2007). For the purposes of this study, structural functionalism informs the process of communication and predictable interplay of specific roles that doctors and nurses have traditionally played in medical settings, as well as how the less-clear responsibility of social workers fits into this ordered setting. Social workers are concerned about this theory not only because of the ways integrating social work can upset and cause reorganization within integrated healthcare teams, but also because of the ways the addition of the social worker role may strengthen the team as a whole. As the members of the team most educated about and concerned with the psychosocial dimensions of chronic pain patients, social workers must be able to understand and articulate how the team can best serve these aspects of the chronic pain patients. This way the entire medical team can be sure they are offering their patients the highest level of care possible.



**Multidimensional Framework**

Although structural functionalism may also serve to explain the theoretical underpinnings of chronic pain, the multidimensional framework approach was specifically developed for use in understanding the complex inner and outer worlds of clients, with the understanding that these may affect each other. According to Ashford, LeCroy, and Lortie (2009), a multidimensional framework is utilized to help clinicians “understand a person’s total functioning (p. 23).” Within this framework, hypotheses are developed around “biophysical, psychological, and social (p. 23)” aspects of a client’s life in order gain a clearer perspective regarding how the client is functioning, problematic aspects of the client’s life, and how these aspects may be interacting with each other. Theories related to each specific layer of functioning may be utilized in the development and evaluation of each hypothesis, but the underlying theme in multidimensional framework is how each element works within the larger whole. In this way, chronic pain can be understood as a multi-systemic problem: although the original cause may have been physical, i.e. a car accident, financial or relational stress can affect the body’s ability to fully heal itself. The financial or relational stress alone would be a problem, as would injury for a car accident. But when these are placed in tandem it is easy to see how the two affect each other.

## Methods

### Research Design

Although some research regarding social workers in integrated care has been conducted, the research question, “How does social worker involvement in the medical treatment team affect chronic pain client satisfaction” has not yet been explored by other studies. Therefore exploratory and descriptive research were utilized in the study. In order to more fully answer the research question, mixed methods were employed: qualitative interviews and surveys containing both quantitative and qualitative measurements. The qualitative interviews allowed social workers currently taking part in integrated healthcare teams to give an in-depth perspective on the unique needs and challenges of chronic pain patients. The surveys were largely quantitative in order to gather descriptive data regarding the type and level of pain the respondents are feeling, as well as their experience with social workers and other medical providers regarding their pain in the past. The survey also included two qualitative measurements intended to explore benefits perceived from interaction with social workers involved in their chronic pain care.

### Sample

**Interviewees.** In order to obtain data for this study, a non-probability convenience sample (Monette, Sullivan, & DeJong, 1986) was used by contacting multiple social workers who are currently part of integrated treatment teams for patients suffering from chronic pain. I sought participant recommendations from skilled clinicians on my research team and known to me through other social work networks. Of the participants contacted and who agreed, I selected two to interview.

**Survey Respondents.** Another sample of people was obtained by purposive, convenience and snowball sampling strategies (Monette et al., 1986) for the online survey portion of this study. Participants in this part of the study necessarily self-identified as suffering from chronic pain, had a willingness to complete an online survey, and had access to the internet. These participants learned of the study through social media. This means there is a possibility that some survey respondents may not be from the Twin Cities, but it is probable that a majority were residents of the Minneapolis/St. Paul metropolitan area.

### **Protection of Human Subjects**

**Interviewees.** Interviewees were recruited through the researcher's previously established network, and by referrals from the researcher's committee members. Potential interviewees were initially contacted by email, informed of the nature and purpose of this study, and invited to participate in an interview with the researcher (see Appendix A). As these participants are clinicians instead of consumers, they are not considered to be members of a vulnerable population as defined by this study. Potential interviewees were informed of the voluntary and confidential nature of the study in order to ensure their safety, and assured that this researcher would change names and any identifying information in study results. They were also assured that participating in this interview will not affect their current or future relationship with the University of St. Thomas / St. Catherine University School of Social Work.

Prior to the interviews, selected respondents received a letter of informed consent to review and sign with the researcher before data collection began. The consent form was approved by the St. Catherine University Institutional Review Board (IRB). (See

Appendix C). The consent form outlined the purpose of the study and all protective measures designed to keep the respondent from potential harm. Protective measures included confidentiality, non-threatening questions, and the ability to back out of the research study at any time. Respondents also had the opportunity to choose the time and location of the interview. The interviews were audio-recorded, but as outlined in the consent form, procedures were taken to destroy these recordings upon completion of the research study. Further confidentiality measures included deleting any identifying information from the transcript and keeping data and notes locked within a drawer in the researcher's home.

**Survey Respondents.** Survey participants were recruited via email and/or social networking websites (See Appendix B). Messages and emails were sent out to potential respondents inviting anyone who identifies as suffering from chronic pain to consider taking a survey “related to their experience of chronic pain treatment.” A link to the Qualtrics survey was included on the electronic message, as well as a request for respondents to pass the survey invitation on to others known to them who are suffering from chronic pain. Survey participants were not necessarily members of a vulnerable population because the researcher had no way of knowing or controlling who chose to complete the survey and who did not. Anonymity and confidentiality were additionally ensured by there being no questions regarding identifying information on the survey. Participation was entirely voluntary, as respondents were able to remove themselves from the research study at any time by simply closing out of the survey webpage. When participants clicked on the Qualtrics link or navigated to the website, they were first directed to a page containing the online version of the consent form (See Appendix B),

informing them of the nature of this study and outlining all precautions taken to keep respondents from potential harm. These protective measures included anonymity, confidentiality, non-threatening questions, and the ability to back out of the research process at any time. Participants were not directed to begin the survey until the consent form was electronically signed.

### **Data Collection (Instrument and Process)**

**Interviews.** Data was collected through 45-60 minute semi-structured interviews. These interviews were audio-recorded for ease of transcription and held in a quiet, confidential area of the respondents' choosing. Upon completion of the literature review, this researcher developed a list of 13 open-ended interview questions (See Appendix D). The researcher's committee chairperson edited and approved these questions based on their clarity and content.

The interview questions explored social workers' experience of working with chronic pain within integrated healthcare settings, specific concerns and challenges related to working with patients with chronic pain, and the effects social workers can have on the experience of living with chronic pain.

- The first interview question asked the age, position, and licensure of each respondent in order to validate their inclusion in the research project. This question was also designed to ease both researcher and interviewee into the research process.
- The second question explored the interviewee's process of becoming a member of an integrated healthcare team, as these continue to be fairly rare.

- The third question inquired as to the general patient base the interviewee works with: age, gender, socioeconomic status, and type of chronic pain the patient was experiencing.
- The fourth question explored the respondent's experience of working with chronic pain patients.
- The fifth question inquired as to any special considerations the social worker feels are important in working with chronic pain patients.
- The sixth interview question attempted to gather information regarding whether the respondent notices complications related to mental health challenges that their chronic pain patients might be experiencing.
- The seventh interview question sought to explore other challenges the interviewee sees chronic pain patients experiencing. Potential answers to this question related to person-in-environment considerations such as difficulty with employment or relationship challenges.
- The eighth question hinged on the seventh, and aimed to learn more about how the social worker attempts to help their chronic pain patients deal with any special considerations they have.
- The ninth question was the first to address the social worker's involvement in integrated healthcare. This question asked about the respondent's experience of working in the integrated team with other clinicians from other disciplines.
- The tenth question focused on challenges the social worker encounters in medical social work as part of an integrated healthcare team, and how she deals with these.

- The eleventh question asked respondents to articulate their understanding of the social worker's role in integrated healthcare, as well as how the respondent believes their cohorts from other disciplines would describe the social worker's role.
- The twelfth question explored benefits the respondent believes chronic pain patients receive through the integrated healthcare model.
- The thirteenth and final question asked how chronic pain patients have endorsed these benefits in their own words.

**Surveys.** Data was collected from 22 respondents through a semi-structured, quantitative and qualitative online survey administered through Qualtrics, an online survey software program affiliated with the University of St. Thomas. The survey, developed by the researcher with guidance from the researcher's committee chairperson, contained 13 closed-ended questions and two open-ended questions (See Appendix E).

- Question one consisted of the consent data discussed above.
- Question two focused on respondent's age.
- Question three asked when the respondent first began to experience their chronic pain.
- Question four asked for respondents' gender.
- Question five asked the original cause of the pain; (physical trauma), (overuse injury), (emotional stress), (I don't know,) and (other) with room to specify if needed.
- Question six asked where the respondent experiences their chronic pain, offering answers such as (head), (hips), (all over), and (other), with room to specify if

needed. This question encouraged respondents to check all possible answers that apply to them.

- Question seven asked whether the respondent is currently experiencing chronic pain.
- Question eight sought to learn whether respondents have ever sought treatment for their chronic pain.
- Question nine asked respondents to indicate the different types of providers that respondents have worked with in order to alleviate their chronic pain. Possible answers included (primary care doctor), (neurologist), and (chiropractor), among others.
- Question ten inquired as to whether the respondent has ever worked with a social worker as part of their chronic pain care team. Respondents who answered “no” to this question were informed that at this point they had completed relevant parts of the survey and were thanked for their time. Respondents who answered “yes” to question ten continued to the rest of the survey.
- Question eleven asked what services their social worker provided to them as part of their chronic pain care. Possible answers to this part of the question included, (helping you find and connect to resources), (helping you understand medical options/make medical decisions), (providing therapy/counseling), (discharge planning if you were hospitalized), and (other) with room to specify as needed. This part of the question encouraged respondents to check all options that applied to them.



- Question twelve measured how effective respondents feel working with a social worker has been in the treatment of their chronic pain, from not helpful at all to extremely helpful.
- Question thirteen asked whether respondents, based on their own experience, would recommend the inclusion of a social worker on the chronic pain treatment teams to friends or family members, with answer options including (yes), (no), and (I don't know).

The final two questions were open-ended and qualitative.

- Question fourteen asked whether and how utilizing a social worker has affected the level of chronic pain experienced by respondents.
- Question fifteen explored the effects that working with a social worker has had on their experience with chronic pain. Space was provided for respondents to answer these two questions in their own words.

### **Data Analysis Plan**

**Interview Analysis.** When conducting qualitative research, the purpose of data analysis is about “identifying themes, patterns, and regularities, and in some cases, stating propositions, causal connections, and developing theories (Monette, Sullivan, and DeJong, 2008). For the purpose of this study, the researcher transcribed the interviews and analyzed them word for word using open coding to develop themes reflective of interviewees’ experience of working in integrated teams to serve chronic pain patients. These themes were then utilized to synthesize a theory of how social workers affect the satisfaction levels of chronic pain patients utilizing integrated treatment teams. This process, defined as grounded theory (Monette et al., 1986), illustrates the process of

movement between the original theory of the research project to data collected from interviewees to conclusions arrived at by the end of the study. This researcher's chair provided oversight for this portion of the data analysis in order to ensure complete and accurate theory synthesis.

**Survey Analysis.** Data collected by the survey portion of this study served to enhance and deepen the quality of research gathered by the study as a whole. The researcher utilized Qualtrix, an online data collection service, to gain survey information which was then entered into SPSS to run statistics gathered by the survey. This process brought to light correlations, discrepancies, and other relationships between the data collected through the survey.

**Descriptive Statistics.** In order to better understand the demographic details of the survey sample, descriptive statistics were compiled for age, gender, age respondent first began experiencing their chronic pain, original cause of chronic pain, and where on their bodies they experienced this pain. Age characteristics of the sample were identified for survey item (2). This variable is ratio and was operationalized by the word "Age." A space was provided for respondents to write in their age. The research question for this study was: What are the respondents' age characteristics?

Age at first experience of chronic pain characteristics of the sample were identified for survey item (3). This ratio variable was operationalized by the phrase "Age at which you first began experiencing chronic pain." As with item (2), respondents were able to fill in the blank with the answer that applied to them. The research question for this study was: What are the respondents' age characteristics regarding how old they were when they first began experiencing chronic pain?

Gender characteristics of the sample were identified for survey item (4). This nominal variable was operationalized by the word “Gender.” Potential responses were (Male), (Female), (Transgender), and (Other (please specify)). The research question for this study was: What are the respondents’ gender characteristics?

Original cause of chronic pain characteristics of the sample were identified for survey item (5). This nominal variable was operationalized by the phrase “What was the original cause of your pain?” Potential responses were (Physical trauma, (i.e. car accident)), Overuse injury (i.e. carpal tunnel syndrome), (Emotional Stress), (I don’t know), and (Other (please specify)). The research question for this study was: What are the respondents’ original causes of pain characteristics?

Bodily location of chronic pain characteristics of the sample were identified for survey item (6). This nominal variable was operationalized by the phrase “Location of pain (check all that apply).” Potential responses are (Head), (Neck), (Back), (Hips), (Knees), (Stomach), (Arms/hands), (Ankles/feet), (All over (i.e. fibromyalgia)), and (Other (please specify)). The research question for this study was: What are respondent characteristics regarding bodily location of chronic pain?

Current experience of chronic pain characteristics of the sample were identified for survey item (7). This nominal variable was operationalized by the phrase “Are you currently experiencing chronic pain?” Potential responses included (Yes), and (No). The research question for this study was: What are the respondents’ characteristics regarding whether they are currently experiencing chronic pain?

The types of treatment utilized by respondents were identified for survey item (8). This nominal variable was operationalized by the phrase “Have you ever sought

treatment for your chronic pain?” Potential responses were (Yes), and (No). The research question for this study was: What are the respondents’ characteristics regarding whether they have ever sought treatment for their chronic pain? Item (9) hinged on item (8) and sought to measure respondents’ characteristics regarding the types of providers they have seen for their chronic pain. Item (9) was a nominal variable operationalized by the question “If yes, what type of provider have you seen? (check all that apply).” Potential responses included (Primary Care Doctor), (Neurologist), (Psychiatrist), (Physical Therapist), (Chiropractor), (Massage Therapist), (Acupuncturist), (Faith or Spiritual Healer), (Pain Clinic), and (Other (please specify)). The research question for this study was: What are the respondents’ characteristics regarding the types of providers they have seen for their chronic pain?

Utilization of a social worker for chronic pain was studied in survey item (9). This nominal variable was operationalized by the phrase “Have you ever had a social worker on your chronic pain treatment team?” Potential responses were (Yes), (No), and (I don’t know). The research question for this study was: What are the respondents’ characteristics regarding whether they have utilized the services of a social worker as part of their chronic pain treatment team?

Survey items (10) and (11) hinged on item (9) and sought to explore the services social workers have performed as part of respondents’ chronic pain treatment teams, as well as how helpful respondents believed their social workers had been. Item (11) is a nominal variable operationalized by the question “If yes, what services did the social worker provide? (check all that apply).” Responses for this item included (Helping you find and connect to resources), (Helping you understand medical options/make medical

decisions), (Providing therapy/counseling), (Discharge planning if you were hospitalized), and (Other (please specify)). The research question for this study was: What are respondents' characteristics regarding services their social workers have provided in the treatment of their chronic pain? Item (12) was an interval level variable operationalized by the statement "If yes, how would you rate the effectiveness of your social worker." The responses included, (Not helpful at all), (Mostly unhelpful), (Neutral), (Somewhat helpful), and (Extremely helpful). The research question for this study was: What are respondent characteristics regarding the effectiveness of their social workers in the treatment of their chronic pain?

The likelihood that chronic pain patients currently utilizing a social worker on their chronic pain treatment team would recommend utilizing social workers to friends and family with chronic pain was identified by survey item (13). This nominal variable was operationalized by the question "Would you recommend the addition of a social worker to the treatment team of a friend or family member experiencing chronic pain?" Potential responses included (Yes), (No), and (I don't know). The research question for this study was: What are respondent characteristics regarding whether they would recommend a social worker to a friend or family member experiencing chronic pain?

**Association.** The association between two nominal variables, whether a respondent is currently experiencing chronic pain and whether a respondent has ever sought treatment for their chronic pain, was tested. The independent variable, current experience of chronic pain, was operationalized by survey item (7): "Are you currently experiencing chronic pain?" The dependent variable, utilization of a social worker for chronic pain treatment, was operationalized by survey item (8): "Have you ever sought

treatment for your chronic pain?” Response options for both item (7) and item (8) were (Yes) and (No). The research question for this study was: Is there an association between respondents currently experiencing chronic pain and whether they have sought treatment for chronic pain? The hypothesis was: There is an association between currently experiencing chronic pain and having sought treatment for chronic pain. The null hypothesis was: There is no association between currently experiencing chronic pain and having sought treatment for chronic pain.

**Note: Due to lack of survey response the following associations could not be tested.**

The association between two nominal variables, utilization of a social worker on respondent’s chronic pain care teams and the type of service a social worker provides were to be tested. The independent variable was operationalized by survey item (9): “Have you ever had a social worker on your chronic pain treatment team?” Response options were (Yes), (No), and (I don’t know). The dependent variable was operationalized by survey item (10): “If yes, what services did the social worker provide? (check all that apply).” Response options were (Helping you find and connect to resources), (Helping you understand medical options/make medical decisions), (Providing therapy/counseling), (Discharge planning if you were hospitalized) and (Other (please specify)). The research question for this study would have been: Is there an association between working with a social worker and receiving particular types of services? The hypothesis was that there is an association between working with a social worker and receiving particular types of services. The null hypothesis was that there is no association between working with a social worker and receiving particular types of services.

The association between two nominal variables, source of chronic pain and utilization of a social worker, was to be tested. The independent variable, source of chronic pain, was operationalized by survey item (5): “What was the original cause of your pain?” Response options included (Physical trauma, (i.e. car accident)), Overuse injury (i.e. carpal tunnel syndrome)), (Emotional Stress), (I don’t know), and (Other (please specify)). The dependent variable, utilization of a social worker on chronic pain treatment team, was operationalized by survey item (9): “Have you ever had a social worker on your chronic pain treatment team?” Potential responses were (Yes), (No), and (I don’t know). The research question for this study was: Is there an association between the original cause of respondents’ pain and whether they are utilizing a social worker for chronic pain treatment? The hypothesis was that there is an association between the original cause of chronic pain and whether respondents are working with a social worker. The null hypothesis was that there is no association between original cause of chronic pain and whether respondents are working with a social worker for chronic pain care.

Two chi-squares were to be run to test for certain associations. The independent variable for both tests, how helpful respondents feel their chronic pain social workers have been, was operationalized by survey item (12): “If yes, how would you rate the helpfulness of your social worker?” Response options were (Not helpful at all), (Mostly unhelpful), (Neutral), (Somewhat helpful), and (Extremely helpful), and would have been arranged on a 5-point Likert scale.

The dependent variable for the first test, type of service provided by social worker, was operationalized by survey item (11): “If yes, what services did the social worker provide? (check all that apply).” Response options included (Helping you find

and connect to resources), (Helping you understand medical options/make medical decisions), (Providing therapy/counseling), (Discharge planning if you were hospitalized) and (Other (please specify)). The research question for this study would have been: Is there an association between the perceived helpfulness of a social worker and the types of services provided by a social worker in the treatment of chronic pain? The hypothesis was that there is an association between the perceived helpfulness of a social worker and the types of services they provide. The null hypothesis was that there is no association between the perceived helpfulness of a social worker and the types of services they provide.

The dependent variable for the second test, whether respondents would recommend use of a social worker for friends or family experiencing chronic pain, was operationalized by survey item (13): “Would you recommend the addition of a social worker to the treatment team of a friend or family member experiencing chronic pain?” Response options included (Yes), (No), and (I don’t know). The research questions for this study would have been: Is there an association between the perceived helpfulness of a social worker and whether respondents would recommend the use of a social worker for friends or family experiencing chronic pain? The hypothesis was that there is an association between perceived helpfulness of a social worker and whether respondents would recommend utilization of a social worker to friends or family experiencing chronic pain. The null hypothesis was that there is no association between perceived helpfulness of a social worker and whether respondents would recommend utilization of a social worker to friends or family experiencing chronic pain.



***Qualitative Analysis.*** **Note: due to lack of survey data this analysis could not be completed.** A qualitative analysis was to be conducted through evaluating respondents' answers to survey items (14): "While in the care of a social worker for the treatment of your chronic pain, do you feel like that person affected your level of pain? If so, how?" and (15): "If you have ever utilized the care of a social worker in the treatment of your chronic pain, do you feel like that person affected your experience of chronic pain? If so, how?" As with the interview data, a content analysis would have been conducted. Data would have been systematically evaluated to identify and establish themes and their corresponding codes. The researcher would have utilized inductive grounded theory to pull important information from the raw data generated by items (14) and 15).

## **Findings**

### **Interviews: Qualitative Analysis**

Two interviews were conducted with social workers who reported significant experience working with chronic pain patients. While both work in the medical field, their differing clinical emphases and agency types provided unique and complementary insights into the social worker's role in integrated care for chronic pain. Pseudonyms have been used in the following report in order to maintain and protect interviewee confidentiality.

The first interviewee, Ashley, is a middle-aged LICSW who works for a family medicine clinic. Ashley noted that she originally had no experience in medical social work but that when she began working in this integrated healthcare setting she found that

she enjoyed being part of a team that looks at patients in a more holistic way. Ashley reported that her client base is diverse in gender, age, racial/ethnic background, socioeconomic status, and chronic pain complaint. Ashley noted that a large percentage of the population she sees are immigrants from Bosnia, Central America, and some common pain complaints including back injuries, car accident injuries, fibromyalgia, depression, and PTSD. She also sees patients with somatic complaints such as stomach pain.

In contrast to Ashley, the second interviewee, Jillian, stated that she decided to become a social worker after witnessing three family members with significant illness struggle to navigate the complex healthcare system. Jillian is an LGSW who has finished her clinical hours and is currently studying for her LICSW exam. Jillian has worked in hospice and is currently employed by a large organization specializing in dialysis treatment with renal patients. This interviewee also noted that her client base is variable in age, gender, socio-demographics, and chronic pain complaints. Jillian noted that 70-75% of her patients are on medical assistance, and that many are undocumented immigrants which makes finding resources extremely difficult. She added that she sees a lot of back pain, hand and foot neuropathy, and overall muscle soreness, fatigue, *“general pain and discomfort.”*

In conducting a content analysis of the two interviews, six major themes began to emerge:

- 1). Power of the Integrated Healthcare Model
- 2). Complications Regarding Long-term Use of Opiate Painkillers
- 3). Client Advocacy
- 4). Educational Role of Social Workers

- 5). Importance of Mind/Body Connection in Chronic Pain Treatment
- 6). Lack of Social Worker Power

**Power of the Integrated Healthcare Model.** Both Ashley and Jillian stated that they enjoy working as part of an integrated healthcare team, noting the ways differing perspectives complement each other, access to a more holistic view of patients than social workers usually enjoy, and the benefits that patients reap when they are working with a medical team whose members communicate with each other as a matter of course.

**Ashley.** Ashley stated quickly and easily that she finds working with medical providers fun, lots of fun. *“It’s not anything I was trained for. I was trained to be a silo’d mental health practitioner and I learned early on that in some cases... you couldn’t ignore the illness in the psychologically healing that was going on.”* Ashley went on to say that learning what it’s like for someone with a terminal illness or chronic pain has been interesting, that she enjoys learning, *how their psychology plays out in that illness.”* Ashley noted that she values seeing patient profiles from multiple points of view. *“So I have a doctor and a pharmacist and maybe a diabetes educator and a nurse care coordinator and myself all working on one team and all seeing [the patient] in a slightly different way. It’s a really interesting way of doing social work.”* Ashley said that she appreciates her ability to raise the issue of a patient’s emotional wellbeing, and *“the factors in their history and in their lives that are making this problem difficult for them... being the carrier of that piece of a patient’s story.”*

Ashley said that she does not see the traditional western way of medicine as helpful for chronic disease, but that integrated healthcare is more helpful to patients.

Within this system, *“if you have a doctor and a pharmacist and a social worker and maybe a psychiatrist, each person would look at that chronic pain. The psychiatrist might be thinking about other types of psychoactive agents, the pharmacist might be looking at drug interactions, the social worker would be looking at barriers and issues of daily living that are complicating and putting more stress on the patient.”* Multiple approaches utilized by multiple providers working together provide, *“a more complete treatment for the chronic pain.”* Ashley shared a story about a patient who had a lot of knee pain, who had been on a lot of narcotic pain medication when she first began seeing Ashley and the rest of the integrated healthcare team. Over time, this patient was able to go off of a third of the medication she had been taking. *“The reality is that in our work together, when she is feeling better, when she is less anxious, when she feels in control of her life... the pain doesn’t bother her as much... she is much more able to cope with the pain she does have.”* Ashley acknowledged that at first, integrated healthcare can be a hard sell to patients who just want immediate relief from their pain. But, over time, patients begin to understand and see for themselves how they are benefiting from this more holistic model. *“We’re a group of people who all have their best interests at heart. And that’s maybe more than they have in the rest of their life. So that makes a difference to them.”*

**Jillian.** Jillian noted that her role is often to complete paperwork and that sort of thing, but that she is also the person who sits with patients when they are in pain and holds their hand. Jillian is also able to discuss with patients when they need more support, to help in accessing personal care assistants and get resources in order. She communicates on behalf of the treatment team that they want to help patients stay out of the hospital or nursing home as long as possible. *“In an integrative model, I see [patients]*

*getting more of a team approach, really meeting them where they're at and looking more holistically... it happens with practitioners who say, 'wait a second, slow down. I need to look at this too. We need to include this in the picture.' And I think social workers have the opportunity to bring that."*

Although clients have not specifically talked to Jillian about the benefits they experience from integrated healthcare, Jillian said she can see a definite difference with patients who are receiving integrated care. *"They don't necessarily verbalize the difference but you can sense it. They're more active in their care. I would say that's probably the biggest piece, that they are actively participating in their care."*

**Complications Regarding Long-term Use of Opiate Painkillers.** Ashley and Jillian both spent significant time discussing the difficulty that all providers find in treating chronic pain, and specifically the problem of chronic pain and opiate painkiller addiction.

**Ashley.** In her role as consultant to doctors in the family medical clinic, Ashley noted that one of the things she does most often is work with doctors around helping patients maintain therapeutic painkiller doses in the face of consistent chronic pain, stating that in some ways her job is as much about narcotics as it is about chronic pain. *"For people who have chronic pain... being psychologically dependent on a drug [is almost worse] than the physiological aspect. That you're taking my drug away."*

**Jillian.** One of the most significant things Jillian discussed is the conflict between being in pain and legitimately needing pain medicine, and the addiction that can arise due to long-term use of pain medicine. *"Anyone who's dealing with chronic pain is going to be labeled at some point as a drug seeker, and they're just trying to get medication,"* she

said. Jillian noted that it can be very hard to navigate this, because pain is subjective, but that she does have patients whose, *“pain seems to come and go depending on when the doctor is around.”* Jillian added that she sees patients self-medicating both by overusing their medications and through use of other substances. *“That’s really hard to try and work with because it was effective, they were able to get rid of their pain.... so who cares about all of this other stuff. Who cares if I can’t talk to my family, who cares if the back pain is gone.”* Jillian added that often her patients describe feelings of isolation and fears that others will not believe that they are in pain if the cause of their pain is not immediately visible. This isolation tends to intensify the desire to eliminate pain by any means necessary, even if it happens at the cost of relationships with family and friends, she said.

**Client Advocacy.** Ashley and Jillian both stated that they see patient advocacy as a huge part of their role in the integrated healthcare team.

**Ashley.** Ashley noted that one thing she often finds herself doing is advocating for patients with doctors to change anti-depressant medications because some of these have non-addicting pain-relieving properties. Ashley also reported that in her agency, it’s important for her to *“raise the issues that are not being thought of related to a person’s psychosocial environment, the potential for trauma in the person’s history that may not be coming out in the medical appointment.”* As a large portion of Ashley’s patients are immigrants and refugees, the role that trauma plays in chronic pain complaints is especially salient. Although these clients come from different parts of the world and may have experienced very different types of trauma, autoimmune concerns such as irritable bowel syndrome and Crohn’s disease are common, as well as somatized emotional pain;

problems that have *“really bedeviled doctors for a long time. The fact that those kinds of issues are often very, very debilitating for people, [doctors] don’t know how to help them.”*

Ashley stated that she sees *“keeping the patient’s wishes front and center, translating patient wishes so that doctors understand [them],”* as a vital component of her role as a social worker.

**Jillian.** In discussing patient advocacy, Jillian related a story in which a hospice patient and her family had agreed that the patient would transition without medication, but when seeing this patient in pain, the nurses on her team were discussing whether to provide pain medication anyway. Jillian said that she needed to stand up for this patient’s right to die as the patient saw fit, regardless of any discomfort this may have been causing her treatment team. *“It just shocked me,”* she said, *“that it’s hospice and our job is to make somebody as comfortable as they want to be...it’s not about our comfort.”* Jillian noted other times when it has been her job to protect the primacy of client wishes, especially in hospice when clients expressed the desire to try various alternative methods and were met with resistance from their doctors. Jillian stated that sometimes she has had to work with other providers around this, especially, *“if I see people coming in with their own agenda, or with their judgment,”* instead of focusing on the needs and wants of specific clients.

**Educational Role of Social Workers.** Both interviewees are the only social worker currently in their setting and therefore spend a majority of their time interacting with doctors, nurses, pharmacists, and other healthcare professionals when working with patients. For this reason, as well as the relative newness of the integrated healthcare

model, both Ashley and Jillian spoke at length about their efforts to educate both colleagues and patients on integrated healthcare, the mind/body connection, and techniques for pain management, among other topics.

*Ashley.* As a consultant for medical residents, much of what Ashley does revolves around helping these doctors grow in their ability to work with chronic pain patients. This education often takes place around the prescription of pain pills. *“It’s about how the doctors can manage their patients’ need for narcotics with their own anxiety about prescribing narcotics. Doing the right thing for the patient and learning how to tell the patient ‘no.’ ...part of it is helping script things for the residents so they can help the patient understand, to educate the patient about why narcotics are not good.”* In consultation with residents, Ashley said that a lot of conversations revolve around education on the nature of pain. *“So helping [doctors] talk to their patients about how to manage their expectations, how to lower their expectations, and how to challenge themselves in different ways.... So it’s really a lot about helping residents learn the motivational interviewing techniques and cognitive behavioral techniques that help patients view their pain differently, and approach their pain differently.”*

In working to educate patients, one common misconception that Ashley stated she often finds is the idea that if a person is in pain, there must be something wrong that needs surgery or medication or a treatment to fix it. *“It’s not well understood that complex pain is more psychogenic – which isn’t to say that it’s all in their head – but there’s a psychological connection that is not well understood.”* Ashley also said she works to educate patients on the nature of pain, and managing it. *“The idea that pain is unbearable, that there is no way to bear pain and you must do anything and everything to*



*stop having pain at all costs rather than learn to manage your expectations around what you're expecting your body to do."* Ashley noted that this desire to extinguish pain at all costs tends to be experienced by both doctors and patients, sometimes with disastrous results. She described a situation with a young patient diagnosed with fibromyalgia who begged to be prescribed narcotic painkillers and eventually received them, but who then died because she accidentally overdosed. *"It was really tragic. But again, that belief that only narcotics will work for me."*

**Jillian.** Jillian stated that she also spends a considerable amount of time educating both colleagues and patients, though she does not occupy a specific consultation role in her agency and therefore education with colleagues is less formal. Jillian noted that sometimes one of her colleagues will return from a training on something like motivational interviewing, and tell her they were amazed to be hearing the same things Jillian is always saying.

**Importance of Mind/Body Connection in Chronic Pain Treatment.** Both Ashley and Jillian noted the importance of recognizing the mind/body connection when treating chronic pain patients, and each discussed their thoughts on Complementary and Alternative Medicine (CAM). This theme came up specifically when the interviewees were discussing the effects that depression, anxiety, and mental illness can have on chronic pain but both also touched on CAM, the holistic approach to care, and the importance of healing the mind/body split.

**Ashley.** *"When I work with someone individually who has chronic pain, we try to look for things that exacerbate the pain, so I take a cognitive behavior approach... and see if changing their thinking style or challenging their faulty beliefs, or thinking will be*

*helpful in alleviating some of their pain.” Ashley noted that learning to help people work with the kind of thinking that exacerbates pain can be instrumental in limiting the pain her patients feel. “There are patients who find that, ‘if I take a walk my pain really is better,’ or, ‘if I do get regular exercise my fibromyalgia is better.’ ... So it’s really a lot about helping residents learn the motivational interviewing techniques and the cognitive behavioral techniques that help patients view their pain differently, and approach their pain differently.”*

Ashley reported that she has found the mind/body connection to be especially powerful when treating people with trauma in their history. Ashley noted that research indicates a large majority of people with childhood trauma have chronic pain as adults. *“So that’s the link in my mind. To help people understand that their brains and their bodies hold onto the trauma. The language of trauma in the brain is pain... the pain is a signal that the body is processing the trauma in some way, or perhaps not processing the trauma in a way that’s needed.”* Ashley stated that she sees resistance to drawing this connection between the physical and the emotional/spiritual in both patients and colleagues. *“I think this is a byproduct of the mind/body split that we’re trying to get over in western medicine. The idea that pain comes from the brain and that changing your thinking can help your brain decrease kind of feels like magic or voodoo or something not real.”*

**Jillian.** Jillian reported a similar understanding of the mind/body connection with chronic pain. *“I think the stress, the depression, the mental illness kind of exacerbate it.... When people are stressed out they’re not really able to relax. Depression is just painful all over anyway.”* Jillian noted that sometimes the interaction between mental and

emotional wellbeing serves as a good jumping off point for helping heal the mind/body split in her patients. *“If you get kicked in the knee, your knee is going to send all those messages up to your brain which will say it hurts. But it can go the other way, too. Your brain can remember something or be triggered by something and shoot that message down, saying, ‘oh, that’s supposed to cause me pain,’ and that pain is real. It’s both ways, our bodies talking to our brain and the brain sending messages to the body.”*

Jillian noted that there are many different CAM types of treatments that have been found to reduce pain, including guided visualization, light massage, and essential oils among others.

**Lack of Social Worker Power.** Although integrated healthcare has many benefits for patients, social workers, and other healthcare professionals, both Ashley and Jillian alluded to some drawbacks as well. One of these is the lack of social worker power, especially when contrasted with the recognition social workers garner in other therapeutic settings. Both interviewees spoke of isolation, lack of perceived power in the eyes of patients, pressure to fit into the medical framework instead of other professions adapting to meet the time and space expectations that work best for social workers, and the slow rate of change toward more equitable integration.

**Ashley.** Ashley said that she enjoys working with doctors but that sometimes it is challenging to *“tailor my comments to what they need. What they need is something they can do in a few minutes’ time... so learning how to help translate concepts into things they can use.”* Ashley went on to discuss how sometimes there may be an interesting or dysfunctional thing happening with a family or a patient’s personality that may be causing some difficulties for the patient in terms of being able to comprehend or follow

the doctor's recommendations. *"They want the shorthand,"* she said. *"They don't have time to do a lot of in-depth exploration that might in some cases... make the person more likely to follow their guidelines or their recommendations for treatment."* In these situations, Ashley said she feels like she must adjust her own practice for the ease of the doctors instead of the doctors changing to give more time and weight to Ashley's perspective on the client's situation. Ashley also noted that being the only social worker in her department can feel limiting and isolating. *"[The doctors] have their shorthand and you'll hear them jabbering about different tests that they're going to order... they have their own lingo. So it's a little bit like they're speaking Portuguese and I only studied French for a few years. I don't quite get it.... I guess just a little bit lonely."* Ashley went on to say that her medical colleagues may not have a full understanding of everything a social worker can do for patients. *"I think initially they see that I'm the fallback person, I'm the person they go to when they need a resource."*

Ashley said she sees this power differential in play with patients as well. *"I know they will say... 'I just want to see my doctor because they're the ones that are going to give me the narcotics. I don't want to see the social worker, or I don't want to see the pharmacist or the psychiatrist, or whoever it might be'."*

**Jillian.** One of the first things Jillian noted when discussing challenges she faces in integrated healthcare is her workload. Jillian stated that she has 125 patients in two different clinics. *"If there's someone in crisis I'm seeing them every time they're here [for dialysis], or at least weekly. But somebody who has resources and seems to be doing really well... I maybe meet with them once a month or once every other month."* When this happens, Jillian said, patients will bond with other staff who may or may not think to

update her when something socially/emotionally/spiritually significant happens. Jillian reported that she does not see the healthcare field truly integrating anytime soon. *“I think in the normal, conventional, western medical model they say they’re doing that... but it’s not really happening.... Unfortunately I don’t see it changing as a whole. I wish I did. I think it’s always going to be me bringing [interest in the holistic perspective] rather than the team. Our outcomes are different... social work is a little bit different.... And I think that affects how social workers as a profession sometimes need their power. I think there’s just some days that it’s just not an equal playing field.”*

Jillian went on to say that social workers’ lack of equal power is not just limited to interactions within the healthcare team, but extends to patients as well. *“With patients,”* she said, *“the doctors typically hold all the power.... It’s hard to even get patients to realize that my goal is to keep [them] home.”*

As with Ashley, Jillian stated she is not sure her teammates really know what she does. *“I don’t think they know what I do most of the time. Besides the resources and really trying to sit with people... I think that if somebody’s in crisis and I am able to calm the situation down. I think that takes pressure off the team.”* Sometimes Jillian’s colleagues expect her to help a patient’s personality trait or a disorder change within a very short period of time. *“Nothing I do or say, no resource I give them is going to change that in a week or two weeks... it might be next year. So it’s hard to quantify that sometimes.”*

### **Survey: Qualitative Analysis**

Two survey respondents reported that they had worked with a social worker in the treatment of their chronic pain, and of these two, only one went on to answer questions regarding this treatment.

On survey item 14, While in the care of a social worker for the treatment of your chronic pain, do you feel like that person affected your level of pain? If so, how?, this respondent reported, “I’ve had several SWs at diff times some have helped wit (sic) emotional support but not that had effected level of pain.”

On survey item 15, If you have ever utilized the care of a social worker in the treatment of your chronic pain, do you feel like that person affected your experience of chronic pain? If so, how?, this respondent stated, “Absolutely kept me going at my hardest times. And it gets hard!”

Content analysis could not be completed for the qualitative portion of the surveys because not enough data was collected. This will be further explored in the discussion section of this paper.

### **Survey Respondents: Quantitative Analysis**

**Descriptive Statistics.** Of the 17 survey respondents who responded to demographic questions, 24% (n=4) were male while 71% were female and 6% (n=1) self-identified as being “other.” This was a fairly young sample, with 50% (n=7) between the ages of 25 and 35, 14.2% (n=2) between 36-45, 14.2% (n=2) between 46-55, and 28.5% (n=4) between 56-65 years old. These age percentages are not surprising due to the necessity of being computer-literate in order to respond to the survey. The majority of survey respondents (52.9%, n=9) indicated that their chronic pain experiences began between the ages of 16-30. Only one respondent reported their chronic pain beginning

before the age of 16 (n=1), while 29.4% (n=6) of respondents' chronic pain began between ages of 31-45 and 11.7% (n=4) indicated their chronic pain began when they were 46-60 years old.

Regarding respondents' original cause of pain, the most common response was "I don't know," with 41.19% (n=7) of respondents indicating this. 23.53% (n=4) indicated a physical cause, 11.76% (n=2) reported overuse injury, 17.65 (n=3) indicated emotional stress, and 17.65% (n=3) reported "other" as their cause of pain. These respondents listed Hashimoto's disease, bone cancer, and a pelvic floor problem as their chronic pain cause. Of the respondents who answered the survey question regarding where they experience their chronic pain, the back was the most common response at 52.94% (n=9). Other responses included neck (47.06%, n=8), head, arms/hands, hips, and ankles/feet (29.41%, n=5), all over (23.53%, n=4), and knees (5.88%, n=1) in descending percentages. 17.65% (n=3) chose "Other," and these responses included "legs," "mine was a pelvic floor problem," and "left uper (sic) leg." See Table 1.

Table 1

**Table 1. Demographics**

<b>Gender</b>	<b>n</b>	<b>%</b>
Male	4	24
Female	12	71
Other (Please specify)	1	6
<b>Age</b>		
25-35	7	50
36-45	2	14.2
46-55	2	14.2
56-65	4	28.5

**Age at first experience of chronic pain**

0-15	1	5.8
16-30	9	52.9
31-45	5	29.4
46-60	2	11.7

**Original cause of pain**

Physical trauma	4	23.53
Overuse injury	2	11.76
Emotional stress	3	17.65
I don't know	7	41.18
Other (Please specify)	3	17.65

**Location of pain**

Head	5	29.41
Neck	8	47.06
Back	9	52.94
Hips	5	29.41
Knees	1	5.88
Arms/hands	5	29.41
Ankles/feet	5	29.41
All over	4	23.53
Other (Please specify)	3	17.65

Regarding whether survey respondents were in pain as the time they answered the survey, 76.47% (n=13) indicated they were feeling pain while 23.53% (n=4) reported they were not in pain. A very high percentage of respondents indicated they have sought treatment for their chronic pain (94.12%, n=16), while only 5.88% (n=1) have not sought treatment. Of those who have sought treatment for their chronic pain, 93.33% (n=14) have talked to a primary care doctor. This makes sense because in western medicine, doctors are often seen as a first step in treatment. Other responses, in descending popularity, included massage therapist (73.33%, n=11), chiropractor (66.67%, n=10), physical therapist (60%, n=9), acupuncturist (53.33%, n=8), neurologist (46.67%, n=7), pain clinic (26.67%, n=4), psychiatrist (20%, n=3), faith or spiritual healer (20%, n=3),



and “other” (20%, n=3). Other responses included “oncologist,” “osteopath and naturopath,” and “spinal surgeon.” See Table 2.

Table 2

**Table 2. Treatment of Pain**

<b>Current experience of pain</b>	<b>n</b>	<b>%</b>
Yes	13	76.47
No	4	23.53
<b>Have you ever sought treatment for pain</b>		
Yes	16	94.12
No	1	5.88
<b>Types of treatment you have experienced</b>		
Primary care doctor	14	93.33
Neurologist	7	46.67
Psychiatrist	3	20
Physical therapist	9	60
Chiropractor	10	66.67
Massage therapist	11	73.33
Acupuncturist	8	53.33
Faith or spiritual healer	3	20
Pain clinic	4	26.67
Other (Please specify)	3	20

Of the survey questions regarding whether respondents’ experience with social workers, only 12.5% (n=2) responded they had worked with a social worker in the treatment of their chronic pain. One participant responded to questions regarding the type and quality of treatment they experienced regarding their social worker. This respondent indicated that the social worker had provided therapy/counseling. This respondent also reported

they found the social worker extremely helpful, and noted that they would recommend the use of a social worker to friends/family members who were also experiencing chronic pain. **Error! Not a valid link.Crosstabulation.** The original plan for this research study was to look at associations between the type of chronic pain identified by survey respondents, the ways they had worked with social workers for the treatment of their pain, and the effects working with social workers had had on their experience of pain. Unfortunately, due to the small amount of relevant data collected, these associations could not be studied. The only association that was able to be analyzed was that between whether a respondent was experiencing chronic pain as of when they filled out the survey and whether a respondent has ever sought treatment for their chronic pain.

The relationship between the experience of chronic pain and whether a respondent sought treatment for their chronic pain, ( $\chi^2(1) = 3.453, p = .063$ ) was significant. The hypothesis was: There is an association between currently experiencing chronic pain and having sought treatment for chronic pain. The null hypothesis was: There is no association between currently experiencing chronic pain and having sought treatment for chronic pain. The p-value for this test was .063 , indicating that the relationship between chronic pain and whether a respondent sought treatment is slightly significant. Therefore, not surprisingly, this test suggests a slightly significant association between currently experiencing chronic pain and whether respondents have sought treatment for their chronic pain. See Table 3.

Table 3

**Table 3: Crosstabulation of Currently Experiencing Chronic Pain, and Seeking of Treatment for Chronic Pain**

Ever Sought Treatment for Chronic Pain						
	<u>Yes</u>	<u>No</u>	<u>Total</u>	<u>%</u>	<u>df</u>	<u>X<sup>2</sup></u>
<u>Currently Experiencing Chronic Pain</u>	13	0	13	76.47	1	3.453
<u>Total</u>	16	1	17	23.52		
<u>%</u>	94.11	5.88				

The question this research project attempted to answer was, “How does the inclusion of social workers on integrated treatment teams affect the client satisfaction of chronic pain patients?” The findings from the interviews and surveys partially answer this question, but also point to complications within integrated healthcare settings as well as lack of visibility of social workers within medical settings. In addition to a discussion of integrated healthcare, the literature review for this project focused on three main assumptions borne out by research: social work involvement is undervalued in the medical community, social work has a positive effect on patient satisfaction, and chronic pain has biopsychosocial dimensions which social workers are uniquely trained to understand. The following discussion will use the results of the interviews and the surveys to explore how this study confirms or refutes each assumption. Finally, implications for social work practice and research, as well as the study’s strengths and limitations will be addressed.

**Social Work Involvement is Undervalued in the Medical Community**

Data collected from both interview and survey respondents tended to agree with both this assumption and relevant literature, though not necessarily in direct ways.

Interview respondent Ashley discussed at length the ways she has felt she needs to fit into the larger, old-fashioned medical model which still dominates our healthcare system even as integrated healthcare gains momentum. In other therapeutic settings, social workers typically have 50 minutes to an hour per week to spend with clients. This larger amount of time aids in building trust and deepen client/therapist connection. Ashley stated that she is expected to only take a few minutes to visit with clients. In working with coworkers, Ashley finds herself trying to cut down complicated biopsychosocial concepts into snippets that can be immediately digested and repeated by doctors and nurses who may spend 15 minutes total with their patients. There is simply not enough time in medical settings to provide the level and specificity of care that clients in other settings enjoy. The fact that provisions for this are not made in current integrated healthcare teams illustrates under-appreciation by the medical community as a whole.

One finding of this study that fits neatly into previously recorded data is the lack of understanding of social worker role among other medical professionals on integrated healthcare teams (Egan & Kadushin 1995, Bikson et. al 2009). Both interview respondents noted that their coworkers will come to them for questions regarding resources, and will call on them when feeling overwhelmed by patient need. Each of these is a legitimate reason to consult the team social worker, however lack of understanding can result in unrealistic expectations. Jillian noted the expectation among her coworkers for her to be able to change patient personality or resolve ongoing familial

concerns in the course of a week, which other social workers intrinsically understand to be a pretty tall order.

Both Ashley and Jillian discussed the lack of power they experience within their integrated healthcare teams. One illustration of this is the fact that each is the only social worker in their department whereas the doctors, nurses, and other medical providers interact with many others of their ilk on a typical day. This isolation not only limits the time available for each patient (Jillian stated that she has a caseload of over a hundred renal patients), but it also limits social worker ability to organize for self-advocacy. This may be aiding in the ongoing struggle for social workers to achieve a more equal power balance in medical settings. Interestingly, the researcher did not find specific references to this integrated healthcare complication in the literature.

Of all survey respondents in this study, only two indicated they had worked with a social worker for the treatment of their chronic pain. If data from these respondents is generalized out to the larger chronic pain population, it becomes clear that they, too, are affected by social work involvement being undervalued by the medical community. Too few social workers in a medical setting, isolated and surrounded by other medical providers who are not necessarily aware of the roles social workers can play, limits their effectiveness and visibility. Doctors appear quick to refer a patient to the social worker when they encounter an emotional crisis they cannot resolve. But if the vast majority of patients are never perceived by doctors to fit into the crisis category, they may never come to the attention of the social worker. Perhaps if social work were afforded more equal power among the integrated treatment team, more chronic pain patients would be

referred for social work care. Patients would know they had seen one and therefore would be able to comment on the effectiveness of their social workers.

### **Social Work Has a Positive Effect on Patient Satisfaction**

Data regarding patient satisfaction is sparse, and often extrapolated from data regarding patient improvement or surveys regarding overall healthcare treatment experience (Crighton et. al 2007). All of the data regarding patient satisfaction used in the literature review was gathered by research teams trying to understand more about how social worker involvement affects patients, and much was gathered in other countries with stronger support for social workers. Therefore it was difficult to research this assumption fully, but information from both the literature review and interview portion of this study do suggest that this assumption regarding integrated healthcare is correct. One of the strongest indicators of this comes from Ashley who stated that while integrated healthcare can be a difficult sell at first, patients are enthusiastic once they understand how multiple providers working together benefit them. Ashley added that this group of people all motivated to help patients in complementary ways may be more than some patients have in the rest of their lives. Jillian, too, pointed to the perceived benefits of integrated healthcare for patients. Jillian stated that although she does not hear specific statements of positive effect on patient satisfaction, she does notice that patients with whom integrated healthcare is used show more active participation in their own care. This illustrates a greater sense of ownership and self-determination among integrated healthcare patients.

This research assumption proved the most difficult to access data about due to the small number of survey respondents who indicated they have consulted a social worker

for their chronic pain. The researcher set out to learn what types of chronic pain survey respondents have, how social workers have aided respondents in seeking amelioration of pain, and how beneficial respondents found working with a social worker to be. On a positive note, of the two respondents who indicated they have worked with a social worker, one provided data stating they found talking to their social worker about emotional problems to be very effective. Unfortunately the other respondent who indicated having seen a social worker chose not to elaborate, and did not answer questions regarding how the social worker affected their experience of chronic pain.

The researcher wonders if perhaps some clients have worked with social workers without being aware that they have. Data from both the literature and this study indicate a lack of visibility and understanding of social work role within hospital and clinic settings. It appears possible for social workers to be involved with a patient's care, without that patient necessarily knowing they are talking to a social worker. This would seem especially true with services such as discharge planning and resource referral; both of which research indicates are provided by nurses as well as social workers. It is also important to note that other types of mental health professionals such as Licensed Marriage and Family Therapists also work in medical settings. The possibility exists that patients may not necessarily know what type of mental health professional they are interacting with, if indeed they are aware they are working with one at all. Additionally, patients may be benefiting from social work knowledge indirectly as in the case of interview respondent Ashley who has a hand in training medical residents.

**Chronic Pain has Biopsychosocial Dimensions Which Social Workers are Uniquely Trained to Understand**

The literature review for this study discussed in detail how chronic pain affects and is affected by everything from social-economic status to chemical dependency and history of physical or sexual abuse in childhood. Literature also indicates that many chronic pain patients have complex presentations wherein poverty, history of abuse, obesity, and pain complicate each other and therefore the treatment of each (Lacey et. al 2012, Rosenfeld et. al 2013, Farin et. al 2013, Sachs-Ericsson et. al 2007). Social workers have been shown to be more sensitive to psychosocial problems than are physicians (Mizrahi & Abramson 2002) and also to have more training regarding these comorbidities. The wide scope of social work practice (van Hook 2004), as well as attention to systems perspective, enables social workers to effectively treat the complexity inherent in chronic pain.

Data gathered from the interview portion of this study joins the literature in confirming the accuracy of this research assumption. Both Ashley and Jillian discussed the importance of their wide knowledge base in their work with patients. Ashley noted that she always enjoys learning how a patient's psychology is interacting with their medical problems. Ashley stated that she is often able to see that a patient's family dynamic or mental health history is affecting a patient's ability to work effectively with their physician, or follow through on medical advice, adding that she appreciates the ability to raise awareness of how these emotional factors affect the physical. Ashley noted that she sees this as one of her most important roles as part of her integrated healthcare team, particularly in work with immigrant patients for whom somatization of emotional trauma is a common occurrence. Ashley reported use of cognitive behavior techniques with chronic pain patients to identify and reduce pain-exacerbating thoughts.



Jillian echoed much of the data gathered from Ashley. Jillian stated many times that her understanding of how chronic pain and stress/anxiety affect each other often serves as a jumping off point in her work with patients. Jillian noted that she is often the person among her colleagues who is able to sit with patients while they are in pain, and to suggest potential treatments such as meditation, aromatherapy, and light massage. Jillian stated that she rounds out her treatment of chronic pain by providing access to resources and advocating on behalf of clients to help ensure their wishes are heard by the other medical professionals on her team.

This was one area that survey data really helped illuminate. More than 17% of respondents indicated an emotional trauma etiology for their chronic pain. This number indicates at least some understanding of the biopsychosocial nature of chronic pain among patients. The researcher wonders whether these respondents were among those who did indicate having consulted a social worker for the treatment of chronic pain.

### **Implications for Social Work Practice**

The major implication of this study for social work practice is the need for increased social work presence in the medical field. This project found that many sufferers of chronic pain utilized many types of providers for their care but almost none utilized or were aware that they utilized the skills of a social worker. Relatedly, both Ashley and Jillian noted lack of awareness among their coworkers regarding what the social worker role even is. Both interview respondents also noted a feeling of isolation among fellow team members, given that they were the only social workers in their departments.

Ultimately, reintroducing social work departments in hospitals and clinics would be instrumental in increasing social work visibility: this is one of the roles of a department. But until this happens, social workers in medical settings can continue to advocate for greater visibility: perhaps offering educational in-services on social work scope of practice to coworkers, or making a point of discussing who and what a social worker is with patients at the beginning of treatment could help. The advent of integrated healthcare may also prove instrumental in some ways: bringing additional social workers into the healthcare arena would serve to increase patient awareness of social work presence. Over time, increased social work presence would become more commonplace, ameliorating confusion and lack of understanding of social work role among physicians, nurses, and other members of integrated healthcare teams. Increased social work presence would also potentially serve to raise social workers' amount of power. Instead of social workers needing to fit their work into the established hierarchy of the medical model in which the doctor reigns supreme, perhaps we would see the nature of healthcare adapting to allow for more time and attention paid to the bio-psycho-social needs of chronic pain patients.

### **Implications for Research**

Domestic studies on the efficacy of social workers in the medical setting nearly ceased to exist after the mid 1990s, coinciding with the elimination of social work departments. Due to this, much of the more recent research utilized for the literature review comes from Canada, Europe, and Oceania, where the medical model does not hold as much weight. In many of those places, hospital social work departments exist as a matter of course, and therefore research on medical social work is completed. Research

on social worker efficacy, specific mental health modalities, and patient satisfaction with social work services comes out every year, especially in Australia and New Zealand.

With the rise of integrated healthcare in the United States, research is vital: how can we know integrated healthcare really is worth the investment if more research does not indicate this? Studies on social worker efficacy, the interaction between social workers and other members of integrated healthcare teams, and the experience of working with social workers from the viewpoint of patients will be necessary.

Interview findings from this study also indicate a need for more comprehensive research on the long-term effects of opiate painkillers specifically within the chronic pain community. Both Ashley and Jillian noted the stigma that comes from opiate painkiller use, as well as the potential for overdose and dependency. Here, too, much of the available research comes from countries in Europe. Knowledge of chronic pain and chemical dependence comorbidity continues to be largely anecdotal in the United States. Future research should not only look at dependence and comorbidity issues, but also at complementary and alternative treatments for chronic pain when the prescription of opiates is not advised (such as fibromyalgia).

### **Strengths and Limitations**

One major strength of this paper is that it seeks to fill a hole in the academic record: to this researcher's knowledge there are not yet any studies focusing on how integrated healthcare affects chronic pain patients even though we know how complicated the typical profile of a chronic pain patient can be. Another strength is that this study focused not only on chronic pain patients themselves, but also looked at how social workers in integrated healthcare settings understand the unique needs and

considerations of working with this population. This study is one small way in which we can better understand the unique needs of chronic pain patients, their perceptions of how social workers augment their care teams, and how we as social workers can act to better their treatment outcomes and experiences.

The major limitation to this study is the small number of respondents reached, particularly for the qualitative portion of the survey. One major issue is that chronic pain survey respondents needed access to and facility with the internet to participate. For many this may not have been a problem, but there is little doubt that the voices of some elderly or socio-economically disadvantaged chronic pain patients were not heard. Another potential issue is that many chronic pain patients may not be aware of the resources available to them, and due the lack of social worker visibility in the medical field, may not even know they are seeing a social worker. One hole in the survey data is the lack of information gathered on painkiller use. This researcher failed to ask respondents to discuss whether they have/are taking pain medications, as well as the type. Given the interview data on chronic pain and opiate pain medication use, information gathered from people who suffer from chronic pain would have rounded this out. Another limitation may be bias of the researcher, based on the fact that the researcher is currently an MSW student with an interest in pursuing a career in integrated healthcare. The researcher attempted to ameliorate said bias through utilization of the research committee and oversight from the research chair.

### **Conclusion**

The purpose of this research project was to explore the ways in which the inclusion of social workers on integrated healthcare teams for chronic pain affects patient

satisfaction. The research was based on three main assumptions: social work involvement is undervalued in the medical community, social work has a positive effect on patient satisfaction, and chronic pain has biopsychosocial dimensions which social workers are uniquely trained to understand.

Unfortunately, some of the data necessary for satisfying the goal of this research project was not available. Ultimately, this project serves to highlight a consistent problem in the world of social work: lack of visibility. Lack of social worker visibility takes different forms and affects different players in many ways, from integrated healthcare team members not being familiar with social work's scope of practice to clients potentially not knowing when they are in the care of a mental health professional, to social workers themselves feeling isolated or pressured to fit into treatment models and timeframes that do not best suit clients' internal biopsychosocial landscapes. More research will be needed to further explore the effects of lack of social worker visibility, as well as how social workers can raise the volume on social work involvement in medical settings.

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## Appendix A

### Interview Recruitment Script

Date:

Dear \_\_\_\_\_,

My name is Annie Spiro and I am a graduate student in the University of St. Thomas / St. Catherine University School of Social Work. I am conducting research on the effect that including a social worker in integrated care teams has on the client satisfaction levels of people experiencing chronic pain. I would like to conduct in-depth interviews with social workers who are currently or who have in the past participated in integrated care with this population. Interviews will be in person and can be scheduled at the time and location of your choosing. Interviews are designed to take 45 minutes to one hour. This section of the research process will take place throughout the months of January and February, 2014. I may possibly contact you after the interview in order to clarify any questions that I encounter in analyzing the information you give me during the interview. Your identity will be kept confidential, and your choice to participate in this research project will in no way affect your current or future relationship with the University of St. Thomas or St. Catherine University. There are no direct benefits to participating in the study, and participants will not be compensated.

If you are interested in participating in this research project as an interviewee or have any questions, please feel free to contact me at (xxx) xxx-xxxx or xxx@stthomas.edu

Looking forward to talking with you soon.

Sincerely,  
Annie Spiro, B.A.  
Clinical Social Work Student  
University of St. Thomas / St. Catherine University

## Appendix B

### Survey Recruitment Script and Consent Form

#### **Introduction:**

You are invited to participate in a research study investigating the effect of social worker involvement on integrated treatment teams for people dealing with chronic pain. This survey will include questions related to your experience of chronic pain treatment: whether you have worked with social workers and whether having a social worker has been helpful in your chronic pain care. This study is being conducted by Annie Spiro, a graduate student in the University of St. Thomas / St. Catherine University School of Social Work, under the supervision of Pa Der Vang, Ph.D., LICSW, an assistant professor in the School of Social Work. You are invited to participate in this research study if you are currently living with chronic pain because your insight is valuable to the understanding of the treatment of chronic pain.

#### **Procedure:**

Before you agree to participate in this study, please read this form. Feel free to call or email with any questions you may have.

If you participate in this study, you will be asked to fill out the following 11-question survey. After the data is compiled, I will run statistical analyses to determine the results. The research project will end in May of 2014, however your only participation as a survey respondent would be this one-time survey.

#### **Risks and Benefits of being in the study:**

There are minimal risks to participating in this survey: some of the questions may be uncomfortable, however you have the right to skip any questions you do not want to answer, without consequence. There are also no direct benefits to participating in this survey. That said, by responding, you will be helping build research to ultimately help social worker and other clinicians provide better care to people experiencing chronic pain once this study is published.

#### **Confidentiality:**

All information provided by survey respondents will be anonymous and will be kept confidential. If/when direct quotes are used, this researcher will change or eliminate any identifying information that could link the quote to any specific individual. Myself and my research chair, Dr. Pa Der Vang, will be the only people who have access to the raw survey data. I will keep all survey data locked in a file cabinet in my home, and will destroy all data once the research has been completed, in May 2014.

Your participation in this research project is entirely voluntary. Your decision to participate will not affect your relationship with the University of St. Thomas or St. Catherine University in any way. If you do choose to participate, you may stop at any point without penalty.

**Contacts:**

If you have any questions or concerns, please feel free to contact me, Annie Spiro, at (xxx) xxx-xxxx or xxxx@stthomas.edu at any time. You may also contact my research chair, Pa Der Vang, Ph. D., LICSW, at (xxx) xxx-xxxx or xxxx@stkate.edu If you have questions regarding the research process or this specific study and would like to talk with someone other than the researchers, you may contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (xxx) xxx-xxxx.

**Please check the box that reflects whether or not you agree to participate in the study:**

Yes, I understand and agree with the rules of consent, and I wish to begin the survey.

No, I do not agree with the rules of consent, and I do not wish to begin the survey.

## Appendix C

### Interview Consent Form

#### **Introduction:**

You are invited to participate in a research study investigating the effects of including a social worker on integrated healthcare treatment teams for chronic pain patients. The study is being conducted by Annie Spiro, a graduate student in the University of St. Thomas / St. Catherine University School of Social Work. Please read this form and feel free to discuss any questions and concerns with the researcher before you agree to be in the study.

#### **Background Information:**

The purpose of this research is to explore whether and how working with social workers affects the client satisfaction rates of people experiencing chronic pain. Research indicates that chronic pain is difficult for doctors to treat because it includes complex relationships between the mind and body. Integrated treatment teams; which may include primary care physicians, nurses, physical therapists, neurologists, and other clinicians, have been instrumental in improving the quality of care for the elderly, children, and other special populations. However, including social workers in treatment of chronic pain patients specifically has not yet been studied. This research study will attempt to begin to fill this knowledge gap. In addition to interviews, I will have chronic pain patients complete an anonymous online survey.

In total this research study will include the perspectives of over thirty chronic pain patients, however this interview will be one of three conducted with social workers involved in integrated treatment teams for patients with chronic pain.

#### **Procedures:**

If you decide to participate, you will be asked to meet with Annie Spiro in the location and time of your choosing for a 45-minute to one-hour interview. The results will be transcribed by the researcher. The results of the interview will be used to complete the research project necessary for graduation from the School of Social Work MSW program. This study may also be published in an academic journal in the future. Quotes will be used in the manuscripts; however, the quotes will not include information that will identify the speaker. If you agree to have your quotes used in the manuscript, please initial here \_\_\_\_\_.

As an interview participant, you will be asked to respond to a set of questions. There is no right or wrong answer. You are being asked to talk from your individual perspective and all opinions and experiences are valid.

#### **Risks and Benefits of being in the study:**

The study has minimal risks. You will be asked to talk about your experience as an social worker in an integrated healthcare setting that treats chronic pain patients. This interview may include questions that make you uncomfortable; if this occurs please inform the researcher and you may stop your participation at any time with no repercussions. There are no direct benefits to participating in this study. Indirect benefits include that once the results of this study are published, there will be more information regarding integrated healthcare treatment of chronic pain which will advance the area of study as a whole.

**Confidentiality:**

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. The researcher will transcribe the interviews, and only the researcher and research chair will have access to raw interview data. This researcher will maintain the confidentiality of all participants. In the final research study, no one will be identified or identifiable and only general data will be presented.

I will keep the research results in a locked file cabinet in my home. Only myself and my research chair will have access to the records while I work on this project. I will finish working with the data by May 1, 2014, at which time I will destroy all original files and identifying information that can be linked back to you.

**Voluntary nature of the study:**

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

**Contacts and questions:**

If you have any questions, please feel free to contact me, Annie Spiro, at (xxx) xxx-xxxx or xxxx@stthomas.edu or my research chair, Pa Der Vang, Ph. D., LICSW, at xxx-xxx-xxxx or xxxx@stkate.edu If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (xxx) xxx-xxxx.

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.

**I consent to participate in the study and I agree to be audiotaped.**

---

**Signature of Participant**

**Date**

---

**Signature of Researcher**

**Date**

## Appendix D

### Interview Questions

1. Please tell me a little about yourself. How old are you, what is your current position of employment and how long have you been in that role? How long have you been working with chronic pain patients? What is your licensure?
2. How did you come to work with chronic pain patients?
3. What is your client base in terms of age, gender, socioeconomic status, and common chronic pain complaints?
4. Please describe your experience working with chronic pain patients.
5. What are some special considerations in working with chronic pain patients?
6. Based on your experience, please discuss how stress, depression, or other mental health challenges may be related to chronic pain.
7. What are some of the challenges you see patients with chronic pain experiencing?
8. How do you seek to address these challenges with your patients?
9. Please describe your experience in being part of an integrated healthcare team.
10. What challenges do you experience as a medical social worker on an integrated healthcare team, and how do you work through these?
11. Please describe your understanding of the role of social worker in the integrated healthcare team. How do you think other members of your team would describe the role of the social worker?
12. What benefits, if any, do you see chronic pain patients receiving through the integrated healthcare model?
13. How have chronic pain patients endorsed these benefits?



## Appendix E

### Survey

1. Consent to participate in survey, ability to continue with the survey contingent on this item being answered in the affirmative.

Place an “X” in the appropriate box:

2. Age:

\_\_\_\_\_

3. Gender:

Male

Female

Transgender

Other (please specify)

4. Age at which you first began experiencing chronic pain:

\_\_\_\_\_

5. What was the original cause of your pain?:

Physical trauma (i.e. car accident)

Overuse injury (i.e. carpal tunnel syndrome)

Emotional stress

I don't know

Other (please specify)

6. Location of pain: (check all that apply)

Head

Neck

Back

Hips

Knees

Stomach

Arms/hands

Ankles/feet

All over (i.e. fibromyalgia)

Other (please specify)

7. Are you currently experiencing chronic pain?

Yes

No

8. Have you ever sought treatment for your pain?

Yes

No

9. If yes, what type of provider have you seen? (check all that apply)

Primary Care Doctor

Neurologist

Psychiatrist

Physical Therapist

Chiropractor

Massage Therapist

Acupuncturist

Faith or Spiritual Healer

Pain Clinic

Other (please specify)

10. Have you ever had a social worker on your chronic pain treatment team?

Yes

No

I don't know

**IF YOU HAVE NEVER WORKED WITH A SOCIAL WORKER FOR YOUR CHRONIC PAIN, YOU ARE DONE! THANK YOU SO MUCH FOR YOUR CONTRIBUTION TO THIS RESEARCH STUDY**

**IF YOU HAVE WORKED WITH A SOCIAL WORKER FOR YOUR CHRONIC PAIN, PLEASE CONTINUE. YOU'RE DOING GREAT!**

11. If yes, what services did the social worker provide? (check all that apply)

Helping you find and connect to resources

Helping you understand medical options/make medical decisions

Providing therapy/counseling

Discharge planning when you were hospitalized

Other (please specify)

12. If yes, how would you rate the helpfulness of your social worker?

Extremely helpful

Somewhat helpful

Neutral

Mostly unhelpful

Not helpful at all

13. Would you recommend the addition of a social worker to the treatment team of a friend or family member experiencing chronic pain?

Yes

No

I don't know

14. While in the care of a social worker for the treatment of your chronic pain, do you feel like that person affected your level of pain? If so, how?

15. If you have ever utilized the care of a social worker in the treatment of your chronic pain, do you feel like that person affected your experience of chronic pain? If so, how?