Pain Management: Role of the Social Worker

What We Know

› Pain is a subjective experience for the client. Pain may be an acute reaction to an injury or it may become a chronic reaction. Acute and chronic pain can create serious health problems and pain-related disability (e.g., an interference with social and physical functioning). There are two primary types of pain, neuropathic and nociceptive pain. Neuropathic pain is associated with damaged or dysfunction nerve fibers, while nociceptive pain arises from stimulation of nerve cells. Many clients with chronic pain experience a complex mix of both types. There are no laboratory or diagnostic tests that can definitively identify the presence of pain.

• Pain acts as a signal to the body that there has been an injury that requires an action (e.g., healing, treatment).
• Neuropathic pain may originate in either the central nervous system (i.e. the brain, the spinal cord) or the peripheral nervous system (i.e., nerves outside the brain and spinal cord). Neuropathic pain often is caused by a disease or lesion involving the somatosensory system (e.g., bones, joints, skin, muscles, internal organs, cardiovascular system).
• Nociceptive pain results when a physical cause stimulates the nociceptive pain receptors in the area, which send a pain message through the sensory system to the brain (e.g., a burn, a twisted ankle, arthritis).
• Acute pain usually is caused by an injury, a surgery, swelling, or an unknown cause but typically dissipates after an anticipated period of time when the wound or injury has healed.
• Chronic pain persists beyond the point at which healing would be expected and continues indefinitely; it may be constant or intermittent. Treatment of chronic pain may be management-oriented rather than cure-oriented.
  – Chronic pain frequently results in negative emotional reactions including depressive symptoms, trouble sleeping, appetite disturbances, loss of interest or pleasure in activities or relationships, and isolation.
  – Depressive symptoms can also cause or intensify pain.
  – Inadequate pain management is associated with poor outcomes including delayed wound healing, inflammation, change in immune function, more intense pain response in subsequent painful experiences, and chronic pain.

› Social work goals align closely with those of pain management: reducing suffering while enhancing the client’s quality of life. Social workers help clients manage pain in several ways.

• Family caregivers of clients at end of life often are primarily responsible for managing the client’s pain and frequently express uncertainty, anxiety, and trouble communicating with the client. Negative attitudes, fears, and beliefs regarding pain management can be addressed by the social worker.

• A study of hospice social workers, who are closely involved in end-of-life care, reported that approximately 21% of their time was spent addressing issues related to pain management. 25.5% of the social workers reported that non-social-worker members of...
the interdisciplinary care team approached them at least once every 1–2 days to help a caregiver with concerns connected to pain management. Another 23.3% stated that this occurred at least once a week\(^{(15)}\)

– The most common barriers to effective pain management reported to social workers by caregivers were caregiver belief that pain cannot be controlled, desire to keep the client more awake and alert, and belief that the client would decline faster if given pain medicine. The social workers also found that caregivers often waited a long time before they would call hospice to report pain\(^{(15)}\)

\(\triangleright\) In the United States, chronic pain affects an estimated 100 million individuals. A 2011 report by the Institute of Medicine reported economic costs of chronic pain between $560 to $635 billion a year when loss of work was included\(^{(10)}\)

\(\triangleright\) Pain carries high social-emotional costs, which are linked to\(^{(10)}\)

• Increased morbidity
• Higher rates of hospital admission
• Longer hospital stays
• Increased number of outpatient visits to healthcare providers
• Decreased ability to function

\(\triangleright\) Pain often is underdiagnosed and undertreated. Reasons for this include biases related to gender, race, and age and physician fears related to opioid addiction\(^{(1,2)}\)

• Age is a frequent source of bias in pain management: pain in older persons is more likely to go unrecognized and uncontrolled than pain in younger persons\(^{(2,8)}\)
  – Older clients may themselves feel that pain is expected with aging and may not acknowledge pain during an assessment or may describe the pain using mild language (e.g., aches, soreness)\(^{(2,8)}\)
  – Older clients may fear becoming addicted to pain medications or have concerns about cost\(^{(2,8)}\)
  – Older adults are more likely to be experiencing cognitive impairments that interfere with their ability to describe their pain in an easily understandable way\(^{(2)}\)
  – Older clients may worry that they will be perceived as “bad” patients if they discuss pain\(^{(8)}\)

• Women are less likely to have reports of pain taken seriously by healthcare providers and are more likely to have their pain dismissed as being emotional or psychogenic in nature\(^{(2)}\)

• Minority clients historically have been less likely to receive adequate and appropriate pain management for both chronic and acute pain\(^{(2)}\)
  – If there are language barriers, the client may have trouble expressing his or her pain needs to staff and may have increased anxiety while trying to make those needs known\(^{(2)}\)

• Physicians may fail to prescribe opioids out of an exaggerated fear of overprescribing or encouraging dependence. This so-called opioidophobia may cause some clients to continue to experience pain that could be alleviated with the correct use of opioids. Often clients do not receive the proper pain medications, receive an inadequate dose, or leave the emergency department or physician’s office still in pain\(^{(9,13)}\)

  – To help reduce physician anxiety related to prescribing opioids, the social worker may want to educate physicians on the use of an opioid agreement form\(^{(9)}\)

  – The first section of this form serves as an informed consent; the client acknowledges what the medication is being prescribed for and agrees to the following conditions in order to maintain the prescription:\(^{(9)}\)
    - Discloses any other treatments he or she is participating in and agrees to taper or discontinue the opioid if other options are appropriate
    - Will take the medication only as prescribed
    - Will keep appointments
    - May receive opioid prescriptions from a single physician only
    - Will notify the pain clinic/physician if the client has an additional condition requiring a controlled narcotic or is hospitalized
    - Designates the single pharmacy that will be used
    - Agrees that early refills will not be honored and that if he or she loses medication or it is stolen, the medication will not be replaced
- Will abstain from use of illegal or recreational drugs, including alcohol, and will submit to blood or urine testing if requested by doctor
- Agrees to exact instructions regarding refills
- Signs a release allowing the physician or staff members to discuss care with primary physician (if different) and any medical facilities providing care

Pain is the most common reason for a visit to an emergency department, but emergency departments often present barriers to pain management. Social workers in the emergency department have an opportunity to advocate for clients and seek improved care.

- Barriers include failure by staff to acknowledge pain, to assess initial pain, to implement care according to the department’s protocols or guidelines, to document pain, and to meet clients’ expectations.
- All of the biases that affect pain management also take place in the emergency department and may require social work intervention.

The social worker in the emergency department setting should ensure that any assessment, whether completed by a social worker or a nurse, includes determining whether the client has had two or more visits to the emergency room within the last 6 months for pain and assessing whether the client is in fact drug-seeking or instead has poorly controlled pain. Not all drug-seeking behavior is intentional; it may result from a failure by the client to self-wean from pain medications after a physician has refused to refill prescriptions.

Red flags for potential misuse of opioids are prescription for minor reasons, prescriptions from multiple providers, and needing refills before the client should be out of medication, indicating the client is taking the medication more often or at higher amounts than prescribed.

In a randomized controlled study researchers found that in emergency room departments adequate pain management was associated with a decreased pain score and a higher level of patient satisfaction.

Palliative care is an approach to care that frequently includes pain management. Barriers to effective pain management that social workers can identify and address in palliative care settings include:

- Concerns about addiction that may be expressed by client, caregivers, or other professional members of the care team
- Tolerance of the pain medication, leaving the client undermedicated
- Stoicism about enduring pain by the client
- Fatalism about pain as a necessary part of life or aging
- Fears of side effects of pain medication such as drowsiness, confusion, constipation
- Perceived stigma taking pain medications
- Fear of being a burden on caregivers and belief that reporting pain is being a burden
- Fear of overdosing on pain medications

The social worker can also use screening tools along with a thorough biopsychosocial-spiritual assessment to determine client needs and effective interventions.

Two common screening tools are the Brief Pain Inventory, a 9-item inventory to assess pain, and the Patient Health Questionnaire (PHQ-9), which may be used to screen for depressive symptoms the client may be experiencing as a result of pain.

The social worker can also utilize the Physical Functional Ability Questionnaire (FAQ5) to assess whether chronic pain is limiting the client’s ability to perform activities of daily living, instrumental activities of daily living, and lifting ability based on U.S. Department of Labor standards.

Interventions provided by social workers to help clients manage pain typically employ cognitive behavioral techniques meant to change negative behaviors and thoughts related to the pain and/or incorporate techniques such as supportive counseling, guided imagery, breathing exercises, and muscle relaxation.

Cognitive-behavioral techniques can be particularly effective during times of distress or feelings of lack of control by the client, which is common during procedures and testing.

Acceptance and commitment therapy (ACT) is based on the concept that negative emotions (e.g., fear, negative memories, pain symptoms) have a negative influence on behavior and can lead to avoidance and inflexibility. The client is taught to alter the associations he or she may have between pain and these negative thoughts and emotions in order to positively change behavior and improve functioning.
Cognitive restructuring monitors the client’s interpretation of his or her experience in order to help decrease feelings of emotional distress, helplessness, and hopelessness\(^2\).

Clients who are using defeatist self-statements can be taught how to replace negative self-talk with internal dialogues known as coping statements that will increase feelings of calm and competence and thereby enhance coping\(^2\).

Distraction techniques help the client refocus his or her attention on non-painful stimuli to distract the client from his or her pain experience\(^2\).

Self-monitoring through journals or diaries helps the client keep a personal history but also allows the client to externalize thoughts, feelings, and behaviors that may, if internalized, increase emotional distress\(^2\).

Guided imagery is a cognitive-behavioral technique in which the social worker helps the client use imaginary pictures, sounds, or sensations to reduce or eliminate pain and/or the anxiety, fear, or tension that are connected to the pain\(^5\).

- The technique uses relaxation training, visualization, and positive suggestion\(^5\).
- Guided imagery teaches the client how to shift his or her focus away from his or her pain and discomfort to more comfortable or enjoyable thoughts\(^5\).
- Guided imagery should be avoided with clients who are actively psychotic, are unable to think abstractly, cannot distinguish reality from fantasy, are having hallucinations or delusions, have moderate to advanced dementia, or cannot communicate\(^5\).
- Common guided imagery techniques for pain include\(^5\):
  - creating a mental image for the pain and then transforming that image into a more manageable or less frightening image
  - imagining the pain disappearing
  - imagining the pain as something the client has complete control over (e.g., if the pain is an electric current, the client can turn the electric switch off)

Relaxation breathing with or without progressive muscle relaxation can alter the client’s reaction to pain and stress in the behavioral, physical, and emotional realms. Family caregivers can be instructed on how to help clients with these techniques\(^2\).

- Supportive counseling interventions work to clarify the relationship between pain and other psychosocial functioning, explore resources, validate the client’s experience, and improve problem solving\(^2\).
- The social worker can develop a plan of care with the client to address the client’s chronic pain. The plan of care should include the following areas of focus:\(^9\)
  - The client should list personal goals that may include improving functional ability and returning to work and/or specific personally enjoyable activities (e.g., hobbies, tasks, sports)\(^9\)
  - Sleep improvement may be achieved through having a specific sleep plan (e.g., no caffeine, no naps, relaxation techniques before bed, adherence to a target bedtime, no electronics in the bedroom) and listing any medications or homeopathic means that are being used to help with sleep\(^9\)
  - The client should be aiming to increase physical activity. The care plan should address physical therapy, if appropriate, and stretching, aerobic exercise, and strengthening\(^9\)
  - Stress management should be incorporated into the plan of care; this may take the form of formal interventions (e.g., counseling, support group, classes), daily practice of relaxation techniques, and/or medications for anxiety\(^7\)
  - Decreasing pain should be addressed in the plan; between visits, the client should record times of his or her lowest and highest pain levels to assist with monitoring\(^9\)

Biofeedback utilizes specific devices to monitor an individual’s physical reaction to stress, which can cause pain or intensify pain symptoms. The device displays either auditory or visual information that reports the presence of stress to the client so the client can learn how to control and calm his or her physical reactions\(^18\).

- Pain and stress are closely linked: fear of pain causes stress and chronic pain amplifies the effect of stressors (e.g., emotional distress, physical discomfort, anxiety). Biofeedback is a method to help clients understand this connection and gain awareness and control\(^18,19\).
- Biofeedback is meant to help clients identify, understand, and eventually control their physical, mental, and emotional responses to stress and pain\(^19\).
• Use of a client-centered approach, in which the provider considers the goals and needs of the individual holistically rather than focusing on the immediate episode of pain, can improve pain management.¹

**What We Can Do**

› Learn about the role of the social worker in pain management so you can accurately assess your clients’ unique characteristics and health/mental health education needs

› Share this information about effective pain management with your colleagues

› Develop an awareness of your own cultural values, beliefs, and biases and develop knowledge about the histories, traditions, and values of your clients. Adopt treatment methodologies that reflect the cultural needs of the client.⁴,¹¹,¹²

› Social workers should practice with awareness of and adherence to the NASW Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to providing culturally competent care to clients in pain and practice accordingly.¹²

› Understand the definitions of pain and the impact of pain on comorbidities

› Recognize the biases present in pain management and be prepared to advocate for those clients who are not receiving appropriate pain management as a result of bias

› Advocate for increased cultural sensitivity in areas of practice (e.g., hospitals, mental health agencies, nursing homes) to reduce disparities in pain management.¹⁶

› Include caregivers in any pain assessment and share any caregiver concerns related to pain with relevant healthcare team members.¹⁵

› Recognize the social worker’s role in the emergency department to advocate for clients while also helping to assess for any substance abuse issues

› Educate clients on their strengths, areas of control, and areas of competence so they can feel more empowered in their pain management.¹⁴

› Teach clients skills and strategies for coping with and managing pain, including relaxation techniques, guided imagery, and breathing techniques.¹⁴

› Utilize appropriate screening tools to assist in biopsychosocial-spiritual assessment

› Develop plans of care for clients that include needs related to pain management

› Refer clients to any appropriate pain management program or support group

**Note**

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**References**


