THE INTERSECTION OF GERIATRIC SOCIAL WORK AND COMPLEMENTARY AND ALTERNATIVE MEDICINE

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ABSTRACT

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Chronic health problems affect millions of older adults each year and the numbers of people living with chronic illness is expected to grow. Meeting the complex needs of individuals with chronic illness and a growing aging population is a challenge for the medical system. Ongoing and open patient-provider communication is essential for chronic illness management. While many older adults are choosing Complementary and Alternative Medicine (CAM) to treat chronic illnesses such as depression, heart disease, back pain and diabetes, few are discussing their use of these treatments with their health care providers. Social workers play a key role in chronic illness management by considering relevant biomedical, psychosocial and spiritual factors and the needs of the individual patient and the patient's family or caregiving network. Based on the literature, it is not clear whether social workers are communicating with older adults regarding CAM use. This dissertation examined social worker-patient communication regarding CAM and how well social workers are equipped to play this role. Thirty-nine semi-structured interviews were conducted with a non-random purposive sample of geriatric social workers. Respondents were recruited from four geographical regions including parts of Michigan (Greater Lansing, Ann Arbor, Grand Rapids); the San Francisco Bay Area; Greater Boston, and Honolulu, Hawaii. The research indicated that social workers in the study did not routinely assess for CAM use, including use of herbs or supplements, nor were they likely to affirmatively recommend CAM modalities. The research also

identified a number of institutional barriers that inhibit communication about CAM, made specific recommendations to improve CAM-related social work education and training and to better accommodate CAM modalities at multiple system levels. In addition, the study also revealed cultural competency deficiencies, specifically, reluctance by social workers to ask about CAM use out of fear that they will appear to be stereotyping based on the patient's cultural background. Social worker respondents also indicated a lack of knowledge about CAM use prevalent in particular patient communities.

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To my family: Sean, Sophie and Sasha, my parents and my sisters.
Much, much love.

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CHAPTER 1

INTRODUCTION

Statement of the Problem

A significant number of older adults in the United States choose non-traditional treatments for both chronic sphysical and mental health problems such as depression, heart disease and back pain, as well as for overall well-being. Generally referred to as Complementary and Alternative Medicine (CAM), these treatments include a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine (http://nccih.nih.gov). *Complementary and alternative medicine* (CAM) has been defined as a "diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, satisfying a demand not met by orthodoxy, or diversifying the conceptual frameworks of medicine" (Ernst, 2000, p. 252).

CAM is also sometimes referred to as Integrative Medicine (Holmberg et al, 2012), the Integrative Mind-Body-Spirit (IMBS) paradigm (Lee et al, 2009; Raheim & Lu, 2014) or Integrative Health Services (Gant et al, 2009). The National Center for Complementary and Integrative Health (NCCIH) is a division of the National Institute of Health (NIH). Formerly known as the National Center for Complementary and Alternative Medicine (NCCAM), the Center's recent name change indicates a shift in focus to the broader mission of "integrative medicine." However, for the purpose of this paper, the term CAM will be used to describe the range of non-traditional treatments, including integrative approaches to medicine.

Key Terminology. The NCCIH lists over 160 types of alternative treatments roughly divided into 5 categories: (1) Whole medical systems (e.g., traditional Chinese, homeopathic, naturopathic, and Ayurvedic medicine); (2) Mind-body medicine (e.g., mindfulness based stress reduction (MBSR), meditation, prayer, mental healing); (3) Biologically based practices (e.g., using substances found in nature, such as herbs, foods, and vitamins); (4) Manipulative and body-based practices (e.g., chiropractic medicine, massage, and osteopathic manipulation); and (5) Energy medicine (e.g., biofield therapies such as qi gong, Reiki and Therapeutic Touch, and bio-electromagnetic-based therapies) (NCCIH website, 2015).

Prevalence of CAM. Across all of these categories, CAM has grown immensely in popularity in the last 25 years and the numbers of CAM consumers increases each year. Americans made an estimated 425 million visits to alternative health care providers in 1990 (Eisenberg, 1993) and 629 million visits in 2005, almost double the number of annual visits to primary care physicians (Ananth & Martin, 2006). The 2007 National Health Survey found that 38% of U.S. adults reported using CAM in the previous year (2007, National Health Review Survey). Older adults are estimated to account for 35% or more of these visits while national studies of CAM users in 2002 and 2007 found the largest group of users of CAM to be among the baby boomers (those born between 1946-1964) (2002 & 2007, National Health Review Surveys). The number of older adults using CAM may increase due to the overall increase of older adults in the population and the greater use of CAM among the aging baby boomers. The baby boomer cohort, individuals who came of age in the 60s and 70s, have deep roots in counter cultures, the second wave of feminism and feminist health care movements, and the growth of the

holistic health movement. This is a generation known for experimenting and alternative ways of being. As a result, alternative lifestyles and alternative paths of care are not new to this cohort and may continue with baby boomers as they age.

CAM use has many beneficial aspects, especially for pain management and stress reduction, both important to older adults who tend to have more chronic pain, physical dysfunction, and health care utilization than younger and middle aged adults (Ness et al., 2005; Willison & Andrews, 2004). Pain management for older adults can be particularly difficult due to sensory, cognitive or psychomotor impairment. Furthermore, many patients do not like the side effects from some pharmaceutical pain strategies (Hanks-Bell, Halvey & Paice, 2004). Alternative means of pain management, such as massage, tai chi, and herbal supplements can address many of these challenges (NCCIH website, 2015).

At the same time, some types of CAM can conflict with conventional treatments. One concern is harmful interactions between some pharmaceuticals and herbal remedies. (Ernst, 2000). This is of particular concern for older adults who make up 13% of the US population, but consume 30% of the pharmaceuticals (Gerontological Society of America, & CHPA White Paper, 2013). Findings from a national study indicate that nearly 3 million older adults are at risk for potential adverse reactions involving prescription medications and herbs or high dose vitamins (Eisenberg et al., 1998). In addition to potential drug interactions between pharmaceuticals and herbal remedies, other concerns about CAM include a patient's choice to delay a physician recommended treatment in favor of a CAM modality and thus possibly losing treatment time (Runfola, 2006). Furthermore, and specific to oncology patients, some CAM treatments have been

found ineffective or harmful to patients undergoing cancer treatments (Berman & Straus, 2004).

As with any other health care, the use of CAM is safest and most effective when coordinated with all medical treatment and discussed with a primary care provider. Unfortunately, patients often do not think of mentioning CAM use or decide not to discuss CAM with their primary healthcare provider (Astin et al., 2000; Foster et al., 2000; Cohen, Elk, & Pan, 2002; Sleath, Rubin, Campbell, Gwyther, & Clark 2005; Cheung, Wyman, & Halcon, 2007) or other medical specialists, for example oncologists (Richardson et al, 1999; Bourgeault I, 1996; Neogi and Oza, 1998) or cardiologists (Tachjian, A. et al, 2010).

There are a variety of reasons for this reluctance, including the fear or assumption that conventional medicine providers will not be knowledgeable about CAM therapies, as well as be dismissive of patient use of CAM therapies (Tasaki et al, 2002). Furthermore, studies indicate that many physicians feel uncomfortable discussing CAM with their patients. Reasons cited include a professional lack of knowledge about CAM, as well as a lack of evidence-based research to support it (Milden et al., 2004; Robinson et al., 2004).

Patient-provider communication regarding CAM use is essential. In order to monitor both the risks and benefits, a member of the medical team must be routinely assessing patients for CAM use. Social workers often work on inter-professional health care teams and may be in a unique position to assess older adults' use of CAM and to facilitate the integration of CAM and traditional treatments. Social workers are employed in a variety of medical settings, including hospitals and primary care clinics, home health care agencies, hospices, community mental health clinics, skilled nursing

facilities and dialysis centers. In all of these locations, social workers have advanced assessment and interviewing skills, and are in roles that could include various aspects of CAM. For example, social workers conduct a bio-psycho-social assessment that provides a comprehensive, patient-centered and holistic picture of the older adult that could include a discussion of CAM use. Social workers provide essential services for health education, disease prevention, and wellness promotion (Gehlert & Browne, 2006) that might include content on CAM. Social workers are typically given more time to interact with patients than other health care professionals, allowing them to cover topics others may not and build relationships that make patients more comfortable disclosing their use of CAM. Social workers have the ability to help a patient construct an illness narrative which can help the heath care team understand a patient's path to care including past and present use of CAM (Kleinman, 1988). In fact, research studies indicate that CAM users are service users – they are more likely to seek out therapies from multiple practitioners, including western medicine, making it quite possible that many patients already use some form of CAM (Astin, 1998; Eisenberg et al, 1993; Davis et al, 2011; Eisenberg et al, 1998). Furthermore, social workers see people from a wide range of socio-economic, ethnic and cultural backgrounds, increasing the likelihood that they will come in contact with older adults who may be CAM users.

Recent policy changes, such as the Affordable Care Act's push for interdisciplinary teamwork and the 2009 Mental Health Parity and Addiction Equity Act (MHPAEA), provide opportunities to increase social workers' role in health care teams and meet an increased demand for behavioral health services. Similarly, a growing movement to bridge behavioral health and primary care will increase social worker

contact with older adults in the health care system.

Given all of the forces described above, geriatric social work appears to be a context in which conversations about the use of CAM could be useful. At the present time, however, there is a paucity of information on whether and how these conversations currently take place or the extent to which social workers are aware of CAM and its potential benefits and risks. This research begins to fill this gap and is the first study that the researcher is aware of to interview social workers who work with older adults in multiple practice settings and to examine their understanding and use of CAM practices.

Overarching Goal of Study

The overarching goal of this study is to better understand social worker-patient communication around CAM through an examination of the extent to which geriatric social workers are aware of and incorporate CAM into their current practice and the factors that facilitate or inhibit their use of CAM with older adults. Findings from this study can inform future efforts to: 1) educate social workers about CAM, 2) develop effective and efficient means of assessing client CAM use, and 3) integrate CAM assessment and practice into the work of inter-professional teams.

In particular, this qualitative study explores the following questions:

(1) To what extent do geriatric social workers know about CAM and assess for CAM use in their practice?

(2) What factors facilitate or inhibit geriatric social workers incorporating CAM into their assessment or practice of CAM?

These questions are examined through two theoretical frameworks, medical pluralism (Kaptchuk & Eisenberg, 2001) and Ecological Systems Theory (Bronfenbrenner, 1979).

Organization of Dissertation

In addition to this introduction, the dissertation is comprised of the following chapters:

- Chapter Two: A review of the literature that connects CAM and geriatric social work using two theoretical frameworks: Ecological Systems Theory and Medical Pluralism.
- Chapter Three: The methodology including research procedures, sampling and interviewee outreach, the interviews, and how the data were analyzed.
- Chapter Four: Findings
- Chapter Five: Discussion (including limitations of the study).
- Chapter Six: Implications for social work practice, education, policy, research and inter-professional communication. Chapter 6 will also review directions for future research.

CHAPTER 2

LITERATURE REVIEW

This chapter looks at the literature most relevant to the topic of geriatric social work and Complementary and Alternative Medicine (CAM). A comprehensive review of the relevant literature is guided by two theoretical perspectives: (1) Bronfenbrenner's Ecological Systems Theory, and (2) Medical pluralism.

Theoretical Perspectives

Ecological Systems Theory. Ecological Systems Theory (Bronfenbrenner, 1979) focuses on how different environmental components interact and influence each other to affect human development. While this theory was originally developed to understand child development, it has also been used in other contexts. In the context of this dissertation, social worker-patient communication regarding Complementary and Alternative Medicine (CAM) is examined in relationship to Bronfenbrenner's five identified environmental systems (micro, meso, exo, macro, and chrono).

At the *micro* level components of an individual social worker's environment such as work setting, patients, colleagues, insurance and payment structure, agency policy and stated beliefs, patients' and colleagues' belief systems as well as the social worker's belief system may influence understanding of and communication around CAM. *Meso* refers to the interrelationships among these microsystems. For example, the social worker's belief in CAM may either agree or contrast with her colleagues' and patients' belief systems just as a patient's belief system may agree or disagree with professional opinions, e.g., a patient's belief regarding cannabis use may be counter to an agency's policies and the staff's beliefs around smoking in general and the use of medical

marijuana more specifically. *Exo* refers to the relationship between the social worker's microsystem and an outside system that is not directly connected to the social worker such as how a patient's views of CAM are influenced by his community, friends and relatives.

The *macrosystem* refers to the context encompassing any group ("culture, subculture, or other extended social structure") whose members share values or belief systems, "resources, hazards, lifestyles, opportunity structures, life course options and patterns of social interchange" (1993. p.25). In the context of this dissertation, the macrosystem refers to professional social work values, belief systems and social structures that may contribute to how social workers communicate about CAM. Social Work values and beliefs are outlined in the National Association of Social Work (NASW) code of ethics and operationalized through the Council on Social Work Education (CSWE), competencies that shape social work education and relevant social structures.

And finally, *chrono* refers to historical circumstances. Historical circumstances may include changes in professional and consumer attitudes and knowledge towards healing practices. This can include shifting cultural attitudes toward alternative practices and differences across age cohorts in beliefs about CAM (such as the potential influence of baby boomers on the national conversation about CAM use). These historical circumstances have the potential to affect the belief system on many levels: the social worker, the health care team, the institution, the patient and the patient's extended community of family, friends and community.

Medical Pluralism. The second guiding theoretical perspective for this dissertation is Medical Pluralism. Medical Pluralism refers to the belief and adoption of more than one medical system of care (Kaptchuk & Eisenberg, 2001; Baer, 2004). Baer states, "In contrast to indigenous societies, which tend to exhibit a more-or-less coherent medical system, state or complex societies exhibit the conflation of an array of medical systems—a phenomenon generally referred to by medical anthropologists, as well as medical sociologists and medical geographers, as medical pluralism" (p. 109). In other words, and in reference to the United States, medical pluralism refers to the presence of biomedicine, the primary health care system, as well as other healing practices. One key piece to the idea of medical pluralism is not just the "use" of more than one medical system, but whether a "belief" in more than one medical system exists among consumers, practitioners, and society as a whole (Kleinman, 1980, 1988).

This meshes well with Ecological Systems Theory. For example, at the micro level, medical pluralism is an acknowledgement of different health beliefs and practices of patients. At the exo level, a medical pluralistic approach means that health care professionals accommodate diverse health practices regardless of their personal beliefs about those practices (Tilbert & Miller, 2007). This, in turn, influences how health care professionals, including social workers, communicate with patients about CAM.

The concept of medical pluralism has been studied by a number of social scientists (Baer, H., 1995; Pescosolido & Kronfeld, 1995; Kelner, Wellman, Saks & Pescosolido, 2000; Gale, 2014). For example, Pescosolido and Kronfeld (1995) provide an historical analysis of medical pluralism in the 1960s and 1970s, including consumers'

frustration with the biomedical approach to chronic illness. The authors discuss the reasons why this frustration contributed to an increased movement toward individual pursuit of different paths to health care.

A number of researchers emphasize the politics around terminology and CAM (Gale, 2014; Raheim & Lu, 2014). Gale, a sociologist, argues that the naming process provides a window into the power and history of medical pluralism. Gale contends that the language around what we call CAM (alternative, complementary, folk, traditional, non-orthodox, etc.) matters and that "Biomedical dominance continues to frame the language with which we engage with issues of health, illness and healing" (p. 806). This question of language is also stressed by social workers Raheim and Lu (2014), who discuss how medical pluralism frames their understanding of healing and ultimately informs a course they developed for social work students about healing.

Raheim and Lu chose the term Integrative Mind-Body-Spirit Practice versus CAM to describe particular mind-body-spirit practices they are teaching social work students. Mind-body-spirit practices are guided by the principles of holism, multi-systemic connectedness, and balance, as opposed to Biomedicine's guiding principles of objectivism, reductionism, positivism and determinism.

At the macro level, biomedicine is clearly the dominant approach in health care in the United States in terms of research, education, practice, and insurance, but that has only been the case in the last 70 years. Biomedicine's role in U.S. health care changed drastically after World War II when the introduction of antibiotics, the discovery of medications to control blood pressure and treat hormonal imbalances, and medical advances, such as heart surgery, kidney transplantation, and artificial respirators

completely changed the landscape of medicine (Gawande, 2014). Up until that time, health care in the U.S. was more pluralistic. According to Gawande "medicine was just another tool you could try, no different from a healing ritual or a family remedy and no more effective" (p.70). Biomedicine has obviously made a huge contribution to improving and saving patients' lives and its importance cannot be overstated.

However, it is important for health care providers, including social workers, to recognize that it is not the only path to care and many people look to other healing systems. And yet, the structure of the US health care system, including what is reimbursed through health insurance and the type of research that is funded, continues to favor biomedical approaches to health care. As the main player in health care at the macro level, biomedicine often claims to be the singular authority of truth and fact over what is medicine. As a result, other approaches to health care are viewed as "other" and are, therefore, evaluated in comparison to the dominant paradigm.

Therapies under the CAM rubric, for example, are evaluated in biomedical terms related to reductionist, diagnostic, scientific, hierarchical, and evidence-based approaches. While evidence-based practice and rigorous testing of physical and behavioral health interventions are important for effective and efficient care, this level of testing does not always match the intended outcomes of CAM practices that focus on balance and holism rather than narrowly focused outcomes such as symptom reduction and the ability of patients to effectively meet their various societal obligations.

And yet, there is a growing body of research as well as significant cultural and historical tradition (for example, the longstanding cultural traditions of Chinese and Ayurvedic Medicine) that supports the significant influence of CAM on overall health

and well-being – outcomes that are less easily measured within the biomedical research paradigm, but that fit well with the strengths-based and holistic approach of social work. Furthermore, with "an understanding of patient belief systems, social workers and other health professionals can more effectively recommend treatments congruent with these ideologies, thereby making treatment adherence more likely," an outcome that is perfectly congruent with the current goals of biomedically-based health care (Cook et al, p.49).

At the micro level, patients are increasingly taking a pluralist approach to their own health care. Prevalence studies show that the use of CAM increased among adults aged 65 and over from 22.7% in 2002 to 29.4% in 2012 (National Health Statistic Report, 2015). In addition, research has consistently found that CAM users tend to be service users; that is, they use CAM in addition to mainstream biomedical care, rather than instead of it (Astin, 1998; Eisenberg et al, 1993; Eisenberg et al, 1998) reflecting a pluralistic view of health care.

The reasons individuals use CAM are also congruent with a multi-pluralistic approach. Studies indicate CAM users augment biomedical health care to improve health and well-being and relieve symptoms of chronic diseases, treat illness more "naturally," have more control over their health care, for cultural reasons, because their illness is not responding to conventional medicine or they are suffering from side effects, and because medication costs are too high (Astin, 1998, Tindle, Davis, Phillips, & Eisenberg, 2005; Eisenberg, Kessler, Foster, Calkins & Delbanco, 1993; Eisenberg, Davis, Ettner, Appel, Wilkey, Van Rompay & Kessler, 1998; Paramore, 1997).

At this juncture in time (chrono), there is a continuum of opinions towards

medical pluralism in the United States. On one end, there are medical professionals who write vehemently against CAM (Barett., 1993, Wahlberg, 2007; Barett, 2015), proposing that CAM is all quackery and consumers are all duped. On the other end, are the anti-biomedical activists, asserting that biomedicine promotes more harm than healing. In between these extremes are those who promote "alternative," "complementary," and "integrative" care.

Integrative care suggests a move to a more medically pluralistic approach. The integrative approach focuses on healing the whole person – body, mind and spirit. In parallel with patients' use of CAM and traditional medicine, in theory, integrative medicine combines conventional Western medicine with alternative or complementary approaches such as acupuncture, herbal medicine, massage, biofeedback, yoga, and stress reduction exercises. A number of integrative medical centers have been established in the last 15 to 20 years. For example, the Bravewell Collaborative, a private foundation which promotes integrative medicine programs, lists over 50 medical schools connected to their Consortium of Academic Health Centers for Integrative Medicine, including the University of California San Francisco Osher Center for Integrative Medicine, the University of Michigan Integrative Medicine Center, the Osher Center for Integrative Medicine at Brigham Women's Hospital in Boston, Massachusetts, and the University of Hawaii Program in Integrative Medicine. The number of hospitals that offer integrative therapies such as acupuncture, massage therapy, guided imagery and therapeutic touch has increased from 8% in 1998 to 42% in 2010 (Ananth, 2006). While some hospitals truly integrate care and the CAM modalities are covered under the same insurance guidelines as biomedical care, the number of integrative medicine centers that are truly

partnered with conventional medicine in traditional medical settings, is still somewhat small. Instead, a number of hospitals have an "integrative center" which may or may not be physically in the same hospital building or under the hospital name, but providers are different and many of the CAM modalities are not covered by insurance. Integrative care at the macro level, therefore, is still fragmented and overall the infrastructure (e.g., insurance coverage) does not fully allow it.

One exception is a movement in the Veterans Health Administration (VHA) towards integrative care. The VHA is the single largest health care provider in the country and has begun to offer integrative care to help address the high costs and poor outcomes associated with a population with chronic conditions and multiple service related conditions (War related illness brochure, VA, 2014). For example, in 2014, the Washington DC VA Medical Center Integrative Health and Wellness Program began to offer auricular acupuncture, Heartmath biofeedback, iRest Yoga Nidra, wellness massage, Mindfulness Based Stress Reduction (MBSR), qi gong/tai chi, reiki, and yoga in additional to traditional physical and behavioral medical interventions. One possible reason the VA is able to provide CAM might be because the VA is a closed system with freedom to offer therapies they deem important, despite the larger macro forces (e.g., insurance) at play. There is also building evidence that mind-body practices are effective in treating PTSD (Van Der Kolk, 2014), something particularly relevant to VA patients.

Shifts towards medical pluralism, whether at the macro or micro level, affect all health care professionals, including social workers. One of the most immediate challenges is the need for practitioners to increase communication with their clients about CAM, which provides the contextual backdrop for better understanding social worker-

patient communication around CAM.

With this backdrop in mind, the following literature review examines existing knowledge in social work and other health care professions about 1) the role of CAM in culturally competent practice; 2) patient-provider communication around CAM; 3) professional knowledge and attitudes towards CAM; 4) professional practice of CAM and 5) professional provider education about CAM.

The Role of CAM in Culturally Competent Practice

Cultural competency is a key component of service delivery across health care professions and is addressed in the research and education literature in nursing (Campinha-Bacote, J. & Munoz Dreher, C. 2002; Dreher, M. & MacNaughton, N, 2002; Maddalena, 2009), psychology, (Carter, 1998, 2000; Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994; Sue, D.W. 2001); substance abuse counseling (Finn, P., 1996; Simpson, D.W., 1997), medicine (Brach & Fraser, 2000; Betancourt, Green, Carrillo, Ananeh-Firempong, 2003; Kirmayer, 2013), and pharmacy (Shaya & Gbarayor, 2006; O'Connel et al., 2013) as well as social work (Boyle & Springer, 2001; Min, 2005; Rosario, & Chadiha, 2014).

Although each profession has slightly different approaches and emphases to incorporating culturally competent practices into teaching and practice, cultural competence across professions is "the ability to interact effectively with people from different cultures" (SAMHSA website, 2015) and common themes emerge across professions around how cultural competence is operationalized. These include understanding the impact of cultural context on health and illness (Sue, 2001; Betancourt, Green, Carrillo, Ananeh-Firempong, 2003); cultural biases and disparities in health and

health care across multiple domains such as gender, race and ethnicity, sexual orientation, socioeconomic status, and gender identity (APA cultural competency guidelines)applying cultural knowledge to various situations (Beach et al, 2005); social justice and advocacy at the individual, organizational, and societal levels (Betancourt et al, 2003); and cultural awareness and knowledge of self and others (Cushman et al, 2015). Cultural competency is one way in which health care assesses and acknowledges medical pluralism.

In social work, cultural competency is one of the ten core competencies taught in MSW education programs (CSWE, Educational Policy and Accreditation Standards). Cross-cultural knowledge, skill, and service delivery, specifically address the intersection of culture and social worker psycho-social assessment and community information and referral (I&R) and these standards guide social work education and social work practice. Social workers are expected to learn the cultural traditions and practices of the major patient groups they serve, use appropriate methodological approaches and techniques to reflect their understanding of patient culture in the helping process, and be knowledgeable about services and community based referrals available for diverse patient needs (NASW, 2001). Furthermore, because culture and language may influence how illness, disease, and their causes are perceived by the patient, social workers need to be sensitive and aware of differences.

While there is a large volume of literature related to cultural competency and social work practice (Boyle & Springer, 2001; Min, 2005; Rosario, & Chadiha, 2014), there is less written about cultural competency specific to CAM and even less written specifically in regards to social work with an older adult population. Nonetheless, findings from the broader literature are relevant to our understanding of cultural

competency in this context. For example, prevalence studies document significant CAM use by ethnic and disenfranchised populations (Arcury et al, 2007; Graham, Ahn, Roger, O'Connor, Eisenberg, & Phillips, 2005; Loera et al, 2001; Tsai, 2007). One potential reason for this may be related to cultural differences in expressions, and therefore treatment of, physical and mental illnesses. Social workers often work in settings that serve patients from ethnically diverse backgrounds. It is important that they consider how culture impacts patients' choice of medical care. For example, previous research suggests cultural differences in the expression of pain (Park, Manotas & Hooyman, 2013; Lavin & Park, 2014) and symptoms of mental distress and illness (Kleinman et al., 1978). These differences may be tied to cultural beliefs about the cause of illness or social stigma within some cultures around mental or other illness. A patient's cultural differences in his or her expression of pain may not appear in mainstream health care because a patient's belief in the stigma to experiencing pain or mental illness. As a result, perceived stigma around pain or mental illness may keep a patient away from receiving mainstream health care and in turn, a reliance on CAM treatments. For geriatric social workers, this is of particular importance. For many older adults, there is a stigma in seeking mental health treatment. Many alternative treatments are grounded in the cultural practices of particular ethnic groups and the older adults in the community are often the ones with the knowledge of and belief in these treatments. As older adults may be the keepers of cultural knowledge, understanding CAM and older adult use is important cultural competency for the geriatric social worker.

Few social work articles about CAM specifically address cultural competency in general, nor specifically regarding social work assessment and practice in health care

settings. Runfola, Levine and Sherman (2006) state "Social Workers are cognizant of the cultural, religious, ethnic, and racial factors which influence individual beliefs, and the folk practices (so called 'traditional medicine') used by certain groups for self-treatment" (p.89), suggesting social workers already approach assessment with a culturally competent eye. Finger and Arnold (2002) also suggests "social workers bring a sensitivity to and experience with cultural diversity that can be used to adapt intervention protocols to meet the needs to ethnically diverse groups" (p. 72). None of the articles on social work and CAM discuss how the field of social work can help students or practitioners learn more about cultural competency – the assumption is that social workers bring a culturally competent approach to care and therefore are adept at all cultural considerations in assessment.

Patient Provider Communication

Patient-provider communication regarding CAM is essential for a number of reasons, including a high risk of drug interaction between pharmaceuticals and herbal therapy or over the counter supplements. A recent New England Journal of Medicine article estimated that at least 23,000 emergency room visits that occurred in the United States from 2004 to 2013 were attributed to adverse events related to the use of dietary supplements (Geller et al., 2015). Twelve percent of these emergency room visits were by adults 65 and older.

Despite the potential dangers, research indicates that patients do not discuss CAM with their usual healthcare provider (Izzo & Ernst, 2001; Rockwell, Liu, & Higgins, 2005; Sparreboom et al., 2004), and care providers do not often ask patients about CAM use (Astin et al., 2000; Foster et al., 2000; Cohen, Elk, & Pan, 2002; Sleath, Rubin,

Campbell, Gwyther, & Clark 2005; Cheung, Wyman, & Halcon, 2007; Elder et al, 2015). One study found that only 28% of CAM users disclosed their use of CAM to their physician (Eisenberg, 1993), although this number is higher (42-53%) in studies specific to older adults (Astin et al, 2000; Cheung, 2005; Foster et al, 2000; Najm, 2003).

The reasons for not communicating with a provider about CAM vary. Some patients may not mention CAM if the health care practitioner does not raise the topic (Roberts et al, 2005). Patients also express a fear of disapproval or another negative response (Tasaki et al, 2002) or believe that the practitioner would not know anything about CAM and therefore could not advise them (Adler et al, 1999, Wetzel, Kaptchuk, Haramati & Eisenberg, 2003). For their part, physicians assume that if the patient does not mention CAM it is not important to them and therefore will not raise the topic themselves (Richardson et al, 2004).

In the social work literature, discussion of CAM with patients most often appears in the context of oncology (Cook, Becvar & Pontious, 2000; Hann, Baker, & Denniston, 2003; Goldstein, 2003; Runfola, Levine & Sherman, 2006). These studies have found that social workers are the provider most likely to discuss CAM with patients in oncology settings (Joyce, 2004; Hann, Baker, Denniston, & Winter, 2004) and that doctors are more likely to refer patients to social workers or support groups for CAM information rather than discussing alternative treatments directly with clients themselves (Roberts, 2005). Other themes that emerge from this literature include the importance of strong communication between the social worker and other members of the team, the social worker as the patient's advocate to the team, and the need for social workers to educate themselves about CAM and to network with CAM practitioners to know referral sources.

Open discussion about CAM is especially important in the context of oncology where alternative supplements can interfere with mainstream cancer treatments. St. John's Wort, for example, can reduce the effectiveness of some cancer treatments (Nightingale et al., 2015).

Communication training is also discussed. Runfola et al. (2006), also writing from the oncology setting, discuss how social workers can increase communication efficacy about CAM between patients and physicians. Specifically, social workers can act as patient advocates on the health care team. While doctors and nurses aim to provide a safe and accepting space for patients to discuss their illness, including concerns regarding treatments and possible side-effects (the context in which discussions of CAM often emerge), their time for these conversations is limited. Social workers have more time with patients and families and are therefore in a better position to review what the patient has heard, provide on-going emotional support and help the patient and family clarify information given by the medical provider. Furthermore, the social worker can help patients navigate any potential worries they have communicating with their physician, and then either help them find the tools to overcome these fears or advocate on the patient's behalf around the potential of alternative treatments.

Communication about CAM also involves creating a "nonjudgmental environment" to encourage open discussion (Cook, p.50) and knowledge of CAM so social workers understand to what a patient is referring. Incorporating CAM into the conversation is a natural fit with the traditional role played by social workers in health care, which includes facilitating communication between patients, families, and health care teams (Gehlert & Brown, 2006). It also is consistent with an increasing emphasis

within health care on patient health literacy and activation. Improving patients' ability to understand their health care issues, effectively care for themselves, and navigate the health care system is a key component of patient-centered approaches to care. Low health care literacy is a potential driver of health care disparities, poor health outcomes, high health care costs, and health communication problems (Liechty, 2011), and social workers play a key role in promoting and implementing health literacy strategies. CAM is potentially one piece of health management and patient activation since patients can access many alternative approaches to care, such as yoga or mindfulness meditation, without professional help or with a limited amount of professional guidance at the beginning. In a medically pluralistic approach to health care, efforts to improve health literacy would incorporate assessment and understanding of patients' belief and value systems related to alternative care.

One approach to social worker-patient communication within the context of CAM is the use of routine, in-depth bio-psycho-social-spiritual assessments that are both holistic and spiritually oriented. Also known as an integrative assessment, this approach is an expanded version of traditional social work assessment and has the potential to complement conventional clinical intakes and social histories with client information on stress and coping strategies, spirituality, client lifestyle choices, and health care prevention choices (Gant et al., 2009). This integrative assessment would be appropriate for a number of practice settings that employ geriatric social workers including but not limited to hospital in-patient and transition care, hospice and palliative care, oncology, primary care, adult day care, skilled nursing residential and rehabilitation facilities, dialysis, and home-health care. Most of these settings include an interdisciplinary health

care team where social workers are responsible for gathering a social history. This literature review did not find any research that evaluates the use of an expanded assessment.

Professional Knowledge and Attitudes Towards CAM

This section will look at social worker knowledge of and attitudes towards CAM, as well as the knowledge of and attitudes towards CAM within the fields of nursing, psychology, and medicine.

The most detailed assessment of social worker knowledge and utilization of CAM is over 15 years old (Henderson, 2000) and surveyed 321 NASW members who worked in mental health (62%), in schools or with families (11.8%), in health care (11.2%), as well as other unspecified areas (15%). There is no indication of how many of those surveyed worked specifically with older adults. The survey included questions related to 1) social worker knowledge of alternative treatment modalities, 2) the number of clients treated with or referred for alternative techniques, and 3) social worker ratings of the helpfulness of these technique. Respondents were most familiar with mind-body techniques with over 80% reporting "great" or "moderate" knowledge. Approximately 50% of respondents had moderate to great knowledge of manual healing techniques such as chiropractic medicine, massage, acupressure, or osteopathic medicine, as well as diet and nutrition. The majority (85.4%) had little or no knowledge of botanical, pharmacological, and biological alternatives.

These patterns were similar in relation to treatment and referral. Respondents used mind-body techniques directly with clients or referred them for these treatments more than any other type of alternative treatment. Interestingly, while over half (59.1%)

reported using mind-body approaches directly with clients, only 30% of those reported "substantial" or "great" knowledge of the technique.

As the only one of its kind, this study is an important contribution to our understanding of CAM in social work practice. There are several limitations in this study that this dissertation directly attempts to address. First, it is not clear from this study where or how respondents learned about CAM. This is an important gap in light of the discrepancy between reported knowledge and use of mind-body practices with clients. Second, there are no data on why social workers do or do not use alternative therapies in practice. Third, the survey does not distinguish whether a CAM treatment was referred by the social worker or if the social worker provided the CAM treatment directly themselves. This dissertation builds on Henderson's work by exploring these questions in more depth.

Little else has been published regarding social worker knowledge and social worker utilization of CAM. One social work study (N=212) looked at social worker knowledge of non-pharmacological pain management techniques, modalities, which fall under the CAM rubric (Sieppert, 1996). This study indicated social workers were favorable towards learning non-pharmacological pain management techniques but displayed low levels of knowledge towards chronic pain and pain management.

There is more extensive literature on professional attitudes toward CAM. One literature review (Sewtich et al,, 2008) looked at 21 US and Canadian surveys of physicians, nurses, public health professionals, dieticians, social workers, medical/nursing school faculty, and pharmacists regarding a number of topics related to CAM. Seventeen of the studies were conducted in the United States and 4 in Canada.

Topics included personal use, personal beliefs on CAM efficacy, patient-provider communication regarding CAM, and knowledge of CAM. Of these 21 reviewed studies, only two studies included social workers (Brems et al., 2006; Hann, Baker & Denniston, 2003). Because of the variation in surveys, comparisons were difficult, although in general, physicians were less positive toward CAM than other health care professionals; younger and more recently trained physicians were more likely to recommend CAM compared to their older colleagues, as well as more positive attitudes among female health professionals than male.

One survey of oncology professionals (physicians, nurses, and social workers) (Hann et al., 2003) looked at different professional familiarity with and attitudes toward CAM and assessed their beliefs regarding patient use of CAM to aid in cancer recovery. Findings indicated that social workers were familiar with more therapies (80%) than nurses (76%) and the nurses were more familiar with therapies than physicians (72%). Another finding was that oncology social workers had the most supportive attitude, stating they would support patient use of 89% of the CAM therapies with which they were familiar, versus nurses (85%) and physicians (58%).

Medical student attitudes towards CAM (Abbott et al., 2011) were mostly positive and more than half endorsed the importance of CAM. Less than half of the medical students surveyed reported using CAM (38%) themselves, and 61% felt that medical school did not provide adequate training in CAM. Respondents said even when CAM classes were offered, classes were not always evidence based so the students did not take the information seriously and classes were dogmatic, either heavily pro or against CAM.

In addition, even if the medical school offered coursework in CAM, these classes were electives and only 17% respondents took the courses.

Professional Practice and CAM

This section will look at (1) outcome studies of mind-body practice (CAM modalities that fall within the social work scope of practice); (2) the use of mind-body interventions in social work practice, and (3) the role of CAM practice within the fields of nursing, psychology, and medicine, and how these professions have incorporated CAM into their practice.

Mind-body techniques are most compatible with social work training and skills and are the approaches that Henderson found to be most familiar to social workers (Henderson 2000). One of the more commonly used of these approaches is Mindfulness Based Stress Reduction (MBSR), a meditative practice, which bridges Eastern philosophy, Western psychology, and neuroscience to help people with issues around anxiety and pain. There is a vast amount of scientific literature that looks at the clinical application of MBSR including a handful of studies focusing on older adults. The results from these studies are mixed. MBSR has been found to have positive effects on physical and emotional well being among institutionalized older adults (McBee, 2008; Prewitt, 2000; Smith, 2006) and in helping older adults manage chronic pain and pain from fibromyalgia (Morone, Greco, and Weiner, 2008; Morone et al, 2008; Prewitt, 2000). Findings on MBSR in the treatment of anxiety and depression in older adults are mixed (Smith, 2006). Other studies that use mindfulness mediation and relaxation have found positive results in terms of quality of life, well-being and energy (Moye & Hanlon, 1996), and reduction in agitation and behavioral problems and reduced depression symptoms

among older adults in nursing homes (Lindberg, 2005), including older adults with dementia (Lantz, Buchalterm & McBee, 1997).

Finger and Arnold (2002) review literature on the use of various other stress-reduction techniques in social work with adolescents and young adults. Finger found that stress reduction skills like meditation are particularly empowering for the clients because the practice can be maintained between sessions and continued once the client/social worker relationship ends. Finger writes that empirical support exists for the use of meditation (Kabat-Zinn, Lipworth, Burney & Sellers, 1987; Sharpiro, Schwartz & Bonner, 1998), progressive muscle relaxation (Bernstein & Borkovec, 1973; Rankin, Gilner, Gfeller & Katz, 1993), biofeedback (Wenck, Leu & D'Amato, 1996; Buckelew et al., 1998), and guided imagery (Mannix, Chandurkar, Rybicki, Tusek & Solomon, 1999; Sloman, 1995). However, Finger and Arnold note that while a few social worker published articles promote social worker mind-body practice, there is a visible absence of social work outcome studies that provide evidence to support use of mind-body interventions to social work practice. Finger's work is not applicable to work with older adults.

Since Finger and Arnold's article, a few CAM outcome studies were published by social work researchers. These studies have looked at social worker led interventions in variations of MBSR (McBee,Westreich & Likourezes, 2004), MBCT (Foulk et al,2014) and relaxation techniques (Lee, Leung, & Leung, 2009). Behrman and Tebb (2009) discuss practice based research supporting the benefits of yoga for older adults but the outcome studies are not led by social work.

An unpublished systematic review of integrative Body-Mind-Spirit (I-BMS) practices (CAM modalities) (Lee, Liu & Wang, CSWE Conference, October 2016) identified 32 RCTs with positive outcomes for stress, 27 RCTs with positive outcomes for depression, and 16 RCTs with positive outcomes for anxiety. These studies included a range of populations (children, older adults, college students, health professionals, caregivers, veterans, and refugees) and CAM modalities including yoga, meditation, relaxation, acupressure, massage, Tai Chi/Qigong, and spirituality based programs. The systematic review included studies from multiple disciplines.

Use of mind-body interventions in social work practice. Specific to work with older adults, much of the social work literature pertaining to CAM and older adults is connected to care in skilled nursing homes. Complementary therapies in these settings range from music and art therapy to aromatherapy to healing touch, typically implemented by the activities department. CAM use is discussed in social work literature (McBee, 2003) for self-care, both for paid caregivers and for family caregivers. Providing care for a family member or as a professional caregiver can be stressful and contribute to feelings of anxiety or depression (McBee, 2003). A number of studies have been published on mind-body practice with institutionalized older adults as well as with formal and informal caregivers (Lantz, Buchalter & McBee, 1997; McBee, 2003; McBee, 2003; McBee,Westreich & Likourezes, 2004; McBee, 2008; Epstein-Lubow, McBee, Darling, & Armey, Miller, 2011). This research documents reductions in depressive symptoms and an increase in mindful attention and calmness among family caregivers (McBee, 2003).

Additional articles about CAM modalities in skilled nursing facilities review

"Namaste programs" (Simard & Volicer, 2010; Simard, 2013; Stacpoole, Hockley, Thompsell, Simard, & Volicer, 2014), the name given to a compilation of CAM modalities such as healing touch, music therapy, and aromatherapy into a small spa-like atmosphere within a skilled nursing facility for residents experiencing late-stage dementia. Research shows a significant reduction in agitated behavior and a reduction in the use of anti-psychotic medications, which are routinely given to nursing home residents to reduce agitated behavior.

Cheung (1999) looked at a joint social work and massage therapy intervention (N=6) to improve the physical functioning of nursing home residents. Three of the six residents showed significant improvement. The researchers suggest that physical improvements for this population are largely influenced by the individual's physical and mental capabilities.

Role of CAM Practice Within the Fields of Nursing, Psychology, and Medicine

CAM modalities are included in the fields of nursing, psychology, and medicine. The nursing field (Helms, 2006; Hayes, 2008) has had a long history of incorporating CAM into practice, including massage, aromatherapy, guided imagery, and meditation and healing touch. CAM practices have been used to help reduce anxiety related to surgery and illness, help to reduce pain, and to reduce agitated behavior.

Spirituality and Prayer throughout health care. Research on the relationship of spirituality and health care practice has grown in the last 20 years. Across health care professions, research has looked at how spirituality is defined, especially in contrast to religion. Religion is linked to formal religious institutions whereas spirituality does not depend on a collective or constitutional context (George et al; 2000). Mauk and Schmidt

(2004) define spirituality as abstract, the core to a person's being that helps to shape their relationship with G-d or a higher being - in contrast with religion, which is an organized set of beliefs. Canda and Furman (2010) state health care professions (nursing, social work, counseling) see spirituality as distinct from religion, but that social sciences such as anthropology blend the two together.

Different health care professions have researched the role of spirituality in health care. The nursing field (Lipson, Dibble & Minarik, 1996; Mauk & Schmidt, 2004) has completed extensive research on the role of the spirituality in nursing. Guides to providing spiritual care in nursing, including a guide to understanding different religions and how people who practice different religions might view topics such as suffering, end of life care decisions, hope, and forgiveness. Counseling (Bruce, 2000; Eck, 2002), clinical psychology (George, L.K. et al, 2000); psychiatry (Koenig, H., 2002) and social work (Canda, 1998; Ai, 2002; Parker et al, 2002; Murdock, 2005; Canda & Furman, 2010) have looked at the importance of the patient-provider relationship, spiritual assessment, and different spiritual interventions.

Professional Provider Education and CAM.

This section will look at (1) reasons to include CAM in the social work curriculum; (2) examples of course work on CAM in social work education; and (3) a review of CAM education in the fields of nursing, psychology, and medicine.

The role of CAM in social work education is sporadically seen in the literature over the last thirty years (Berkman, 1984; Collins & Shannon, 1988; Henderson, 1994; Keefe and Turner, 1996; Starak, 1984; Turner, 1996; Dziegielewski, 2003; Wolf, 2003; Gant et al., 2009; Napoli et al, 2011; Behrman, 2012; Raheim & Lu, 2014). Scholarly

articles that address CAM and social work education argue CAM information should be included in formal social work curriculum (Gant et al, 2009; Raheim & Lu, 2014; Tebb, non-published 2015). Studies show that social workers typically learn about CAM through their own personal practice and experience, versus in a traditional social work classroom or field training (Behrman & Tebb, 2009). Scholars cite a number of reasons why CAM knowledge should be obtained within the classroom: 1) In connection with student cultural competency (Gant, Benn, Gioia, & Seabury, 2009; Raheim & Lu, 2014); 2) learning clinical assessment and communication skills that facilitate CAM disclosure (Runfola et al, 2006; Cook et al, 2000), 3) teaching CAM skills within the social worker scope of practice (Finger & Arnold, 2002; Henderson, 2000); 4) belief in a multiple pluralistic healing system (Raheim & Lu, 2014), and 5) social worker self-care (Brenner & Homonoff, 2004; Birnbaum, 2008; Lynn, 2009).

At present time the majority of schools of social work in the United States do not teach students about CAM. Tebb et al. (2014, unpublished study) looked at the current status of Integrative – Mind-Body-Spirit (I-MBS) practice in social work education. (I-MBS refers to a number of the mind-body practices under the CAM umbrella). In 2014, they surveyed MSW programs and whether they provide any information on I-MBS practices in their MSW curriculum or whether any I-MBS courses are offered at their school. Fifty-six MSW programs responded to the survey out of the 231 accredited MSW programs contacted. Of the 56 schools that responded, slightly less than a quarter (21.43%) include coursework on mindfulness, 26.79% have coursework on spirituality, 19.64% in either art, play, or music therapy, and 10.71% in stress reduction. The authors included "CAM" as a separate category and only 7.14% identified coursework in CAM,

possibly indicating that they did not understand the term CAM. Schools that indicated they do not offer CAM/I-MBS coursework identified the top following reasons: 1) not able to add more content to curriculum (53.85%), 2) lack of resources (38.46%), and 3) lack of faculty expertise (34.62%).

Inclusion of CAM in the social work curriculum has included social worker knowledge of CAM for self-care and for use of self in the therapeutic relationship. For example, educators have looked at the value of mindfulness training to increase social worker students' ability for self-awareness, to pay attention to the use of "self" in the therapeutic relationship, and to remain present with clients (Brenner & Homonoff, 2004; Birnbaum, 2008; Lynn, 2009). In this case, the purpose to train students in CAM modalities such as meditation and mindfulness is not in order for the social worker to teach the modality to a client experiencing stress, anxiety or pain, but as a tool to increase the social work student's ability to remain connected and present with the client.

A popular textbook on social work practice with older adults (McInnis-Dittrich, 2014) has included a chapter on CAM since the book's first edition in 2002. The chapter focuses on interventions such as music, art, recreation, massage, and animal-assisted therapies. There is no mention of other practices such as herbal remedies, energy and biofield manipulation, and reflexology, because they lack a strong enough evidence base (e-mail conversation, Dr. McInnis-Dittrich, January 11, 2015). The interventions are described in general for social work referrals versus direct practice. All of the studies included in the chapter are from non-social work disciplines.

CAM in Social Work Curriculum. Gant et al. (2009) describe two graduate level social work courses offered at the University of Michigan School of Social Work -

"Complementary, Alternative, and Indigenous Healing Systems" and "Mind/Body Practice Based Skills." The first course addressed cultural competency and the authors suggested that "armed with knowledge of healing traditions, social workers would be more likely to show cultural sensitivity with various client groups and to collaborate with alternative healing practitioners." The second course was offered to give students the opportunity to "learn, experience and practice a specific set of empirically based mind-body skills" (p. 414). This course was based on an interdisciplinary course originally created and taught at the Center for Mind-Body Medicine and adapted for social work students.

Raheim and Lu (2014) designed a course entitled Integrative Social Work Practice – Mind-Body-Spirit Approaches. This course intended to introduce students to I-MBS practice and to encourage social work critical discourse related to integrative and allopathic approaches to health care and personal well-being. The authors administered a pre and post test to students (n=37) which showed a significant increase in students' perceptions of their knowledge of I-MBS/CAM practices and application of I-MBS/CAM in professional practice and cultural competence.

CAM in nursing, psychology, and medical curriculum. The arguments to include CAM education within health care curricula vary by profession, but each profession includes the increased use of CAM by consumers as the number one reason for their discipline to be knowledgeable about CAM (Wetzel, 2003; Helms, 2006; Cowen & Cyr, 2015). Articles in support of including CAM within the nursing curricula state a professional goal for holistic practice, nursing knowledge of CAM for adequate assessment of herbal therapies, and the importance to learn modalities within the scope of

nursing practice (massage, aromatherapy, mind-body practice). (Helms, 2006). Helms states that as of 2006, most nursing schools relegated CAM education to elective coursework and only a few nursing schools included CAM within their required curriculum.

Surveys of medical schools indicate a range of CAM-related coursework in the last 18 years (Wetzel, 2003; Cowen & Cyr, 2015). A 1998 survey indicated 64% of medical schools offered at least one course in CAM in contrast with 84% in 2002 and 51% in a 2015 survey. The surveys either suggest less enthusiasm at present for CAM in medical school education or a possible bias in over reporting in previous surveys. In contrast to nursing schools, reasons to include CAM in medical school education included 1) learning about CAM will foster positive attitudes towards CAM, 2) helping physicians better counsel patients about health choices, and 3) studying CAM will help physicians to identify evidence based CAM practices for which they can make referrals as needed (Cowen & Cyr, 2015). Similar to social work, a number of the medical school courses on CAM focus on student self-care.

There is less written about coursework about CAM in psychology. A number of psychology programs include mind-body practices in their curriculum, but similar to medicine, nursing, and social work, CAM is still taught at an elective level versus integrated into their curriculum.

What is missing throughout much of the literature is a specific focus on how this professional knowledge and practice of CAM connects to work with an older adult population. This dissertation begins to fill this gap through an in-depth look at how geriatric social workers understand CAM, both for assessment and practice.

CHAPTER 3

METHODOLOGY

The IRB determined the study was "exempt" on April 17, 2014, and no further action was recommended or needed (See Appendix A for IRB).

Sample

For this qualitative research pilot study, 39 semi-structured interviews were conducted with a non-random purposive sample of geriatric social workers from four different geographical regions. The four geographical regions included parts of Michigan (Greater Lansing, Ann Arbor, Grand Rapids); the San Francisco Bay Area; Greater Boston, and Honolulu, Hawaii. These four regions were chosen because of their variation in terms of CAM insurance coverage, racial/ethnic diversity of older adults, and population use of CAM. In addition, practical reasons, including access to contacts to interview, were considered.

This study used a snowball sampling technique where the first identified subjects were asked to give the names of other people who possess the same attributes they do (Berg, 2009). Initial respondents were recruited through phone calls and e-mails (See Appendix B for sample e-mail) to the following key people in the targeted regions: 1) Social work directors in specific health care settings (hospitals, skilled nursing facilities, dialysis centers, hospice and palliative care, PACE and ADHC programs, community mental health, primary care and geriatric assessment centers, gero-psychiatric and out-patient oncology); 2) professors or field-office directors at Schools of Social Work; 3) NASW, and 4) the researcher's personal contacts. Social media was helpful in Boston,

MA on a (non-social work specific) parent list-serve, in Honolulu on a social worker skilled nursing facility list-serve, and in the Bay Area on a medical social worker list-serve. (See Appendix C for response rate table).

All participants were told in advance that the interviews would be audio-recorded, confidential, and would last approximately 60 minutes. The researcher received a grant after data collection began in order to provide gift cards in harder to reach communities, particularly in Boston and Honolulu. All interviewees in Boston and Hawaii and the last 3 San Francisco participants received $20 gift cards (Starbucks or Jamba Juice), which were helpful for the researcher to gain saturation. Hawaii was a particularly difficult community to reach participants, however it is not clear if the gift cards made much of a difference. Obstacles to reach participants in Hawaii were partially related to outsider status, which is especially pronounced in Hawaii, and individual hospital policies. For example, one hospital asked for a copy of the IRB and outreach materials. After reviewing the materials, hospital staff did not believe their social workers could contribute to the study because they do not assess for or use CAM. In general, the $20 gift cards helped to encourage participation, but this researcher does not believe it was the only variable that swayed interviewee's decision to participate. Overall, reasons given for participation in the study included an interest in CAM, an interest in helping a fellow social worker, and a belief that social workers are not included in enough research studies. Data collection took place during the following time periods: Michigan (May 29, 2014- September 8, 2014); SF Bay Area (August 7-13, 2014 & August 21-24, 2015); Honolulu (December 22, 2014-January 8, 2015); and Boston (April 1-April 8, 2015).

Characteristics of participants. Thirty-nine social workers were interviewed. All of the respondents have an MSW and the majority are licensed within their state. The average age of the respondent is 43 years old. The majority of the respondents identify as Christian, Catholic, or Jewish; others identified as either Atheist, Buddhist, Unitarian or no religion at all. Most of the respondents are Caucasian; others identified as Asian, Latino, Native American, and Native Hawaiian. Thirty-seven of the 39 respondents are women. Respondents graduated from MSW programs between the years 1979-2014. Undergraduate degrees include BSW (7), Psychology/Sociology (21), Human Development (2), Anthropology (2), Women's studies (2), History (2), Public Administration (1), Music (1), and Adult Education and Organizational Development (1). Two of the respondents also studied gerontology as a minor or as a certificate degree.

Respondents are employed at the following health care settings: Skilled Nursing Facility/Rehab/Assisted Living, Dialysis, Hospice, In-patient Hospital, Oncology, Primary Care, Geriatric Clinic, Dementia care, Palliative Care, Adult Day Health Care/PACE model, Counseling (CMH), and Out-patient Neurology. Table 3 describes the breakdown between region and health care setting.

Characteristics of settings. The interviews took place in a wide range of settings. The diversity of the setting included the geographical boundaries (rural, urban, suburban) and the socio-economic and racial/ethnic diversity of the populations served. All interviews took place at settings where at least 50% of the client population was aged 65 or older. If a setting did not have a majority of older clients it is described as 'mixed age'. The following section describes the settings where interviews took place.

Table 1*:* Health Care Settings via Region

Region	Hospice	In-patient hospital	Palliative Care	Dialysis	SNF/ Assisted Living	Neuro	Onc	CMH	Geriatric clinic /Primary Care	ADHC/ PACE	Total
Michigan	1			1	2	1	2		3		10
Greater Boston		1	2		2	1		1		3	10
SF Bay Area	2	1	1			1	1		2	1	9
Hawaii	1	2	1	2	2		1			1	10
Total	4	4	4	3	6	3	4	1	5	5	

Hospice

- Michigan: Not-for profit hospice serving rural, suburban and urban region; socio-economically diverse; primarily Caucasian and Christian reform patients; mixed age population.
- SF Bay Area: 1) Managed care hospital-run hospice serving suburban and urban region; socio-economically and ethnically/racially diverse; mixed-age population; 2) Non-profit hospice serving rural, suburban and urban region; socio-economically diverse and ethnic and racially diverse mixed-age population.

- Hawaii: Non-profit Hospice serving rural, suburban and urban region, including greater Oahu and Molokai Island; socio-economically diverse and ethnic and racially diverse mixed-age population.

In-patient Hospital (including in-patient palliative care, ICU and Emergency Room Care)

- Greater Boston: Large teaching/research hospital serving suburban and urban region. Socio-economically diverse and ethnic and racially diverse mixed-age population.
- San Francisco Bay Area: Small hospital serving urban area and socio-economically diverse and ethnic and racially diverse mixed-age population. Social worker worked primarily with low-income and ethnic and racially diverse mixed-age population.
- Hawaii: Mid-size teaching/research hospital serving rural, suburban and urban region. Socio-economically diverse and ethnic and racially diverse mixed-age population.

Palliative Care (out-patient)

- Greater Boston: mid-size managed care insurance company which provides home-care/hospice/palliative care and behavioral health to residents across Massachusetts. Socio-economically diverse and ethnic and racially diverse mixed-age population.

Dialysis

- Michigan: Mid-size corporate run dialysis center serving rural, suburban and urban region. Socio-economically diverse and ethnic and racially diverse mixed-age population.
- Hawaii: 1) Large corporate run dialysis center serving rural, suburban and urban region. Socio-economically diverse and ethnic and racially diverse mixed-age population. Multiple languages spoken at center. 2) Mid-size corporate run dialysis center serving suburban and urban region, socio-economically diverse and ethnic and racially diverse mixed-age population. Multiple languages spoken at center.

Skilled Nursing Facility/Assisted Living

- Michigan: 1) Mid-size skilled nursing facility serving rural, suburban and urban region. Primarily Caucasian and Christian clientele; socio-economically diverse, but primarily middle-class older population; 2) Small assisted living center located on an Indian tribe reservoir. Serving rural region for Native American older adult community.
- Greater Boston: 1) Large assisted living/senior housing serving urban/suburban region. Primarily Jewish/Caucasian residents. Socio-economically diverse; 2) Small skilled-nursing facility serving suburban region. Primarily Jewish/Caucasian residents. Socio-economically diverse.
- Hawaii: 1) Large skilled nursing/assisted living facility serving suburban region. Socio-economically wealthy. Diverse ethnic/racial residents; 2) Small skilled nursing program serving very small population of elderly Hawaiian residents who have lived many years with Hansen's disease (leprosy).

Neurology

- Michigan: Partnership between Alzheimer's Association and large teaching/research hospital. Serving suburban and urban region, socio-economically and racially/ethnically diverse mixed-age population.
- Greater Boston: Large teaching/research hospital outpatient program. Serving suburban and urban region, socio-economically diverse and ethnic and racially diverse mixed-age population.

Oncology

- Michigan: 1) Radiology clinic out of mid-size hospital serving rural, suburban and urban region. Socio-economically diverse and ethnic and racially diverse mixed-age population; 2) Radiology clinic out of small hospital Serving rural, suburban and urban region. Socio-economically diverse and ethnic and racially diverse mixed-age population.
- San Francisco Bay Area: Oncology clinic out of large managed care hospital serving suburban and urban region. Socio-economically diverse and ethnic and racially diverse mixed-age population.
- Hawaii: Private oncology office serving suburban and urban region. Socio-economically diverse and ethnic and racially diverse mixed-age population.

Community Mental Health

- Greater Boston: Mid-size community mental health office serving 5 counties outside of Boston. Socio-economically diverse and ethnic and racially diverse older population.

Geriatric Clinic/Primary Care

- Michigan: 1) Geriatric clinic housed in large teaching/research hospital serving rural, suburban and urban region; socio-economically diverse and ethnic and racially diverse older population; 2) Geriatric clinic housed in large teaching/research hospital serving rural, suburban and urban region. Socio-economically diverse and ethnic and racially diverse older population; 3) Primary Care clinic housed in mid-size clinical center serving a rural, suburban and urban region and socio-economically diverse and ethnic and racially diverse mixed-age population.
- San Francisco Bay Area: 1) Mid-size geriatric clinic providing integrated care; serving urban region and socio-economically low-income and ethnic and racially diverse older population; 2) Geriatric clinic providing complex care within a managed care out-patient care setting; socio-economically low-income and ethnic and racially diverse older population.

ADHC/PACE programs: (Adult Day Health Care & Program for All-Inclusive Care for the Elderly)

- Greater Boston: 1) Two interviews took place at a large size PACE program which serves an urban, socio-economically low-income and ethnic and racially diverse older population; 2) a small PACE program serving an urban socio-economically low-income and ethnic and racially diverse population; a large number of clients served are younger and need behavioral health than typical PACE program.

- San Francisco Bay Area: a mid-size PACE program serving a suburban and urban socio-economically low-income and ethnic and racially diverse older population.
- Hawaii: a mid-size ADHC connected to a skilled nursing facility an urban, socio-economically diverse and primarily Asian older population.

Interviews

Interviews took place in a number of different locations including a participant's place of employment (private office or conference room), coffee shop/restaurant, public library, or a participant's home. After introductions, participants were given a copy of the informed consent form and asked to read the consent form (See Appendices D & E for consent forms). Per IRB's request, participants were asked to not sign the consent form in order to further protect their confidentiality, but were told that they provided consent by continuing to participate in the interview.

The interviews were open-ended and semi-structured and lasted 45 to 90 minutes. The interview included three parts (See Appendix F for interview questions): (1) Interviewer questions regarding their current job; (2) participant completion of a CAM modality checklist (See Appendix G for CAM modality checklist); and (3) interviewer questions specific to CAM. Parts 1 and 3 of the interview were audio-recorded.

The first part of the interview included questions regarding the social worker's job, specifically practices related to assessment, day-to-day practice interventions with clients, and information about their role working on an interdisciplinary team.

In part two of the interview respondents were asked to review a checklist of 47 different CAM modalities and to indicate the ones they were familiar with and the ones they believe their clients/patients utilized. The majority of the CAM modalities on the

check-list fall into one of the five different CAM categories described by the NCCIH: 1) Mind body Practice, 2) Whole Medical Systems, 3) Pharmacologically or Biologically based practice, 4) Manipulative and body based practice, or 5) Energy Medicine. A sixth category for spiritual practice was also added because it has been included in previous surveys about CAM use.

In the third part of the interview, the completed checklist was used to guide further discussion about respondents' knowledge and use of CAM. Respondents were asked to give their definition of CAM. The respondents were also asked how they knew their clients/patients were utilizing the CAM modalities they marked on the checklist. This question was followed by a series of questions regarding the assessment tools at their place of employment and then a series of questions regarding patients' use of CAM; social worker practice, knowledge and attitudes towards CAM; social worker personal use of CAM; and questions regarding health care team members practice, knowledge and attitudes of CAM and CAM related policies at their health care setting.

As a semi-structured interview, the order of the questions slightly varied based on the flow of the conversation, however, the researcher attempted to ask the same questions in each interview. Some variation of the interview script occurred as certain questions were added or dropped throughout the year and a half of interviews, based on data analysis and the direction of individual interviews. Initial interviews, for example, did not include a direct question about respondents' definition of CAM and a question regarding health insurance and CAM use was added later in the study as well.

Data Analysis

All interviews were conducted and recorded by the researcher and transcribed verbatim by two undergraduate research assistants. Each transcription was approximately 15 pages long with a total of 613 pages across all 39 interviews.

The researcher kept a field log (See Appendix H for sample field log) and an audit trail for all one-on-one interviews, as well as any telephone, e-mail, or other contacts with interview subjects. The field log included the date, time, and location of each interview and hand-written notes with researcher observations, follow-up questions, and reflexive statements. The audit trail included the field log, a record of meetings with the undergraduate researchers, which included first and second level coding, thematic interpretation, and summarization of findings. After the interviews were transcribed, data were imported into NVivo qualitative data analysis software for second level coding.

Grounded Theory. Grounded theory framework was used for data analysis. "Grounded theory" originally coined and developed by Glaser and Straus (1967) has also under gone a number of revisions. Glaser and Straus' described grounded theory as a general framework to generate theory and a set of inductive strategies to collect and analyze qualitative data (Glaser & Straus, 1967). Important characteristics of grounded theory (Glaser & Straus, 1967) include concurrent data collection and data analysis, developing analytical codes and categories from the data rather than from an already determined hypothesis, construction of middle range theories to help explain processes, and making comparisons between data.

When designing the study this researcher paid attention to recommendations about creating homogeneity of the sample in order to support establishing a grounded

theory. For this reason, all social workers were MSW level, employed in a health care setting, and at least 50% of their case load included adults 65 years of age and older.

Coding. The data analysis initially began with the researcher reading and then re-reading the transcribed interview many times and meeting bi-monthly with an undergraduate research assistant for initial coding. Both undergraduate research assistants (employed at different time periods) were trained in coding and participated in the coding process. A number of codes emerged after the first few readings. After the interviews were imported into the NVivo software, the researcher created nodes for and assigned text to initial codes (See Appendix I for initial codes). As each subsequent interview was imported into NVivo, the transcript was read again, and text was assigned to already created nodes (NVivo's word for codes) or new codes were created. This process continued throughout the data collection process. After each interview was imported and initially coded, previous interviews were re-read and assigned the new codes as appropriate. Codes were then reviewed again for patterns and categories. After a number of such cycles of coding, themes began to emerge and the process continued until saturation and no new categories emerged.

Themes were then categorized into higher-level concepts in order to generate a theory about the intersection of geriatric social work and CAM. Data analysis proceeded at the same time as data collection, which meant that a few interview questions were modified in the middle of data collection. Interviews continued until categories were developed and theoretical saturation was achieved.

Member check. To strengthen internal validity, this researcher contacted a sub-section of social worker interviewees to review the interpretation of data results and

probe the interviewees for clarification of data. Social workers were re-contacted after second order coding. Ten of the 39 social workers interviewed were re-contacted via e-mail and 8 of these 10 social workers responded. Social workers were chosen to be re-contacted primarily on two factors: 1) Interviews that required follow-up questions or clarification; 2) Interviews that held very rich information I wanted to explore more. The social workers were sent a copy of the check-list they completed during the interview and asked to review it for accuracy. The social workers were also sent follow-up questions that may have been added after they were interviewed and were asked to review selected information from their transcribed interview for accuracy and clarification (See Appendix J for sample member check e-mail).

Data validity. Data validity was also increased through data, investigator, and theory triangulation. Data triangulation of time, space, and persons was accomplished by conducting interviews in four different regions with social workers employed at a range of health care environments that serve older adults. Investigator triangulation was accomplished by employing multiple coders (two undergraduate students) of the collected data. Lastly, theory triangulation was accomplished by developing research questions, structuring interview questions, and analyzing data from the perspective of two different theories: (a) Medical pluralism, and (b) The person-process-context of Ecological Systems Theory.

CHAPTER 4

FINDINGS

Primary Themes

Five over-arching themes emerged from the interviews: 1) Knowledge of CAM, 2) assessment of CAM, 3) practice of CAM, 4) barriers to CAM use, and 5) the role of culture in the use of CAM.

Knowledge of CAM. Respondents discussed varying levels of knowledge about CAM, understanding what the definition of CAM encompassed, and ways in which practitioners learned about CAM.

In general, most of the social workers interviewed described themselves as knowledgeable or very knowledgeable about CAM. When asked to provide their own definition of CAM, most used words such as "non-traditional" or"holistic" and "not prescribed by a doctor." For example, social workers in varied settings described CAM as the following:

> *Holistic medicine. Things that are maybe beyond the scope of traditional western medicine. Things that probably look at mind, body connection. (Skilled Nursing Facility Social worker, Greater Boston)*

> *It means kinds of treatments that are not part and parcel of medical or nursing or western allopathic medical education and training. I think the key word is well-being. It's not about curing. It's not about treating, it's about supporting well-being. (Palliative Care Social Worker, Boston, MA)*

It's all of those things that have the potential to help my clients feel better, that are not going to be prescribed by a physician. (Community Mental Health Social Worker, Greater Boston, MA)

As evident in Table 1 below, most of the social workers knew at least 50% of the CAM modalities listed. Interviewees were most familiar with acupuncture, massage, Reiki, prayer, exercise, Traditional Chinese Medicine (TCM), meditation, yoga, tai chi, aromatherapy, music therapy, art therapy, herbal therapy, dietary supplements, and medical marijuana. They were least familiar with Ayurvedic medicine, crystal healing, laetrile (an alternative cancer treatment) and flower remedies.

Despite this, there was some confusion about what is considered CAM and what is not. A number of social workers, for example, indicated the importance of pets and pet therapy for their clients and they were surprised this was not listed as a CAM modality. Similarly, some activities such as exercise and prayer, which are identified as forms of CAM seemed very mainstream to the social workers interviewed.

Differences in CAM knowledge. There were several differences in CAM knowledge by region (Table 2) and by the type of agency respondents worked in (Table 3).

Regional Differences.

Table 2*:* Regional Differences in Social Work Knowledge of CAM and of Client Use of CAM

	Total N=39		Greater Boston N=10		Honolulu, HI N=10		Mid Michigan N=10		SF Bay Area N=9	
	SW Knows[a]	Client uses[b]	SW Knows	Client uses	SW Knows	Client uses	SW Knows	Client uses	SW Knows	Client uses
Mind body practice[c]	7.6	4.3	8.5	5.8	8.3	3.8	5.6	3.5	8.2	4.2
Whole medical systems[d]	5.1	2.3	6.2	1.0	6.2	1.8	1.6	1.1	6.4	5.2
Pharm/bio based	7.8	5.8	8.6	7.4	8.2	6.3	5.8	4.2	8.6	5.2
Manipulative and body-based practice	7.6	3.9	8.3	4.3	9.0	3.0	5.0	3.3	8.0	5.0
Energy medicine	5.6	3.4	7.5	4.2	7.3	5.3	1.5	.75	7.5	3.3
Spiritual practice	6.6	4.1	7.3	5.0	8.3	5.0	3.3	3.3	7.6	3.3

[a]Social worker is familiar with or, at a minimum, has heard of the CAM modality.
[c]Includes MBSR, meditation, hypnosis, art therapy, biofeedback, imagery, relaxation therapy support groups, music therapy, cognitive-behavioral therapy, aromatherapy, yoga, Tai Chi, dance therapy, drumming, visualization, sound therapy
[d]Includes acupuncture, accupressure, Ayurvedic medicine, homeopathy, naturopathy, traditional Chinese medicine, Native American/Native Hawaiian healing, folk medicine.

Workplace differences.

Table 3*:* Work Place Differences

	Offered at agency: Social Worker CAM provider	Offered at agency: Non-Social Worker CAM provider	Not offered at agency but social worker reports client use of CAM modality.
ADHC/PACE program *	Guided imagery Meditation Mindfulness based stress reduction	Acupuncture Aromatherapy Dance Therapy Exercise	Dietary supplements and vitamins Light box Medical Marijuana

Table 3 (cont'd)

	(MBSR)	Herbal therapy Hypnosis Music therapy Prayer Spiritual healing Tai Chi Therapeutic touch Yoga	
Community Mental Health	Guided Imagery Relaxation Techniques Meditation MBSR Prayer/Spirituality Self- help books Support Groups Visualization		Acupuncture Chiropractic care Dietary supplements and vitamins Exercise Light Therapy Meditation Music therapy Prayer Reiki Sound therapy Special diet Spiritual healing Vitamins
Dementia Care: Alzheimers Association partnership with Neurology clinic	Meditation MBSR Relaxation Techniques Support Groups	Art Therapy Drumming Music Therapy	Art Therapy (partner with DIA) AXONA Coconut Oil Dietary Supplements Exercise Medical Marijuana Prayer/Spirituality Tai Chi
Dialysis clinic	Guided Imagery Relaxation Techniques Meditation Prayer/Spirituality Support Groups	Special diet	Acupuncture Chiropractic care Cow utter cream Dietary supplements and vitamins Faith healing Folk Medicine: Eating starch and clay Herbal therapies Naturopathy Prayer Medical marijuana Water therapy

Table 3 (cont'd)

Geriatric Primary Care clinic	Mindfulness CBT Mindfulness Forgiveness group Relaxation exercises Support Group		Acupuncture Aromatherapy Chiropractic care Exercise Herbal therapy Juice therapy Light therapy Medical Marijuana Meditation Water therapy Prayer Support Groups Tai chi Yoga
Hospice	Guided imagery Meditation Prayer Sound therapy Support Groups Mindfulness	Art therapy (for kids and adults) Aromatherapy Hospice choir Massage Reiki Spirituality/prayer Therapeutic touch	Acupuncture Biofeedback Chiropractic care Dietary supplements Herbal Therapy Homeopathy Medical Marijuana
Hospital (ER, ICU)	Reiki Guided imagery Relaxation techniques Sound therapy	Healing touch Music therapy Prayer/spirituality Support Group	Acupuncture Biofeedback Chiropractic care Dietary supplements Exercise Herbal Therapy Homeopathy Massage Reiki Yoga Massage Meditation Medical Marijuana Native Hawaiian Healing Special Diet Traditional Chinese Medicine Tai Chi Yoga

Table 3 (cont'd)

			Water therapy
Neurology clinic	Guided imagery Relaxation techniques	Tai Chi Meditation	Acupuncture Art therapy Dietary supplements Drumming Exercise Fasting Herbal therapy, Homeopathy, Medical marijuana or marijuana Massage Music therapy Prayer Reiki Self-help books, Special diets Tai Chi Traditional Chinese medicine
Palliative Care (in-patient and out-patient)	Guided imagery Meditation Reiki Relaxation techniques Sound therapy	Aromatherapy Art therapy Music (Healing Harp, Care channel with music) Healing Touch Prayer/Spirituality	Acunpuncture Ayurvedic medicine Biofeedback Chiropractic care Coffee enema DietarySupplements Drumming Fasting/juice Faith healing Homeopathy Massage Medical marijuana MBSR Reflexology Tai Chi TCM Support Group Yoga
Oncology	Body scans Guided imagery Self-help books Support Group Meditation Humor Therapy Visualization Mindfulness	Aromatherapy Drumming Exercise Healing touch therapy Prayer Spiritual healing Yoga	Acupuncture Biofeedback Juicing Massage Medical Marijuana Reiki Self-help books Special diet

Table 3 (cont'd)

	Relaxation techniques		Tai Chi Traditional Chinese Medicine (TCM) Vitamins Yoga
Skilled Nursing/Assisted Living	Relaxation techniques Support Group Visualization	Drumming Exercise Healing touch Hula Massage Music therapy Namaste Program Prayer Special Diet Tai Chi Therapeutic touch Traditional Chinese Medicine Music Therapy Yoga Water aerobics Vitamins	Acupressure Acupuncture Chiropractic care Dietary supplement Faith healing Folk medicine Herbal therapy Homeopathy Medical Marijuana Native Hawaiian Healing Naturopathy Reflexology Reiki Special diet

The setting where the social worker is employed influences social worker knowledge and practice of CAM, as well as social worker communication regarding CAM. Setting refers to a number of factors: 1) the type of health care setting (hospital, nursing home, dialysis, home based hospice, etc.); 2) location of health care setting (regional differences, urban/rural, neighborhood income level and 3) Organization structure (leadership, employees, culture). For example, a social worker may be knowledgeable about CAM, but work at a setting where CAM is discouraged by the leadership. Conversely, a social worker may be employed at a setting where medical pluralism is encouraged but the social worker lacks the knowledge and expertise in CAM modalities. The culture of the organization plays a large role in promoting medically pluralistic practices. Table 2 provides a glimpse of differences based on type of setting.

Based on this chart, a major difference by setting is the contrast between a social worker administering CAM and non-social work staff. Social work respondents in community mental health, dialysis, and geriatric primary care report few CAM modalities practiced by non-social work professionals. In contrast, the number of social worker led CAM modalities are fairly consistent across setting.

The health care setting and the setting's practice focus strongly influences which CAM modalities are prevalent and may be offered on site by social workers or other health care professionals. For example, settings such as hospice and palliative care focus on pain management and CAM modalities such as relaxation techniques, healing touch, aromatherapy and prayer are very common. Settings such as Adult Day Health Care or Skilled Nursing are activity dependent and are more likely to have CAM modalities such as music and art therapy available. At health care settings where it is important to monitor a medically approved diet, such as a dialysis center or oncology, professionals need to be more careful when reviewing CAM informed diets (i.e. juicing). When reviewing work place differences, it is important to acknowledge that many of these differences are driven by the practice focus.

Furthermore, social workers tend to use CAM modalities such as mindfulness, relaxation techniques, guided imagery, and support groups. The majority of the interviewees indicated these CAM modalities, which fall more clearly into the social work scope of practice than other types of CAM, are routine in their social work practice.

What is unclear from this study is how the clients themselves affect the culture of CAM use at individual work settings. Column three in Table 2 details the number of CAM modalities the interviewee believed their clients use, but which are not offered at

the health care setting. For example, acupuncture is often listed here. Future research should explore the extent to which patients would utilize these modalities if they were incorporated into treatment at certain health care settings.

Source of knowledge. Overall, interviewees reported that their knowledge about CAM was obtained from their own personal connection to CAM modalities (i.e., yoga practice, meditation practice, own spiritual journey, exploration for self-care) or on the job rather than during their formal social work education or via other learning opportunities. In response to a question about where the social worker learned about CAM, a Boston based hospital social worker stated:

> *Probably through Hospice care. But I mean I was always kind of interested in it. I will tell you, I was an anthropology major as my undergrad. So I think it goes part and parcel that we know that there are people all over the world who do things in different ways. So it was before I was a social worker. (Palliative Care Social Worker, Boston)*

In fact, the majority of the social workers interviewed reported they received little if any information about CAM during their MSW education. The exceptions were social workers in Hawaii who attended the University of Hawaii where the MSW curriculum included information about Native Hawaiian Healing. A few social workers mentioned that CAM was discussed briefly in classes, although the topic was raised in relation to self-care rather than patient care.

> *That self-care technique was pushed pretty hard during my graduate degree. Generally we had to develop a self-care plan in almost every class. Like how do*

you take care of yourself while you're taking care of other people? (PACE Social Worker, MA)

Exceptions to this were in courses that talked about mindfulness for dialectical behavioral therapy (DBT) or information about mindfulness cognitive behavioral therapy (CBT). A number of the interviewees learned about CAM via social work continuing education classes that focused on modalities such as mindfulness training or yoga.

A few social workers mentioned they wished they had more extensive training in certain CAM topics. For example, a Michigan based oncology social worker said:

I would like to get more training on perhaps Reiki, visualization and meditation. I have some training in it, but I'd like to have more to do the body scan with people or feel more comfortable doing visualization and relaxation techniques with people. Often I see doctors prescribe Ativan if people are anxious with the machine (radiation) and we can talk to them about alternative techniques (to lower anxiety) but I want more training. (Oncology Social Worker, MI)

A few social workers indicated they learned about CAM in childhood as a part of their cultural upbringing. CAM was part of their parents' approach to medical care and continues to be their own. For example, one primary care social worker in Michigan stated:

I think because of where I grew up and close proximity to Mexico and a lot of like folk medicine and herbal healing it was common. It seems like a normal practice. Like brushing your teeth in the morning. (Primary Care Social Worker, MI)

Assessment of CAM Use. All of the respondents reported that there was no specific question or section on their initial assessment form that formally asked about clients' use of CAM. Conversations regarding CAM emerged around the topics of coping, self-care, and medication. Barriers to assessment included social work assessment tools (including electronic based assessment tools), agency attitude towards CAM, and time.

Even though there is not a specific question in assessment tools about CAM use, a number of the social workers mentioned they learn of patient CAM use, including information regarding herb and supplement use, through open-ended questions such as "How are you coping?","What keeps you strong?", "How do you get through your day?", "What types of activities do you do on a regular basis?" or "You're dealing with the madness of this illness, what brings you peace and comfort?"

Social workers assume that patients will share that they are using a CAM modality in response to these open-ended inquiries if it is important to them. As a hospice social worker in California stated:

> *In terms of what we use at my hospice, I don't tend to ask. I tend to listen for what the person is telling me and I get to know them. I'm inquiring more about the particular that maybe you think is helpful to them. There is not anything on my assessment where I'm asking that question, so it's kind of interesting. Now that I think about it, that would be a good thing to ask, but usually I'm listening because people offer that information. And they usually tell me if it's really important to them. (Hospice Social Worker, CA)*

A Boston-based social worker describes how an open-ended question like "How are you doing leads to CAM information:

I might just stumble into it. I go in to it like 'How are you doing', 'Oh I'm good, the food in here is so horrible you know I really miss the regular food that I have at home', 'Oh what's that?' you know and then you can hear about it. Or sometimes people say 'Oh the doctors aren't letting me take my normal pills that I take at home', 'Oh what pills are those?' And then they tell me about all their supplements or whatever. (Hospital Social Worker, Boston, MA)

Assessment topics that lead to CAM discussion. Interviewees identified discussions about coping and self-care and medication and finances as a time when patients may talk to the social worker about CAM use. For example, interviewees identified they learn about patient CAM use when doctors specifically ask them to assess why a patient is not taking their medication. Problems with medication compliance often arise when patients have cognitive impairment and forget to take their medication or cannot access medication due to high costs of insurance deductibles or prescription co-pays. Information about the client's use of herbal therapies or supplements may come up in these conversations – not necessarily because of any correlation between cognitive impairment or finances and herbal therapies, but when social workers dig deeper into how patients are managing their medication, other information emerges. In some cases, clients will be financially motivated to document their use of herbs and supplements because these costs may affect discretionary income and subsidized housing policies. A patient may ask for the social worker's help to document these costs, as described by a geriatric primary care social worker in California:

We also have people who heavily research their own health conditions and kind of prescribe their own supplements and herbs and will come in and tell us about

it, because the cost is really pretty prohibitive for people. And that's how we become aware that they're using various complementary practices or treatments. (Geriatric Primary Care Social Worker, CA)

Barriers to assessment. A number of the interviewees commented that asking open-ended questions is the key to gaining information about CAM. However, a few social workers commented on communication barriers such as electronic based assessment tools, which may affect their ability to ask more open-ended questions. A Michigan based dialysis social worker describes this barrier:

Because we have a computer-based assessment, it's really cut and dry. You know, you only get to pick this....(Dialysis social worker, MI)

Assessment tools often work as prompts reminding a clinician to ask patients important information. A Michigan based Hospice social worker commented:

If a question is not prompted by the assessment tool, we don't ask…. We occasionally have patients from an Asian culture and maybe they use CAM and don't say it, but I don't ask because it's not on our assessment tool. We don't talk about it. (Hospice Social Worker, Michigan)

At least one social worker felt that CAM was not included in the assessment because of the structure of the setting. For example, a social worker in a skilled nursing facility in Michigan stated:

I feel like we are a very structured facility, with certain expectations, certain tasks that need to be performed. So that's just not something that has come up in our assessment. I mean I know as social workers we should always step out of the box, but in this role I feel like it is very much, you know, these are the questions.

And of course we explore with the patients in conversation and I do take cues from my patients and from families and kind of dive into as needed. But as a whole, it just hasn't been a part of the assessment process here. (Social Worker, Skilled Nursing Facility, MI)

*Time***.** Time is another barrier for CAM assessment. Interviewees describe very high case loads (e.g., dialysis social workers carried approximately 110 clients; geriatric primary care social workers had on average 75-80 clients). Social workers in settings such as dialysis and skilled nursing are required to complete multiple layers of paperwork for each client. Paperwork becomes more challenging when the social worker has non-English speaking patients from multiple cultures. While some of the tools help to gain information about a client's illness narrative, translation can be difficult.

Agency attitude towards CAM. Interviewees also acknowledged that for some patients, disclosure about CAM at all depended on the health care team's attitude towards CAM. Social workers indicated that they felt that patients did not always share information about CAM use during the initial assessment or even during following sessions for fear their health care provider would disapprove. One dialysis social worker in Hawaii suggested that this fear is justified:

People utilize alternative medicine and often times I think that they are afraid to tell us. I think sometimes they don't even realize that it's alternative. But the experiences I've had when patients present to the medical team, that they are utilizing some alternative, the reaction generally speaking from the team, I hope not for me, but definitely from the team, is that it's not good. It's not a positive response most of the time and the reason being is because it's not something that

we fully understand and we cannot control it. So if it is something that we can't measure and we can't validate it for ourselves, we have a problem with it. (Dialysis social worker, HI)

A few social workers articulated that it is important for the social worker to remain open-minded about CAM in order for patients to confide in them. Sometimes patients confide in them about CAM use rather than others on the medical team because the social worker provides a non-judgmental space. As one hospice social worker in California stated:

I think with marijuana there is a lot of shame and fear about it and a lot of that fear is that anyone from Kaiser or a medical environment is going to react in a negative way or in a shaming way. And I would like to think that as the social worker brings a space of acceptance and encouragement to be able to be honest and supportive that they feel we'll honor whatever their wishes are. (Hospice Social Worker, CA)

At the same time, social workers need to be clear with the client that this information will be shared with the health care team. They stressed the need for open, non-judgmental communication about CAM from the entire health care team to facilitate client disclosure. A palliative care social worker in Hawaii made clear that communication with the entire team about CAM use is important for the patient's overall medical treatment:

I've had patients that have been into these coffee enemas. Because the social worker is the person that you can ask anything and everything, they asked ' I want to bring in my coffee maker because I'm really into these coffee enemas.' And it's

helpful for me to know, because from what I hear from the different doctors, there are some things that will really dehydrate patients and so that's helpful for them to know. If their levels are getting kind of funky then the doctor needs to know what's going on and if it's his treatment or something else. And so I think I try to be open and allowing patients to know about anything that they are venturing into. So that we can make sure it's the right thing and helpful thing. (Palliative Care Social Worker, Honolulu, HI)

One notable exception to the lack of formal assessment of CAM use was reported by the four oncology social workers interviewed for the study. Each oncology social worker stated that a member of their team (physician, nurse, dietician, or pharmacist) asks patients about their use of herbs or dietary supplements because of the high risk of drug interaction with chemotherapy, and that patient use of herbs or dietary supplements was not a question that oncology social workers were responsible for asking. In general, however, questions regarding herbs and supplements do not feature in any of the reported social worker assessment tools and are not addressed by any team member in non-oncology settings.

Practice of CAM. Whether social workers include CAM in their own clinical practice depends on a number of factors, including what is appropriate to include at specific health care settings, agency acceptance or promotion of CAM, the cost and insurance coverage, and the social worker's skills to provide CAM. This section will look at social worker use of CAM in social work practice and differences in CAM use via different health care settings.

Scope of practice. Depending on the location or situation, a social worker may not have anything to do with the actual administering of a CAM modality. For example, since these CAM modalities are out of the scope of social work practice, it is other health care providers who may provide acupuncture to help with pain management for a patient in palliative care, lead a music therapy session to decrease a dementia client's agitation, or provide massage therapy to a family caregiver to reduce caregiver stress. However, a social worker may still play an integral role in CAM practice for older adults. This may include their knowledge of CAM resources and CAM practitioners to act as a responsible referral source for clients and family members; providing patient-centered and culturally sensitive care by advocating for a patient's desire for CAM modalities; and working with the health care team to advocate for ways to include CAM in their health care setting.

Interviewees provided examples of how they incorporated different CAM modalities into their own social work practice and reasons why they have chosen those modalities. CAM modalities have been helpful for clients managing symptoms around anxiety and depression. Social workers have suggested clients try or increase movement-based therapies such as exercise, yoga and tai chi for mental health. They have also utilized Mindfulness Based Stress Reduction (MBSR), guided imagery, and meditation

with patients to manage their mental health.

CAM and technology. A few social workers report the intersection of technology and CAM has been helpful for clients to continue practices such as meditation on their own. One geriatric primary care social worker in California talked about helping clients find meditation apps for their smartphones:

> *I use a lot of meditation and guided imagery in my practice with certain clients that come in with problems with anxiety, depression, working on phobias, that kind of thing. Something I've been encountering more and more is that clients who come in with smart phones I'm able to do some research with them to find apps that they can put on their phones that will continue the work that we do in the sessions and in between our sessions, which is kind of an evolution in technology. (Geriatric Primary Care Social Worker, CA)*

This social worker has also used a meditation app to help prepare an anxious client for their sessions:

> *There is one woman that has an anxiety disorder and she arrived for her visit visibly shaking. Her hands shake and she takes public transit which can be anxiety provoking, but in general she's just a very anxious person. She struggled with doing (mindfulness exercises) at home, but when she comes for appointments she's now told me that she wants to do this five-minute practice before we get started with the session. So she comes five minutes early, no matter how early she has to take the bus to get there. She comes early so she can sit and do her practice for five minutes, and I use an app on my phone and just leave the room. I don't even sit there with her. And when she's finished she opens the door and I can just*

see the difference in how she looks. Her face is more relaxed, her hands aren't shaking, her voice is calmer, her breathing is calmer and it only takes five minutes. She is one of many people that I see on my caseload who either uses these practices at home or comes in and request them from time to time to use them in the session. (Geriatric Primary Care Social Worker, CA)

Social workers discussed how certain CAM modalities could be individualized:

I started to incorporate guided meditation in my sessions with clients and recommending that as practice. With one particular individual, because I know her faith was important to her, we looked on the web to find meditations with a Christian leaning. (Neurology Social Worker, Boston, MA)

Most social Workers provided examples of CAM modalities included at their place of employment, which were not administered directly by the social workers. Amongst the many examples, an ER based social worker commented on free CAM modalities offered to very low-income patients:

Acupuncture was offered at the clinic that I partnered with and it was free. Meditation was offered for free. Medicinal marijuana was talked about. Tai chi was also offered by the clinic as well as a support group for chronic pain. (ER/Health Clinic Social Worker in grant partnership with non-profit social service agency, CA)

A social worker at a complex care geriatric center commented on how CAM modalities were included at his place of employment for health prevention:

I mean there's a whole push for kind of the whole mind body thing. Huge. I mean help that is really supportive. We have wellness coaches. People have access to

the wellness coaches for everything from weight to smoking cessation to depression, anxiety, stress where you can have a coach, you can talk to the person and get connected with. What's the new diet? The plant based diet? That's huge, especially with cardiac... I don't know much about it because I'm a carnivore. I have not quite embraced it just yet, but for a lot of our cardiac patients the class is teaching them plant based food, diet and nutrition. I think they're very good at doing preventative work. (Geriatric Social Worker, CA)

A Hawaii based hospital social worker commented an aromatherapy available at her hospital to help with pain management:

There is an actual prescription for something that's called Quessies and it's a cotton swab that's saturated with a peppermint oil that patients use that have had chemotherapy and are very nauseous. They put it under their pillow or leave it at their bed stand and it will permeate the room with this peppermint oil and that's helpful. And that's ordered - it's not just an aroma therapy recommendation. (Pallilative Care Social Worker, HI)

Integrative Care. A number of the respondents also discussed integrated care centers connected to their place of employment. A Boston based medical social worker described what's available at the integrative center near her:

There is an integrated health center right here. Doctors can suggest their patients go to tai chi, yoga, meditation, or attend relaxation or stress management classes. I think most of it is private pay. Insurance does not pay for anything. (Medical Social Worker, MI)

In regards to the Integrative Center at her hospital, a Michigan based geriatric social worker discussed her lack of connection to the Integrative Medical Center:

> *I think I've seen it and I'm thinking of one person. But I wouldn't be able to immediately identify something. But if someone was very interested I would do the research to guide them. (Geriatric Social Worker, MI)*

Another Michigan based social worker discussed how CAM practices are sometimes integrate with conventional medicine, but how combining the two may need to be encouraged:

> *My grandma goes and sees a traditional healer all the time. I'm like 'Grandma you're not taking your medicine for your diabetes', and she says, 'I go see my doctor.' Yeah, and I'm like 'You can still go see your doctor, but you still need to see your other medical doctor.' I said 'there's no reason why you can't do both.' (Assisted Living Social Worker, MI)*

Locations of CAM practice. All of the social workers interviewed discussed CAM use in their health care settings. In general the hospice, palliative care and Adult Day Health Care (ADHC) social workers described the largest variety of CAM modalities available through their programs, typically at no extra cost to the patient. (One exception is a for-profit hospice that refused to pay for CAM modalities such as music therapy and massage therapy). Many hospices where the interviewees work offer CAM modalities such as healing touch therapy, massage therapy, music therapy, art therapy, and aromatherapy. At the Palliative Care programs where interviewees work, they offer music therapy, Reiki, healing touch, massage therapy, aromatherapy and art therapy. The

ADHC programs where interviewees work offer a range of CAM modalities, including acupuncture, music therapy, art therapy, dance therapy, and massage therapy.

One hospice social worker in Hawaii describes an art therapy activity that provides a lasting piece for family:

> *We do hand casting. We have trained people who will actually use the stuff that you use in a dental mold and they put their hands in it. And it could be the patient themselves or the wife or loved one holding hands and then it sets after only 5 minutes and they pour in this hard special plaster stuff and it comes out incredibly beautifully. You can see every wrinkle and every vein and they can wear their ring or they don't have to wear the ring. It's very identifiable. You can look at it and see that is their hands. (Hospice Social Worker, Honolulu, HI)*

Programs for All Inclusive Care for the Elderly (PACE) are Medicare/Medicaid funded adult day health care programs which provide medical care, rehabilitation, social work services, caregiving and activities for adults who are eligible for nursing home care but opt to stay living in the community supported by these services. Four PACE model social workers were interviewed for the study (3 Greater Boston, 1 Bay Area). One of the PACE programs outside of Boston offers a large selection of CAM modalities. The social worker described the pluralistic treatment options as a way to hopefully find at least one treatment that will support their individual clients. One PACE social worker describes the variety of techniques they might try for clients with pain:

> *So we'll say 'Ok let's give them the option of physical therapy; let's give them the option of our exercise programs.' We have yoga and Tai Chi in the day center through our PT department. Let's see if they'll do that. We have the chair dancing,*

let's see if they can do that. Ok, if that's not going to work maybe they can get a massage. Let's see if they can fit them in for acupuncture. It kind of gets tossed around with either with the docs or the nurses or within our department as well as kind of just general brainstorming. And then some more specific things like a touch therapy or aromatherapy. That's usually something we would integrate with our clients. (PACE model Social Worker, MA)

The large variety of CAM options at PACE programs is partially due to agency discretion on how to spend funding they receive from Medicare/Medicaid on patient-care. However, despite agency flexibility to pay for alternative treatments, the challenge is often to find practitioners willing to accept the reimbursement structure. For example, a PACE social worker at another facility talked about finding an acupuncturist willing to work for the Medicare/Medicaid rate and with the PACE client base:

It's interesting, at my current job we're trying to get acupuncture covered and we were actually willing to cover it. We just need to find an acupuncturist who will agree to the rate that we're going to do and will agree to work with our client base, because they're a little bit out of the ordinary. (PACE Program Social Worker, MA)

The social workers in long term care, either skilled nursing or assisted living, report a mixture of CAM use at their facilities. In general, anything CAM related (healing touch, massage, aromatherapy, music therapy, art therapy) is offered through recreational therapy or nursing and is not specifically part of social work practice. The exception is when the CAM treatment is identified by social work in their behavioral plan. For example, one SNF team outside of Boston received special training in a CAM program

called ‘Namaste’. The ‘Namaste’ program brings together a number of CAM like modalities, including healing touch, music therapy, and aromatherapy into a small spa-like environment created for residents experiencing late-stage dementia. These residents receive a majority of their personal care and ADLs in the “spa” room. A Massachusetts SNF social worker described the benefits of this approach ranging from behavioral and nutritional advantages for residents to making visits easier for family:

> *We’ll have people go in if they just need help for reducing anxiety and any kind of behavioral outbursts. It works wonders for the residents. I mean, because besides all of the soothing affect, you also have someone in there giving fluids, you know they’re sitting in a comfortable chair so it’s good for their skin, it’s good for nutrition. On a lot of accounts it’s very good. The families love it because most people would rather come in and see a family member in sort of like a spa-type setting rather than lying in a bed 24 hours a day. (Skilled Nursing Facility Social Worker, MA)*

The social worker does not directly provide the Namaste care (the certified nursing assistants are trained in Namaste care), but they intentionally incorporate the intervention into treatment plans to reduce residents’ symptoms around depression and anxiety as well as to address behavioral problems as needed. The same social worker also noted how the Namaste program allows them to reduce medication use for many residents, a common challenge for residents with dementia:

> *I’m proud of this- we are kind of ahead of the curve with reducing antipsychotic medication. Once it (Namaste) started we jumped ahead. So even before the other regulations were put in we started looking at that and we reduced medication. So*

I actually have a behavior plan that I made up that's for people with dementia with anti –psychotic medication and one without, so that we're looking at what can be done rather than sort of slapping the anti-psychotic medication on them. Now there are people who need them, don't get me wrong. So Namaste is often part of the behavior plan, especially for people who are trying to decrease their psychotropic or their antipsychotic meds. (Skilled Nursing Facility Social Worker, MA)

Barriers to CAM use. Social work interviewees identified major barriers to utilizing CAM with patients as cost, lack of support from physicians, time, and their scope of practice.

Cost. Cost is often the most significant barrier to CAM, since the services can be expensive and are often not covered by insurance. Because the cost of CAM is often a significant concern, social workers state they would not recommend it to many of their clients. Cost would primarily be an issue for older adults who either cannot afford to pay the out of pocket costs for CAM or choose to pay and then struggle to pay for other necessities.

The location of care also makes a difference whether the cost of certain CAM practices are covered. A few large hospital groups, such as Kaiser and the VA, will now cover CAM modalities such as acupuncture and biofeedback, based on diagnosis. Similarly, programs like PACE and many hospices may choose to include certain CAM modalities in their program, although a few social workers who worked at for-profit hospices stated CAM modalities were considered a "luxury" and the agency did not provide these interventions. A social worker in in-patient palliative care described the

challenge this way:

> *Maybe I'm jaded. Right, because there's no way for it to get paid inpatient. Another hospital said 'Oh we know you're doing this Reiki program you know we're trying to think about how we can get acupuncture and other services inpatient and how did you start this?' Well this is a volunteer program because it's not insurance reimbursed. You can't get insurance reimbursement for Reiki. And one of the things they realized is that they couldn't get inpatient insurance reimbursement for acupuncture and some other services and so therefore could not provide them because they couldn't pay people to do them. (Medical Social Worker, Boston, MA)*

Power. A second identified barrier was the beliefs about CAM of those in power who influence whether or not CAM is considered an acceptable treatment modality. This was especially true with hospital-based social workers where the biomedical model is most pervasive. While CAM modalities are available in many of these health care settings, and the medical team has indeed recommended them to patients, CAM is typically not the doctor's first line of treatment for patients. As one social worker noted, CAM is seen as a treatment of last resort or an added benefit once the crisis has past:

> *You know, we're still a medical model and the majority of the people here have gone to some type of medical school and have medical training. So if someone is having an issue, the first thought is 'Ok, let's give them a drug' or you know, 'let's send them out for testing'. Once it sort of gets past that point, either the medication is not effective or the client's having lots of side effects, then they become more open to looking at other modalities. Or if the client's stable but*

would probably benefit from some of these programs, you know, they're very keen to ask for some of the more life-style therapies like the exercise, dance, and yoga. From the onset of joining our program we encourage our clients to do those things. It's sort of the more specific treatments like meditation or aromatherapy or something like that, that usually you have to negotiate. But the broader ones are very encouraged. (PACE model Social Worker, MA)

A palliative care social worker in Massachusetts also discussed the difference between support from a doctor and support from a social worker in being able to include CAM in care:

What I'm thinking is a power barrier. OK, you know if the head of medicine stands up and says 'Ok now we're going to do mindfulness based stuff with all of our patients' it carriers a heck of a lot more weight than if a social worker says it, even the Director of Social work. I mean we are part of a culture where medicine is hierarchal at least particularly acute care. (In-patient Palliative Care Social Worker, MA)

Time. A third identified barrier to CAM use was lack of time. Social workers feel they do not have the time to teach clients certain CAM modalities like meditation or mindfulness. This was especially true for in-patient care settings and agencies where social workers were more involved with crisis management.

As a PACE social worker in Massachusetts said,

CAM doesn't always come up in conversation because you're just putting fires out all the time. (PACE Social Worker, MA)

The idea that CAM modalities are considered "extraneous" or "extra time" and something that would take away from valuable assessment/intervention social work time was discussed by a geriatric social worker in California:

> *In all honesty I'm not doing guided imagery. I'm doing counseling and emotional support but I'm not going to pull a half hour away out of my assessment or my interaction with the patient and do something specific like any kind of music therapy or art therapy. Once in a while you'll do some relaxation and every once in a while if someone's getting real anxious and we have to stop and we'll kind do the breathing exercises to bring someone back in. But I would honestly say that's probably the most I would do. (Geriatric Social Worker, Geriatric Hospital Clinic, CA)*

Dialysis social workers also identified time as an issue based on their high volume of patients. While patients may have the time during their 3 hours/3 day a week dialysis sessions to engage with CAM, the social worker is managing psycho-social assessments and care plans for over 100 patients and can not routinely monitor patient meditation or MBSR sessions. As a dialysis social worker in Hawaii explains:

> *But actually teaching someone (meditation/mindfulness) and monitoring to the point of being supportive is really hard because our time is so limited. I think if somebody doesn't know what to do for some kind of intervention they really need a lot of support at the beginning, and our schedules are so tight that we don't really have time to keep checking. I think something like that you would want to check with someone weekly, until they are off and running and don't have a lot of questions and they can sustain it themselves.*

(Dialysis Social Worker, Honolulu, HI)

Scope of Practice. A fourth identified barrier to CAM was scope of practice. For example, social workers stated that if they believed a CAM practice might help with pain, it would be out of their scope of practice to mention it to the client without first consulting with the medical provider. If the doctor does not believe in acupuncture or medical marijuana then it does not matter if this practice was on the social worker's radar. As a hospice social worker in California stated, circumventing this hierarchy could create problems:

> *I think there would be a backlash to bringing it up with the client. The doctors saying 'Why are you bringing this stuff up?' I could go to the doctor and say (and that does come up in our team meetings) 'Would medical marijuana work for this person, or acupuncture?' and then we can bring that stuff up. But unless the client has brought it up I think there would be a backlash for me moving out of scope of practice (Hospice Social Worker, CA).*

Patient Motivation. A fifth identified barrier was patient motivation. Social workers discussed how the profession promotes client self-care and self-empowerment, but they also recognize that CAM requires an individual to buy into this philosophy to a greater extent than traditional health care. The perception is that using CAM with patients is difficult unless a patient is motivated and that patient motivation is limited by the societal belief that "a pill can fix anything." As exemplified by this Boston based social worker:

I think patient's motivation and willingness to engage in any self-care activities, including patient's access to CAM financially and physically getting out of the house to

get to the place or doctor. (Medical Social Worker, MA)

Policy. The last barrier identified was policy related. One example of this policy barrier is related to medical marijuana as an alternative for pain management. Despite the legal status for medical marijuana in each of the four states where interviews were held, the majority of the social workers indicated that their facility does not support medical marijuana use and has specific written policies to that effect. A few respondents indicated that because their agency relies 100% on federal dollars, even though their state has approved medical marijuana, their physicians cannot write a letter in support of patient use. A few interviewees stated that the physicians at their place of employment were not willing to write a letter to allow a patient to receive a medical marijuana card and others stated the system was not set-up for "regular" physicians to prescribe medical marijuana or write a letter in support. However, it was not clear in the interviews if the reported physician's refusal to participate was based on based on the physician's ideology towards medical marijuana, overall agency policy or structure of the state to disseminate medical marijuana cards.

At a reservation in Michigan it was clearly an agency policy:

We at the tribe here have a strict no use policy. So we don't have policies in place that allow that. And the tribe has taken a pretty firm stance that you know marijuana medical cards are not allowed on the reservation. (SNF/ Social Worker, MI)

At a Boston based hospital it was also an agency decision:

We actually just had an ethics conversation about medical marijuana. I think the conclusion from that was that it is not a good time right now. We're not there yet

as an institution that we want to be doing that. (Medical Social Worker, Boston, MA)

An oncology social worker in Hawaii noted that there are differences even within the state:

No one (is prescribing marijuana) on Oahu, but definitely they are on the Big island and maybe Kauai. I could be wrong, but I want to say that it is licensed on Oahu. I'm not 100% sure. But the doctor's here don't. There was a patient not long ago saying 'I want Dr. X to prescribe me medical marijuana.' And she (the physician) was like, 'I can't. I just don't.' I know I've had patients from neighboring islands who get medical marijuana, heavily on the Big Island. I think maybe Kauai too. (Oncology Social Worker, Honolulu, HI)

In California, where medical marijuana is legal, one agency responded to possible abuse by stopping all letters of support for medical marijuana:

Some of our clinics were over prescribing for a variety of conditions that didn't fit for what medical marijuana is typically prescribed for. We were also making changes to our opiate prescribing policy so it made sense to our clinicians in leadership to make those changes together. So we made a whole new system for how we prescribe opiates and in what condition and treatment contract and at the same time stopped prescribing medical marijuana and talked to people about where they could go to get a prescription. (Geriatric primary care social worker, CA)

A medical social worker in the Boston area noted that this is more of an issue with younger patients than older patients:

Well, medical marijuana is still new kind of here. I mean, it's still new and the hospital does not provide it and does not prescribe for it. And that actually has come up with certain patients…Not as much with the older population though, but I have had younger patients with MS and things who are very upset that they won't prescribe marijuana.

(Medical Social Worker, Boston, MA)

Age. Finally, age was discussed, not so much as a barrier to use CAM with clients, but as a possible challenge depending on the team members' understanding of and beliefs about aging. Some may not consider CAM as an option for older adults or may choose to introduce the idea of CAM in a different way. With older adults, for example, they might describe a particular CAM modality differently than they would for someone younger. An oncology social worker in California states that instead of labeling something CAM she will talk about it more generally:

I start with 'Maybe this is something that could help. Why don't we sit and try this for a minute.' And then I see how they respond…I provide some interventions like visualization, some kind of meditation or mindfulness practice but I rarely call it meditation, either because people might have a religious connotation for that or they might say ' Oh I can't meditate, I can't do that.' I talk about some tools or exercises for relaxation that might help with managing certain feelings that might come up or experiences. I might call it visualization if it's somebody that I think is going to respond to that. Some people do respond to mindfulness, but most people have heard of mindfulness. (Oncology Social Worker, CA)

A number of social workers mentioned they did not think age was much of an issue, but that the motivation to try CAM had more to with feeling so bad that patients want to try anything to feel better. Two social workers in Michigan commented on this:

I hate to say it, but when people are desperate and you don't feel well, they'll try things no matter what their age. But we don't always give them the benefit of the doubt. (Geriatric Primary Care Social Worker, MI)

I think the elderly are very open to CAM. They will do anything that could help them. (SNF Social Worker, MI)

A few social workers indicated they thought older adults were as open to trying new things as a younger person. As indicated by three different Medical Social Workers in Boston:

I think a lot of them are open-minded to experiencing anything that would work. You know, they're ok with 'Oh that seems plausible, let's try it. (Medical Social Worker, MA)

I think that there's a stereotype for when people are older that they are sort of set in their ways and just want to do what they want to do. But for most of our clients, if you present them with an option like 'oh, do you want to try this' they say 'oh, sure why not?'(PACE Social Worker, MA)

I think a lot of baby boomers are encouraging their loved ones to try new stuff. That happens here a lot. We have a patient whose daughter said, 'Oh mom, they

have a Reiki service, you should go try that.' (Medical Social Worker, MA)

The role of culture in use of CAM. On one hand, the role of culture appeared to not be an important factor in social worker assessment of client use of CAM or in the consideration of a CAM modality as an intervention. Most social workers indicated they did not believe their own cultural background or that of their patients influenced their decision to inquire about potential CAM use. One explanation for this apparent contradiction may be rooted in social workers' discomfort identifying ethnic/cultural difference in people, believing identifying or acknowledging differences was considered racial profiling. A few of the social workers indicated they felt that inquiring about CAM under the rubric of 'cultural competency' was uncomfortable. For example, one social worker states:

> *And the cultural, you know, it's the power dynamic. I mean I'm white, right. Even if one is trying to do this sensitively, it can sound very ethnocentric, right and prejudicial, so it's awkward. (Medical Social Worker, MA)*

On the other hand, the interviewees, for the most part, were aware that some of their patients use CAM and that there were cultural differences in CAM use. A medical social worker in Massachusetts, for example, acknowledged a split in the types of CAM she sees her patients utilize based on cultural background:

> *I think I would say among African Americans you're seeing a lot more spiritual things. I think upper middle class white folks are going for the Reiki, acupuncture, exercise, and I think that lower income folks are asking about medical marijuana. Interestingly, my biggest meditator is a former army guy; the army taught him*

how to meditate through pain. He does a lot of visualization and meditation. (Medical Social Worker, MA)

A hospice social worker in Michigan considered CAM practice to be rooted in diverse ethnic populations, not used by older conservative Caucasians in her community:

I can't think of anyone in the last five years who had acupuncture or Reiki. Mind body stuff, no, yoga, no. This is a pretty- pretty rigid population because of their religious backgrounds and that kind of stuff would be rare. Now the younger group they'd be the ones that would be more interested in that. The 30 to 50 or 30 to 60 years old. I think even the 50 year olds are pretty rigid. The 60 year olds, hmm, I think the farthest they would go out was to buy an herbal supplement. Or go to a Chiropractor. Those would be the two that they would most likely do. (Hospice Social Worker, MI)

A SNF social worker in Hawaii discussed how health education in combination with respect for patient self-determination helped her facility determine treatment interventions for patients from different ethnic backgrounds:

Depending on the culture we try to adjust ourselves to the culture and understand why they behave in that way or why the families believe in different medical treatment, not westernized medical treatment. At the health center in our facility in the nursing home we respect their choice and we provide information regarding westernizing medical treatment. And like I said, we promote self-determination and their right to the treatment. So we talk about pros and cons and let the families and participant choose what they really want to do.

(Skilled Nursing Facility Social Worker, HI)

A dialysis social worker in Hawaii commented on how her patients access herbs, either locally or via mail from their home countries:

> *I guess it might be called folk medicine or dietary supplements/ folk medicine. I've had patients that have tried to utilize a concoction…that's not a good word, because it has a negative connotation, and I don't want it to be that way. But it's not Western medicine and in the hope of it actually healing them. …The patients usually grow it themselves or they will get it from a family member. I've had some patients actually get it mailed to them from their homeland, like for example Micronesian patients. But most of the time, if someone is going to use folk medicine, they are going to have it accessible to them here. (Dialysis social worker, Honolulu, HI)*

This same social worker noted her own cultural background and its influence on her use of CAM:

> *I will tell you I'm Hawaiian, and for me, I will use herbs every now and then when I need to. It's like plants herbs and I'll pound it up or mix it with something - for blood pressure control or even normal ailments like cold or congestion. Things to relieve that kind of stuff. (Dialysis Social Worker, Honolulu, HI)*

Another social worker in Hawaii reflected on the questions regarding CAM and commented on how it was important for her to be mindful of patient's belief systems:

I think just being more mindful of the fact that people in different cultures gravitate to different types of interventions that might be more comforting. (Palliative Care Social Worker, Honolulu, HI)

A Hawaii based social worker commented on both the challenges and the benefits to working with a culturally diverse population.

Right now with KDQOL-36 (a kidney disease quality of life instrument) the assessment isn't available in many languages and we are mandated to provide it. There was one point in time where I actually had 13 languages on my case load and they were languages where the KDQOL experts could not really help us with. But CNS Medicare requires it. It's very interesting. I mean I look at it like it gives me another opportunity to meet with a patient and get to know them. And that is the beauty of my job. I mean I can't believe it! I'm getting paid to sit down and converse with somebody and figure out how I'm going to help you. (Dialysis Social Worker, HI)

CHAPTER 5

DISCUSSION

The overarching goal of this study was to increase our understanding of the intersection of geriatric social work and Complementary and Alternative Medicine (CAM). Chapter five, the discussion phase of this dissertation, looks at the research findings in response to the initial guiding questions:

(1) To what extent do geriatric social workers know about CAM and assess for CAM use in their practice?

(2) What factors facilitate or inhibit geriatric social workers incorporating CAM into their assessment or practice of CAM?

As a qualitative research study, the present study is not designed to provide quantifiable answers to these questions (e.g., "75% of the geriatric social workers interviewed know a great deal about CAM" or "25% of the geriatric Social Workers interviewed assess for CAM use in their practice"). Instead, this study applies a grounded theory approach to the process of data collection using semi-structured interviews, note taking, coding, sorting and writing, in order to better understand the intersection of geriatric social work and CAM.

Primary Themes for Discussion

This chapter provides a discussion of the core themes that emerged from this study (knowledge, assessment, practice, barriers, and culture), how these findings relate to the intersection of medical pluralism and ecological systems theory and the impact on geriatric social worker-client communication about CAM. The discussion section will also review limitations to this study.

Knowledge. Respondents reported a high level of knowledge regarding CAM. Most respondents knew about CAM modalities through their own CAM practice (e.g., yoga practice, massage for stress reduction, meditation, books). Respondents also identified CAM knowledge from childhood/parent use, mentorship at work, undergraduate school classes, social work continuing education, and social work conferences. As indicated in the findings, few respondents indicated they learned about CAM modalities in their MSW training.

Knowledge of CAM for social workers is multi-fold. Knowledge refers to knowledge about individual CAM modalities such as acupuncture or mindfulness. Knowledge also refers to knowing the evidence behind certain CAM modalities and how it may help clients, for example whether meditation helps reduce anxiety or research on mindfulness training and caregiver burnout. For social workers, there is also knowledge regarding client populations and their belief systems. For example, this would include whether a social worker knows if a client believes that alternative treatments rather than chemotherapy will help cure his cancer or the role of spirituality and prayer in certain populations.

Social workers are expected to use evidence-based practice for social work interventions. "Best research evidence" means clinically relevant research from basic and applied scientific investigations evaluating the outcomes of social work services and the reliability and validity of assessment measures (McNeece & Thyer, 2004, p.9). Social workers are aware of evidence-based practice via school, through journal articles, consultation/supervision and by completing their own literature review. Information regarding efficacy of CAM modalities, specifically mind-body practices, is found in a

number of websites, including the Cochrane review, Pubmed, Google scholar and the NCCIH website. The majority of the published research on mind-body practice is not specifically with older adults. Of the CAM studies listed on the Cochrane Review specific to older adults 25 focus on dementia. These reviews examine different herbal supplements or interventions such as exercise, massage therapy, aromatherapy, or healing touch to reduce agitated behavior or slow the progression of the cognitive decline. All studies showed either inconclusive evidence or no evidence that the CAM modality is effective.

There is an extensive evidence base for the efficacy of Mindfulness Based Cognitive Therapy (MBCT) and Mindfulness Based Stress Reduction (MBSR). However, many CAM modalities such as Reiki are difficult to test and, in general, there is a dearth of randomized controlled research studies that look at mind-body practices. The majority of the meta-analyses state there is not yet sufficient evidence to determine whether a practice is effective. Many of the studies conclude that the scientific research to determine efficacy needs more rigorous study design. However, researchers in this area describe the difficulty of studying mind-body practice under a biomedical framework and argue that standard efficacy measures are inappropriate. Different research methodologies demonstrate that there is not only one-way to know the truth; however, biomedicine claims a monopoly on the methodology for finding truth, as well as the truth it uncovers. This is problematic for studies of CAM. Despite the fact that a large percentage of bio-medical practices have not undergone rigorous testing and yet are conventionally accepted as good practice, critics of CAM point to established research protocols to dispute efficacy.

It is not known whether social workers gravitate towards choosing CAM modalities where there is more evidence towards efficacy. In this study interviewees were not asked to describe what factors contributed to their decision to use a particular CAM modality.

Where social workers obtain knowledge for clinical practice is an important determinant of how much content on CAM they receive. MSW curricula are informed by CSWE competencies, as well as the NASW code of ethics, and the goal of course content is to train social work students to be competent social work practitioners. MSW course work, in combination with field work, the social work signature pedagogy, is where social work students learn clinical skills for practice. However, respondents stated there was little mention of CAM modalities in any of these school curricula, except for information on self-care or UH's coursework on Hawaiian traditional culture. For example, respondents mentioned a course that required students to develop a self-care plan. In almost every class, the focus of the CAM-related content was on "How do you take care of yourself while you're taking care of other people?" and included class exercises such as relaxation techniques.

Similar to changes in medical and nursing school curricula in the last 20 years to increase coursework on CAM, schools of social work need to provide students the opportunity to learn more about CAM modalities and to receive training in CAM practices which fall under the scope of social work practice in order to effectively practice in a medically pluralistic field. As indicated in the interviews, a lack of this type of knowledge inhibits assessment of culturally based CAM use or CAM modalities such as herbal therapies, about which a social worker may not feel confident to inquire.

The present study supports Henderson's (2000) findings: while over half (59.1%) of the social workers in his study (N=321) reported using mind-body approaches directly with clients, only 30% of those reported "substantial" or "great" knowledge of the technique. Similarly, respondents in this study report using mind-body approaches in their social work practice (meditation, mindfulness, guided imagery) while having limited training in these techniques in a formal MSW program. Among the 39 respondents, 11 Schools of Social Work were represented (Michigan State University, University of Michigan, Western Michigan, UC Berkeley, San Francisco State University, University of Hawaii, Boston University, Simmons, Virginia Commonwealth University, Ohio State, and Smith.) However, respondents stated there was little mention of CAM modalities, except for UH's coursework on Hawaiian traditional culture, in any of these schools' curricula, or information on self-care. Respondents graduated from MSW programs between the years 1979-2014. Knowledge about CAM is not being disseminated in MSW programs to support social worker use of CAM modalities in practice despite evidence that CAM use is becoming more prevalent.

From an ecological systems perspective, social worker knowledge regarding CAM figures at multiple ecological system levels and interconnects with the second theory, medical pluralism. At the micro level, knowledge of CAM may connect to the social worker's personal belief system and the extent to which they value multiple ways of healing versus reliance on a biomedical approach. As suggested in the interviews, a social worker's attitude and knowledge of CAM may be influenced by a personal experience using CAM modalities, childhood exposure to CAM, or exposure to CAM in the work place or in school.

At the exo level there are a number of variables that affect social worker knowledge and training in regards to CAM: 1) a rising patient interest in CAM partially driven by baby boomers, 2) changes to the US health system through the Affordable Care Act which are focused on cost-cutting and outcome focused care as well as well-being reimbursement models which may further increase future demand for CAM, 3) a push for electronic records in medicine, which facilitate attempts to improve overall care and avoid conflicts (e.g. tracking all medication in one place) but may also constrain open-ended assessment approaches that can elicit information about CAM use, and 4) growing evidence of medical pluralism in medicine, seen by integrated care centers at the top medical schools and an increase in mind-body practice. At the macro level, knowledge of CAM touches on values, belief systems and social structures of the profession as outlined by NASW and CSWE competencies, which in turn dictate social work curricula as well as continuing education and licensing requirements.

At the chrono level, historical changes have contributed to changes in social work education. Social work in North America before the 20th century initially developed from religious charity movements for charity and community service. A few changes occurred in social work education and practice in response to Flexner's famed speech. In 1915, education reformer, Abraham Flexner concluded that social work was not a profession because, amongst a number of other reasons, it did not have its own knowledge base. Flexner's report endorsed that all knowledge must stem from the scientific method and its guiding principles: objectivism, reductionism, positivism and determinism. In contrast, knowledge understood through a medically pluralistic lens focus more on holism, multi-system connectedness and creating balance, all of which are a focus of CAM. While

social work philosophy may straddle both of these worlds, the social work profession has worked to create a profession of evidence-based practices, parallel to evidence-based practices in biomedicine and other allied health fields and students are taught the importance of evidence based practice in MSW programs. The straddling of both worlds creates an internal tension in social work balancing a holistic approach to care with the appropriate use of evidence based methodologies and a continuing (and growing) role of CAM in the dominant health care system.

And yet, based on the increasing rates of CAM use, social worker knowledge of CAM in a health care setting will remain important to meet the needs of a diverse aging population. There is an on-going push among all health care professionals to strive for patient-centered care. The Institute of Medicine defines patient-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." (IOM website, 2015). While patient-centered care does not need to incorporate CAM practices, social worker knowledge of CAM, particularly viewed through a medically pluralistic lens, connects social workers to the range of patient's different belief systems and will likely increase social worker responsiveness to patient preferences and values.

Assessment. The majority of the respondents reported there were no specific questions on their social work assessment tools that asked about CAM use, including questions regarding herbs/supplement use. Many respondents indicated they often learn about patient CAM use when they ask about coping strategies through open-ended questions such as "How are you coping?" "What keeps you strong?" or "What types of activities do you do on a regular basis?" A few respondents indicated they only ask

questions based on the assessment script and they would not think to ask about CAM use. Respondents indicated they often did not have the linguistic or cultural competency to pursue inquiries about "stuff" they know their patients are doing, or they did not want to be labeled a racist based on stereotyping.

The problem with not including questions regarding CAM use in routine social work assessments is the strong risk of missing information regarding CAM use that might interfere with conventional medicine and have potentially life threatening consequences. Therefore, what social workers choose to ask about, or are dictated to ask about, will impact what information they receive from the patient and will directly affect patient care. Assessment of CAM plays out at in all five ecological system levels. Social work assessment, typically a psycho-social assessment, helps to establish how a patient's health problems are impacted by social and environmental factors. Social work assessment may include information about a patient's family and social supports, employment and financial status, level of education, immigration status, racial, ethnic and spiritual background, patient's level of coping, current stressors, and obstacles to care. Looking at a social work assessment under a medically pluralistic lens, assessment addresses the patient's illness narrative – what they believe is the root of their health problems and what treatment they believe will be helpful. At the micro level, choosing to include an assessment of patient CAM use may be related to a social worker or another health care professional's belief that it is important to assess for CAM use. This belief to assess may or may not be because the health care professional believes that CAM modalities are effective, but because they recognize that patients use CAM and may not share that unless asked.

While social workers receive training in conducting psycho-social assessments and may have the skills to illicit information regarding patient use of CAM and a pluralistic outlook to medical care, they often encounter multiple institutional barriers. At the meso level, there may be conflict between a social worker's push to include CAM in an assessment tool and system barriers such as lack of time, rigid computer based assessments, or a supervisor. For example, sitting with a patient and exploring their health belief is time intensive. For social workers with high case-loads, the system may not allow ample time for adequate discussion. Similarly, at the macro level, systematically including assessment of CAM in health care settings would mean large institutions accept the idea of medical pluralism or at least acknowledge the importance of a formal CAM assessment. At the chrono level, including an assessment of CAM acknowledges an increased prevalence of CAM use at this time, as well as the significance of aging baby boomers and rising immigrant populations to expected ongoing increases in CAM use.

Assessment must also explore patient use of herbal therapy and dietary supplements. The majority of the respondents indicated they do not routinely ask patients about herbal therapy or dietary supplement use. The majority of the respondents indicated they are not responsible for reviewing prescription medications so questions about herbs or dietary supplements typically falls under another health care provider (typically an RN, pharmacy tech or dietician, depending on the health care setting). Respondents indicated that if they learn about patient herbal therapy or dietary supplement use, they report it to the medical team. In general, the main concern with herbal therapy and supplements is a possible drug interaction with a prescription medication or medical treatment such as

chemotherapy. As indicated in the literature review, there is a low rate of communication between health care providers and patients regarding CAM use, specifically herbal therapy and dietary supplement use. This was echoed in the interviews for this study. The discussion below reviews system-level obstacles to social worker assessment of herbs and supplements.

One main obstacle to social worker assessment of herbs and supplements is knowledge. Most MSW programs do not include any pharmacology courses in their curriculum and yet social workers are expected to be knowledgeable about medication. Social workers are routinely called upon in medical settings to help determine if there are social explanations to medication non-compliance (e.g., cost or changes in insurance plan) or are in charge of medication reviews for psychotropic medication in skilled nursing settings. When Medicare Part D began, social workers were often called upon to assist patients to figure out the best drug plan and to help pick up the pieces when patients landed in the "donut hole" where they were required to cover the full cost of prescriptions. Each of these examples demonstrates that social workers are not completely disconnected from patients and prescription medication use (or possible herbal therapies or dietary supplement use). Increasing social work knowledge about pharmacology, including information about herbal therapy/drug supplements, will help social workers perform a competent assessment of CAM.

Practice. Respondents indicated they include a range of CAM modalities in their social work practice: Reiki, meditation, mindfulness based stress reduction, healing touch, humor therapy, guided imagery, prayer, relaxation techniques, support groups and self-help books. Respondents also indicated a number of CAM modalities included at

their place of employment provided by other practitioners (i.e., spiritual support, therapeutic touch, acupuncture, music and art therapy, hypnosis, Tai Chi and yoga).

The inclusion of CAM modalities in the respondents' health care settings indicates a medically pluralistic approach to care. Viewed at the micro level of the ecological system, inclusion of CAM indicates a number of the players (social worker, clients, other health care professionals) may support the use of a CAM modality.

However, the respondents indicated the inclusion of different CAM modalities is not without conflict at multiple system levels. For example, most insurance works within the biomedical paradigm and, therefore, will not pay for a recommended or desired CAM modality such as acupuncture for pain relief. Medicare, the leading insurance for adults 65 and older, provides very little coverage of CAM modalities. Another example of conflict is disagreement among colleagues regarding inclusion of CAM in a health care setting. A Boston based social worker provided an example of a new club to help support brain health. The brain "workout" includes two CAM modalities, mindfulness and Tai Chi. She described the tension between those who advocated for the program and those who believed there was no evidence to support the use of mindfulness and Tai Chi and did not want to implement the program. Ultimately the issue was resolved and the program was started with these two CAM modalities included.

Discussion about CAM use in social work practice intersects with a discussion about evidence-based practice. Each profession has its own evidence base and the social work field has moved more in the direction of evidence-based practice versus the idea of "practice wisdom". The movement towards evidence-based practice guides social workers to follow research based interventions versus "practice wisdom," and encourages

a more systematic review of knowledge. There are pros and cons to this move. In the context of medical pluralism, there is the risk that in the push for evidence based practice, certain interventions have been ignored, either because understanding their effects is not amenable to the dominant paradigm's research methodology or because there is a lack of funding sources to support appropriate research studies.

Barriers. Respondents identified a number of institutional factors that support or inhibit CAM practice, including cost, time, and social work scope of practice. These barriers suggest a conflict between medical pluralism and limitations at the macro level.

Cost. Respondents discussed the role of cost for CAM use in their different health care settings. On one hand, the presence of these modalities within health care settings indicates a more medically pluralistic belief system in the United States. However, the majority of CAM modalities are not covered by insurance, so on a structural level, the cost of CAM makes it unavailable for many health care consumers. Medicare, the main health insurance provider for adults 65 and older, covers very few CAM modalities. Chiropractic care is one of the few CAM modalities covered. When respondents talked about an individual patient's use of CAM, separate from their health care setting, they often identified practices such as acupuncture, massage, and dietary supplements as popular with middle and upper middle class patients and practices such as folk medicine and prayer as popular with lower income groups.

At the institutional level, if CAM is provided by an agency, CAM use becomes more democratic across income class. One example was shown at an all-inclusive care for the elderly program (PACE). One respondent indicated cost was not a primary factor because of an agency decision to use Medicare/Medicaid funds to cover different

therapeutic practices, including practices defined as CAM. In this case, it does not matter whether Medicare is willing to pay for acupuncture because of the funding structure. The PACE program receives a certain dollar amount per patient to cover the cost of care and the staff was willing to try different CAM modalities. Cost was not an issue because of the flexibility provided to the health care team and the team's medically pluralistic approach to care. Furthermore, several team members were skilled in CAM approaches (one doctor was trained in acupuncture, one nurse received training in hypnosis, another nurse received training in herbal therapies) so they did not need to hire additional practitioners.

In contrast, in-patient hospital care settings are primarily bio-medically driven. A number of hospitals are now offering integrative care centers, but the cost to receive CAM modalities at these centers is mostly out of the pockets of patients. One respondent shared information about a volunteer-run Reiki program at her large research hospital. She thought the Reiki service, not covered by insurance, would not exist if health practitioners did not volunteer their time. Similarly, respondents who worked for a managed care company in California indicated a number of CAM modalities were offered at the hospital; while patient use was encouraged to promote well-being, these CAM modalities were only available at cost (mindfulness based stress reduction, yoga, Tai Chi, support groups).

Time. As indicated in results related to social work practice, time was also identified as a barrier to CAM. Time does not just refer to the time a social worker has available to include questions during an assessment to illicit information about CAM or the time it takes to administer a CAM modality. Time also refers to how much time a

patient and/or the system is willing to allot to see a difference with a CAM modality. For example, a number of respondents indicated patients are not motivated to take the time many CAM modalities require to inform the healing process (e.g., increased exercise, changes in diet, meditation) versus a pharmaceutical approach (e.g., blood pressure medicine, anxiety medicine).

Social worker scope of practice and role in the medical setting. A number of the respondents brought up the topics "scope of practice" and "power." One identified barrier was a consideration of what is "ok" to talk about with patients, especially CAM modalities administered by another health care professional, rather than directly by the social worker. At both the macro level and the meso level, this is partially a question of scope of practice which may vary depending on the context; for example, in some contexts it maybe ok for a social worker to mention acupuncture as a possible intervention to help with pain. In other contexts it may be that that information can only come from the medical doctor.

Culture. Cultural competency across all health care professions is "the ability to interact effectively with people from different cultures" (SAMHSA website, 2015). Social worker goals to achieve cultural competency is based on individual social competence and clinical helping skills. In the healthcare setting this means, for example, being cognizant that people may approach healing in different ways from the dominant medical system and make inquiries about it in patient interactions.

In the context of this study, a social worker's understanding of cultural competency means they acknowledge that medically pluralistic behavior exists along cultural dimensions. Within the health care system, social workers interact with patients

from diverse backgrounds and it is up to social workers to learn about the culture of the populations they serve. Throughout the myriad of social work tasks: assessment, interventions, I & R, etc., social workers need to consider cultural implications. In addition, in their role as health educators, counselors, and members of interdisciplinary teams, social workers use cultural competency skills to help train patients to communicate health needs with their medical providers.

In general, in the interviews outside of Hawaii, respondents indicated that culture does not play a role in their assessment questions nor does a patient's ethnic/religious background influence their choice of intervention. In addition, respondents appeared to be less aware of how these cultural factors impact their patients' potential use of CAM. As noted in the findings section, one respondent discussed her discomfort in discussing CAM use under the rubric of cultural competency, feeling like it was "racial profiling." It is not clear from the interviews whether other respondents' comments regarding a client's cultural background and CAM were also rooted in a similar discomfort; however, it does raise a question of how best to teach cultural competency.

Interview data from two social workers in Hawaii, both working at dialysis centers with similar populations, illustrate one way culture may play a role in social work assessment. Social worker #1, part Hawaiian, grew up on Oahu. Social worker #2, Caucasian, moved from the Northeast about 2 years ago. Social worker #1 stated that many of her patients used the following CAM modalities: acupuncture, herbal therapies, dietary supplements and vitamins, folk medicine, medical marijuana, meditation naturopathy, prayer, relaxation therapy, support groups, and water therapy. She was very knowledgeable about the different herbal therapies used by her patients. Social worker #2

indicated that a few of her dialysis patients meditated, and otherwise prayer, spiritual practice, and support groups were the only CAM modalities practiced by her patients. No clear conclusions of cultural competence can be made by looking at these data. It may be that, in fact, their client based differed in this regard. However, given the context, it is unlikely that the differences in clients would be that large. It is possibly an indication of differences in clinical skills and engagement in the assessment process. It is also possible that differences in the practitioners' cultural background informed the types of questions they asked during the assessment. This example suggests that training in cultural competency would be enhanced by including information on medical pluralism, its implications for client care, and ways to assess for patients' use of alternative treatments.

Grounded Theory

Based on the findings for this dissertation, the following grounded theory is proposed:

'Social worker-patient communication regarding CAM is influenced by social worker knowledge and practice of Complementary and Alternative Medicine (CAM), which is both facilitated and constrained by the ecological forces within social work education and practice environment, as well as its intersection with medical pluralism.'

The following figure provides a visual look for an Ecological Systems Model For Social Worker-Patient Communication Regarding Complementary and Alternative Medicine (CAM).

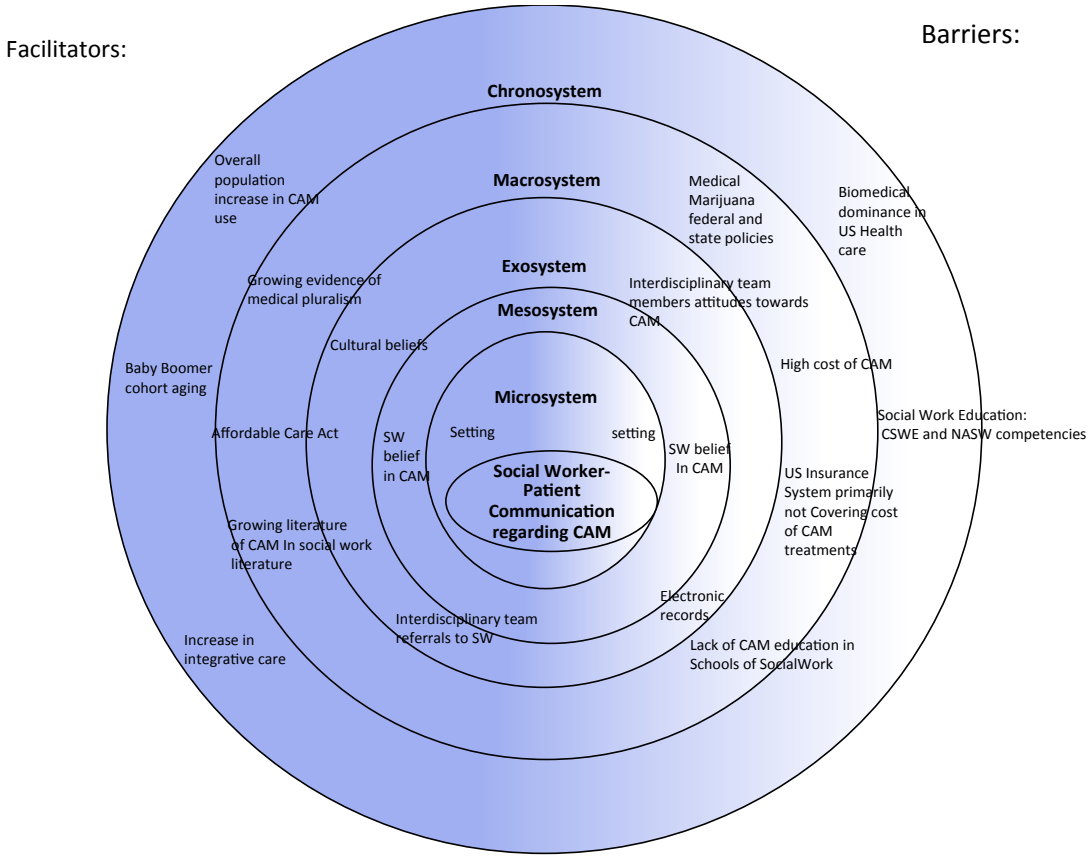

Figure 1: Ecological Systems Grounded Theory Model for Social Worker-Patient Communication Regarding Complementary and Alternative Medicine (CAM)

Limitations

Results from this study should be considered within the context of several limitations. One limitation is the lack of diversity in the sample. While it may not be a goal of qualitative research to find a representative sample, relying on a convenience sample based on the researcher's contacts and a snowball outreach to other social workers, ultimately did not include the voice of African American social workers. This researcher attempted more targeted outreach, by contacting African American Social work list serves, but was not able to recruit an MSW-level African American social worker who worked in a health care setting with older adults to interview for the study. Similarly, while the majority of MSWs are women, having only two male social workers

in the sample is not representative of MSWs in the United States. Given racial/ethnic and gender differences in the use of CAM demonstrated in previous research, this may result in the omission of important different perspectives.

The inclusion criteria also limited the focus of this study. Because the research criteria includes "MSW level social workers based in a health care setting," social workers who work with older adults in other settings such as non-profit social service agencies, local offices on aging, and other government agencies serving older adults were excluded. In addition, a number of the interviewees include social workers that identify as "medical social workers" versus "geriatric social workers." The training and approaches to working with older adults may differ and influence responses to the interview questions. Furthermore, social workers employed in non-health care settings may face different constraints or opportunities in terms of offering CAM as an option for clients.

CHAPTER 6

IMPLICATIONS

The overarching goal of this study was to increase our understanding of the intersection of geriatric social work and Complementary and Alternative Medicine (CAM). Chapter six looks at the implications of the core themes that emerged from this study (knowledge, assessment, practice, barriers, and culture) in response to social work practice, education, policy, and research.

Social Work Practice Implications

CAM modalities are popular with older adults for health care treatment and prevention (Ness et al., 2005; Cheung, Wyman, & Halcon, 2007) and will most likely increase due to demographic diversity and aging baby boomers. A patient's choice to use CAM indicates a medically pluralistic approach to their health care, although they may not see it in that light. As indicated in the research findings, most of the social workers indicated they included a few mind-body practices in their work with patients, many of the social workers were aware that their patients utilized CAM modalities, and most were aware which CAM modalities were offered by other professionals at their place of employment. Many of the social workers were aware of this information without formally assessing for CAM, but not all.

Implications for social work practice include improving social worker-patient communication about CAM, incorporating CAM into understandings of cultural competency, advocating for recognition and inclusion of CAM at multiple system levels, and broadening understanding about the variety of settings in which CAM might be within the scope of social work practice.

Social worker-patient communication and CAM. Key points of social worker-patient communication occur during assessment, within the context of social work clinical interventions, and through the process of information and referral. First, reorienting practice to include CAM implies making assessment of CAM, especially of client use of herbal therapies and dietary supplements, a priority. Second, a number of mind-body practices are certainly within the scope of clinical social work group practice (e.g., support groups, stress management groups, Cognitive Behavioral Therapy groups, mindfulness meditation groups) as well as mind-body practices taught at the individual one-on-one level. For example, social workers, with the right training and/or certification, can teach yoga infused trauma groups, mindfulness caregiver support groups, or mindfulness forgiveness groups. Social workers can also advance CAM practice by lobbying for agency support of these practices. Third, if patients are going to increasingly want more CAM preferences, then social workers need to be knowledgeable of acceptable referral sources. The future equivalent of a Rolodex for a geriatric social worker may look different with contacts for acupuncturists, massage therapists, hypnotists and yoga instructors, as well as home health care agencies and geriatric psychiatrists.

Social Work practice, CAM & cultural competency. In terms of cultural competency, social workers are expected to learn the cultural traditions and practices of the major patient groups they serve, use appropriate methodological approaches and techniques to reflect their understanding of patient culture in the helping process, and be knowledgeable about services and community based referrals available for diverse patient needs (NASW, 2001). One implication for cultural competency and CAM includes

training social workers in traditional practices and culturally relevant CAM practices. Similarly, implications of cultural competency training reinforces the concept of medical pluralism and teaches students that individuals may hold different beliefs towards healing than those discussed in conventional health care.

An additional approach to addressing cultural competencies includes adding related questions during an assessment. Efforts to reduce disparities in health care, as well as to provide effective patient-centered care, have focused on how professional 'cultural competency' can be helpful. Cultural competency in social work means acknowledging that cultural differences may occur and exploring with clients how these differences may affect health care. Paying attention to cultural competency is especially important in assessing for patient use of CAM. Social workers who work with older adults in health care settings will interact with patients whose cultural background may be a factor in how they understand their health care needs. This may differ from how the health care team understands the patient's care needs. Just as medical social workers are trained to look at how social issues may affect a patient's access to health care (literacy to understand medical directions, transportation to appointments, finances to pay for medication etc.) extending assessment to how a patient's understanding of why they are ill and what they believe will be helpful in their health care will help the medical team understand the patient's preferences for care. Because this type of assessment may identify a patient's medically pluralistic approach to care, this information will help to assess whether a patient uses CAM or believes CAM will be helpful in their course of treatment.

Kleinman's Explanatory Model (EM). Psychiatrist and anthropologist Arthur Kleinman's (1976) theory of Explanatory Model (EM) asserts that patients may have vastly different beliefs towards health and disease than their health practitioners. While social workers are not seeking a medical diagnosis, their use of the EM can be instrumental in understanding a patient's cultural understanding of their current situation. Based on the EM, social workers may add a few of the following questions (Kleinman, 1976) to their assessment:

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is your sickness? In your opinion, how long do you think it will last, or will you be better soon?
- What are the chief problems your sickness has caused?
- What do you fear most about your sickness?
- What kinds of treatment do you think you should receive?
- What are the most important results you hope to get from treatment?

The addition of these questions to a social work assessment, within a health care context, will provide the social worker a greater understanding of a patient's cultural background (increase cultural competency), as well as increase the social worker and larger health care team's understanding of a patient's use of CAM and beliefs in medical pluralism.

The EM can be useful for teaching social work students about cultural competency as well. It can provide a framework for discussing CAM in the context of

medically pluralistic beliefs and provide students a lens into the importance of not assuming clients have the same world view regarding illness and health care. Assessment of CAM, and the use of the Explanatory Model, provides social worker students tools to discuss potential cultural differences with clients –especially differences that might impact client care.

Advocacy. At an advocacy level, social workers can advocate on behalf of individual patients for inclusion of CAM in treatment plans. They can work with legislators to advocate for insurance coverage of certain CAM modalities. Social workers can pursue membership on hospital health care boards to encourage medically pluralistic approaches to care. Social workers can initiate practice-based research and evaluations to demonstrate cost-effective social work led interventions with CAM modalities and then share findings with groups that have power (e.g., insurance companies, hospital administrators) in order to initiate change. Social workers can volunteer their time in professional organizations (CSWE, NASW) to encourage awareness of social work competencies to reflect CAM philosophy. Social workers can strategically connect on inter-professional care teams to advance information about assessment for medical pluralism.

Settings for CAM use. Finally, there are implications related to the variety of settings in which CAM might be within the scope of social work practice. One such setting for social work practice and CAM is in geriatric primary care. With a growing movement toward integrated care for behavioral health there is a place for social workers trained in mind-body practices, as well as other conventional social work practices, to work with older adults and their families on reducing caregiving stress, mental health

symptoms, and to help with disease prevention and overall well-being. A second setting is hospital based wellness programs that offer mind-body practice workshops and one-on-one coaching sessions to help patients with health change strategies. Medical social workers provide essential services for health education, disease prevention and wellness promotion and see people from a wide range of socio-economic, ethnic, and cultural backgrounds. As social workers continue to carve niches for themselves in health care settings, this could be another site for social worker led CAM interventions. A third setting is within integrative care centers, which at this time, based on an informal internet search, do not currently have a large social work presence. A fourth setting is within home-health care and home based geriatric care management. Similar to the CAM modalities, which in-home hospice and palliative care social workers have incorporated into their social work practice, social workers who make home-visits are in a position to assess for CAM, utilize CAM modalities, and provide I & R for CAM practices.

Educational Implications

Incorporating CAM into the curriculum. One major implication from this study is the importance of incorporating content on CAM throughout the social work curriculum. Increasing social work's awareness of CAM implies supporting the transmission of CAM information at multiple levels: in course work, field work, and in continuing education. At this time, most schools of social work that offer course work in CAM offer it at as an elective. Strengthening social work's awareness of CAM will mean integrating CAM across social work curricula by including learning objectives in practice, human behavior and the social environment (HBSE), social policy/advocacy, and research and evaluation courses and in field liaison groups and practicum courses.

Course work. Course work in CAM would include an overview of medical pluralism, assessment (particularly of use medications and herbal therapy), information about CAM modalities and current research on CAM, CAM use for special populations (including older adults), and cultural competency issues regarding CAM.

Policy Implications

Implications regarding social work policy around CAM address the following: 1) Changes in health care provision under the Affordable Care Act, 2) the role of health insurance and CAM, and 3) policies specific to medical marijuana.

Changes in health care provision under the Affordable Care Act. The Affordable Care Act (ACA) is of historical precedent. The ACA has vastly expanded health insurance to an estimated 15 million Americans (United States Department of Health and Human Services, 2014). While insurance coverage under the ACA has had less significance for older adults due to Medicare coverage, certain provisions and changes in health care as a result of the ACA significantly affect older adults. The ACA does not mention CAM, but encourages culturally appropriate care and emphasizes preventive care, linked with community prevention services, for which CAM may be helpful. And while the ACA does not specifically mention social work, one implication of the ACA may be an increase in social work related tasks. For example, the ACA states a push to increase dementia and abuse prevention training, nursing home transparency, and care transitions programs, all programs that heavily affect older adults.

In addition to extending health care insurance to uninsured Americans, the Affordable Care Act has 5 other objectives: 1) Improve health care quality and patient safety; 2) emphasize primary and preventive care, linked with community prevention

services; 3) reduce the growth of health care costs while promoting high-value, effective care; 4) ensure access to quality, culturally appropriate care, including long term services and supports, for vulnerable populations; and 5) improve health care and population health through meaningful health information technology (HHS.gov).

Initiatives of the ACA to achieve these objectives, in connection with social work and CAM, may be helpful to older adults with chronic physical and mental health problems such as depression, heart disease, and back pain, as well as for overall well-being. One goal of the ACA is to reduce the growth of health care costs while promoting high-value effective care. As indicated in the literature review, a number of mind-body practices (MBSR, Meditation, acupuncture) have been found helpful to older adults. In general, CAM modalities are not expensive to administer and expenditures in CAM, especially for well-being and disease prevention, may help to lower overall healthcare costs.

However, while the intersection of social work and CAM and the ACA holds promise, obstacles at different system levels need to be overcome in order to be more hospitable to medical pluralism. For example, at the meso level, community transformation grants are funds available through the ACA to help communities prevent chronic diseases such as cancer, diabetes, and heart disease. They require a project proposal to include an evidence based practice – a standard that many CAM modalities do not currently meet. Also at the meso level, there is possible competition between different health care professionals wanting a bite out of the ACA funds. Social work is not any different. Key roles that social workers can play include advocating for social work led CAM interventions to be covered by the ACA, pursuing leadership roles on

health care boards that influence ACA policies, and advocating at the legislative level for ACA coverage.

At the macro level, another possible implication of the ACA is related to the number of newly insured Americans who had not been receiving conventional health care and might have turned to alternative methods of care. Social work needs to be ready for this new, possibly CAM using population. As discussed in the practice section, an excellent psychosocial assessment is needed to learn about potential CAM use.

The role of health insurance and CAM. The lack of health insurance coverage for CAM is one of the main systemic obstacles to a medically pluralistic system of care. Until health insurance companies reimburse for CAM, the same way insurance companies cover bio-medical care, there will never be an equal playing field for CAM use. Respondents indicated lack of insurance coverage and high costs of CAM were leading barriers to CAM use.

Leading up to the passage of the ACA and beyond there has been a parallel advocacy effort in both the social work field and in certain CAM practitioners (e.g., acupuncturists) to push for a greater presence in the US health care system under the ACA. Advocacy efforts for CAM and the ACA are mostly with health insurance companies, promoting insurance coverage and greater access in the health care system to licensed CAM practitioners. The experience of chiropractic care provides a useful precedent. Medicare will now provide coverage for chiropractic care, but that only happened in 1972, when Congress approved it after extensive lobbying by practitioners. Under different state laws, certain CAM modalities are covered under insurance: California, Maryland, New Mexico, and Washington have included acupuncture for

treating pain, nausea, and other ailments in their essential-health benefit plans, the threshold that most insurance plans must meet under the law. For nutritionists and registered dieticians, the ACA states they can be a part of medical care homes, but are not required to be team members. However, the law is less specific about how they are reimbursed and does not *require* medical homes to include them. The burden rests on practitioners to show the value and cost-effectiveness of their work.

Medical Marijuana. Medical marijuana will continue to be a point of discussion as more baby boomers age and confront issues around pain management. While marijuana continues to be classified as an illegal drug at the federal level, in the last 17 years, 22 states plus the District of Columbia have passed medical marijuana legislation, legalizing limited access to marijuana with a doctor's letter of recommendation. The conversation regarding medical marijuana happens in the ballot box, public discourse, and within the medical establishment. The conversation within the medical establishment is the point of interest here. While medical marijuana may be legal in certain states, as evident in this research study, at an institutional level, medical marijuana is not always available to patients. The respondents had mixed responses regarding medical marijuana, mostly wanting to support patient self-determination and a belief in marijuana's help with pain and symptoms like nausea. However, other social workers, especially those who had worked in substance abuse, have concerns regarding advocating for its use. Respondents indicated this was also an issue at the institutional level; it may be legal but doctors do not want to prescribe. This appeared to be the case at agencies where the patient population had a history of substance abuse. This researcher does not pretend to have an answer as to how medical institutions should manage marijuana use, nor the

position the social work field should take. However, one implication from the study was that marijuana use with older adults has grown and will continue to be an issue for social workers.

Research Implications

In order to be a player in health care reform, social workers need to provide evidence that social work interventions are cost saving measures. Through practice-based research, social workers can both demonstrate which CAM modalities used by social workers with an older adult population are effective as well as increase social worker visibility in practice research. Research endeavors should include academic partnerships with community based health care agencies as well as with CAM practitioners.

Adults of all ages utilize CAM modalities for health care treatment and prevention. CAM has shown to be effective for stress management groups, Cognitive Behavioral Therapy groups, and mindfulness meditation groups. But social workers need to be active in demonstrating CAM efficacy. At a systems level, one of the barriers to CAM practice is lack of a solid research base, which is often related to a lack of funds for this type of research. Social workers with an interest in CAM should explore funding mechanisms and work to establish partnerships between academia and community practice as well as with CAM practitioners.

Education. One future direction from this study is to incrementally work to increase CAM's presence in the social work curriculum. This includes several immediate steps:

1. Create a course on Social Work Practice and CAM, with a focus on medical

pluralism, definitions and understanding of CAM modalities, scope of social work practice, and social worker-client communication, especially related to psycho-social assessments.

2. Work with colleagues to integrate material into other social work classes much as has been done with gerontology and other topics in the past. On a personal note, this researcher created a new social work and older adult practice class this semester. A module concerning CAM was added to the syllabus and the assigned text included a chapter about CAM use for older adults (McInnis-Dittrich, 2014). In addition, this researcher included information regarding this dissertation study, and initiated an on-line dialogue with students to review their definitions of CAM, how CAM is communicated about in their field placements, and then discussed the student's own use of CAM. Students were well aware of the definition of CAM and noted there was no formal assessment for CAM at their agencies. Students enthusiastically expressed an interest in learning more about CAM modalities for patient use and a few students asked whether information regarding CAM could be included in other parts of the course. This researcher was pleased to see an interest and awareness of CAM and noted where information regarding CAM would be best imbedded in future coursework.
3. Reach out to social work colleagues at other universities who have created CAM related courses and organize a workgroup to strategize around ways to include CAM information into the core CSWE competencies.
4. Create a continuing education workshop on Social Work Assessment of CAM in Health Care. The workshop would include background about current rates of

CAM use, reasons to assess for CAM, issues regarding cultural competency and CAM, and CAM modalities within the social worker scope of practice.

5. Develop a CAM reference sheet for social workers to add to their 'tool box'. This reference sheet would include questions to help guide a conversation regarding CAM use, highlight different CAM modalities that are considered within the scope of social work practice, and a list of possible CAM modalities for referral.

Research. Future directions for research in CAM and social work would include community based practice research with older adults and social work practitioner research.

Community based practice research. There are many potential opportunities for community-based practice research regarding social work practice and CAM, especially with older adults. For example:

1. Reach out to both health care and long-term care settings to conduct research on social work led CAM interventions.
2. Replicate research based on Cognitive Stimulation Therapy (CST), which is considered an evidence-based practice in Britain and the only funded, non-pharmaceutical intervention for dementia in Britain. There have been limited social work studies on this intervention in the United States.

Social work practitioner research. Examples of social work practitioner research include:

3. Conduct an exploratory study to look at how social workers working within a primary care system (*integrated care*) utilize CAM modalities with behavioral health clients.

4. Conduct an exploratory study on social workers in *integrative care* centers and the institutional factors that promote and discourage social worker presence within integrative care.
5. Conduct a follow-up study based on this dissertation to explore timing and whether CAM is considered largely for prevention, as a treatment of last resort, or part of the normal range of treatment modalities they consider for patients; whether social workers' consideration of CAM evolves over time as they gain more practice experience; and the views of social workers who embrace CAM personally, but do not include it as part of their social work practice.

Conclusion

A significant number of older adults in the United States choose non-traditional treatments (CAM) for both chronic physical and mental health problems such as depression, heart disease and back pain, as well as for overall well being. Different CAM modalities may be helpful for older adults, but patient-provider communication regarding CAM is necessary in order to ensure that CAM modalities are safe and will not interfere with conventional treatment. Social workers in a health care setting should be included as one of the team members who need to communicate with patients about CAM, both to assess for safety, as well as to assess whether a patient holds a medically pluralistic belief system towards his health care. This communication also extends to whether patients are interested in CAM modalities. At the time this research began there was a paucity of information on whether and how these conversations took place or the extent to which social workers are aware of CAM and its potential benefits and risks. This dissertation sought to fill this gap.

The overarching goal of this study was to better understand social worker-patient communication around CAM through an examination of the extent to which geriatric social workers are aware of and incorporate CAM into their current practice and the factors that facilitate or inhibit their use of CAM with older adults. This dissertation examined social worker-patient communication regarding CAM and how well social workers are equipped to play this role. Thirty-nine semi-structured interviews were conducted with a non-random purposive sample of geriatric social workers from four different geographical regions. The four geographical regions included parts of Michigan (Greater Lansing, Ann Arbor, Grand Rapids); the San Francisco Bay Area; Greater Boston, and Honolulu, Hawaii. The research indicated that social workers in the study did not routinely assess for CAM use, including use of herbs or supplements, nor were they likely to affirmatively recommend CAM modalities. The research also identified a number of institutional barriers that inhibit communications about CAM, made specific recommendations to improve CAM-related social work education and training and to better accommodate CAM modalities at multiple system levels. In addition, the study also revealed cultural competency deficiencies, specifically, reluctance by social workers to ask about CAM use out of fear that they will appear to be stereotyping based on the patient's cultural background. Social worker respondents also indicated a lack of knowledge about CAM use prevalent in particular patient communities.

A guided theory that emerged from this study was the following: *Social worker-patient communication regarding CAM is influenced by social worker knowledge and practice of Complementary and Alternative Medicine (CAM), which is both facilitated*

and constrained by the ecological forces within social work education and practice environment, as well as its intersection with medical pluralism.

Implications for the study include how CAM affects social work practice, education, policy and research. Implications for social work practice include improving social worker-patient communication about CAM, incorporating CAM into understandings of cultural competency, advocating for recognition and inclusion of CAM at multiple system levels, and broadening understanding about the variety of settings in which CAM might be within the scope of social work practice. An implication for social work education is the need to incorporate content on CAM throughout the social work curriculum, supporting the transmission of CAM information at multiple levels: in course work, field work, and in continuing education. In addition, implications from the study include considering how including education regarding social worker communication and assessment of CAM may be helpful in teaching cultural competency. Implications regarding social work advocacy are at the macro level, looking at the role of social work and CAM within policies under the Affordable Care Act as well as advocacy on changes in the insurance system to support use of CAM. Implications regarding research are the need for social work to increase their role in social worker led studies regarding CAM efficacy.

APPENDICES

Appendix A: Institutional Review Board Approval

April 17, 2014
To: Amanda Woodward
222 Baker Hall
Re: IRB# x14-343e Category: Exempt 1-2
Approval Date: April 17, 2014
Title: The Intersection of Geriatric Social Work and Complementary and Alternative Medicine

The Institutional Review Board has completed their review of your project. I am pleased to advise you that your project has been deemed as exempt in accordance with federal regulations. The IRB has found that your research project meets the criteria for exempt status and the criteria for the protection of human subjects in exempt research. Under our exempt policy the Principal Investigator assumes the responsibilities for the protection of human subjects in this project as outlined in the assurance letter and exempt educational material. The IRB office has received your signed assurance for exempt research. A copy of this signed agreement is appended for your information and records.

Renewals : Exempt protocols do not need to be renewed. If the project is completed, please submit an Application for Permanent Closure .
Revisions : Exempt protocols do not require revisions. However, if changes are made to a protocol that may no longer meet the exempt criteria, a new initial application will be required.

Problems : If issues should arise during the conduct of the research, such as unanticipated problems, adverse events, or any problem that may increase the risk to the human subjects and change the category of review, notify the IRB office promptly. Any complaints from participants regarding the risk and benefits of the project must be reported to the IRB.

Follow-up : If your exempt project is not completed and closed after three years, the IRB office will contact you regarding the status of the project and to verify that no changes have occurred that may affect exempt status. Please use the IRB number listed above on any forms submitted which relate to this project, or on any correspondence with the IRB office.

Good luck in your research. If we can be of further assistance, please contact us at 517-355-2180 or via email at IRB@msu.edu. Thank you for your cooperation.

Harry McGee, MPH
SIRB Chair

c: Sheryl Groden

Sincerely,
Initial IRB
Application
Determination
Exempt

Office of Regulatory Affairs
Human Research
Protection Programs
Biomedical & Health
Institutional Review Board
(BIRB)
Community Research
Institutional Review Board
(CRIRB)
Social Science
Behavioral/Education
Institutional Review Board
(SIRB)
Olds Hall

Appendix B: Request for Participation E-mail Communication

Michigan State University social work doctoral student is seeking MSW level social workers who are willing to meet for a one-hour interview regarding the topic 'Complementary and Alternative Medicine' (CAM). CAM refers to a group of diverse medical and health care systems, practices, and products that are not presently considered part of conventional medicine, including acupuncture, yoga, herbs and dietary supplements, massage, and mind-body techniques. I am interested in exploring the role CAM plays in social work practice and assessment with an older adult population.

For the purpose of this study, social workers must be Masters level social workers (MSW), employed in a health care setting that serves older adults, with at least half of their client caseload 65 and older. The following health care settings would qualify for the study: hospital, dialysis center, skilled nursing rehabilitation, behavioral health, adult day health care, hospice residential and hospice home health care, and integrated primary care.

I will be in Boston February 9-13 for interviews. Interviews are approximately one hour, audiotaped and confidential. Interviews will take place in a quiet, confidential space (your work office, public library).

Interview subjects do not need to have any knowledge of CAM or to include alternative therapies in their social work practice in order to participate in the study.

Each participant will receive a $20 gift card for participating in the study.

Please contact Sheryl Groden at (510) 295-5865 or grodensh@msu.edu to schedule an interview or for questions regarding the study.

Appendix C: Response Rate Table

Table 4*:* Response Samples by Agency Type Rates and Final

	Total Contacted	Non-responders	Reasons for not participating[a]	Final Sample
In-patient hospital	19	5	b(5), c(1) d(3)	4
Dialysis Clinic	7	2	a (2)	3
Hospice	9		b (5)	4
SNF/Assisted Living	14	4	b (1), c (1), d(2)	6
Oncology (out-patient)	6		b (2)	4
Neurology/Dementia clinic	5		b (2)	3
Geriatric Assessment clinic	9	3	b (2),	4
Primary Care Clinic	5	4		1
Palliative care (out-patient)	2			2
Palliative care (in-patient)	2			2
Adult day program (PACE) model	9	2	b (2)	5
Community Mental Health	3		b (2)	1
Total	**90**	**20**		**39**

Note. [a] Reasons for not participating include: (a) not interested (b) not available during time frame of interviews (c) not permitted to participate (d) did not meet study criteria The number in parentheses indicates how many agencies did not participate because of reason (a), (b), (c) or (d).

Appendix D: Informed Consent (Without Gift Card)

Informed consent

Study Title: The Intersection of Geriatric Social Work and Complimentary and Alternative Medicine (CAM)
Researcher and Title: Amanda Toler Woodward, PhD, Associate Professor; Sheryl Groden, MSW, Doctoral student
Department and Institution: School of Social Work, Michigan State University
Address and Contact Information: 222 Baker Hall, East Lansing, MI 48824
Phone: 517- 432-8702, E-mail address: awoodwar@msu.edu, grodensh@msu.edu

1. Purpose of Research:
You are being asked to participate in a research study of Michigan State University's School of Social Work (MSUSSW). You have been selected as a possible participant in this study because you are a MSW social worker working in a health care setting with at least 50% of your caseload 65 years of age and older. The purpose of this study is to better understand the extent to which geriatric social workers are aware of and incorporate Complementary and Alternative Medicine (CAM) into their current practice and the factors that facilitate or inhibit their use of CAM. Your participation in this study will take about 60 minutes.

2. What you will do:
Participants in the study will answer interview questions during an individual face to face or phone interview or via a small focus group. All participants are welcome to learn about the survey findings and can contact the researchers after May 2016 for results.

3. Potential benefits:
You will not directly benefit from your participation in this study. However, your participation in this study may contribute to the strength of our understanding of geriatric social workers awareness of and incorporation of Complementary and Alternative Medicine (CAM) with their social work assessment and social work practice.

4. Potential risks:
There are no foreseeable risks associated with participation in this study.

5. Privacy and confidentiality:
The data for this project will be kept confidential. Data will be coded and a key will be maintained separately. Information about you will be kept confidential to the maximum extent allowable by law. The data will be stored in locked file cabinets and on password-protected computers in locked offices until the completion of the project. We will store the data for three years. Only the two researchers on the study will have access to the data. The results of this study may be published or presented at professional meetings, but only in the aggregate and the identities of all research participants will remain anonymous.

6. Your rights to participate, say no, or withdraw:
Participation in this research project is completely voluntary. You have the right to say no and you may change your mind at any time and withdraw. You may choose not to answer specific questions or to stop participating at any time.

7. Costs and compensation for being in the study:
You will not receive money for participating in this study.

8. Contact information for questions and concerns
If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact the researchers, Professor Amanda Toler Woodward at Michigan State School of Social Work, 222 Baker Hall, East Lansing, MI 48824; phone: 517- 432-8702; e-mail address: awoodwar@msu.edu or Sheryl Groden at Michigan State School of Social Work, 22 Baker Hall, East Lansing, MI 48824; phone: 510-295-5865; e-mail address: grodensh@msu.edu

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously, if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax-432-4503, or e-mail irb@msu.edu or regular mail at 202 Olds Hall, MSU, East Lansing, MI 48824.

9. Documentation of informed consent:

By clicking 'next' to continue with the survey you acknowledge that you voluntarily agree to participate in this research study.

Appendix E: Informed Consent (With Gift Card)

Informed consent

Study Title: The Intersection of Geriatric Social Work and Complementary and Alternative Medicine (CAM)
Researcher and Title: Amanda Toler Woodward, PhD, Associate Professor; Sheryl Groden, MSW, Doctoral student
Department and Institution: School of Social Work, Michigan State University
Address and Contact Information: 222 Baker Hall, East Lansing, MI 48824
Phone: 517- 432-8702, E-mail address: awoodwar@msu.edu, grodensh@msu.edu

1. Purpose of Research:
You are being asked to participate in a research study of Michigan State University's School of Social Work (MSUSSW). You have been selected as a possible participant in this study because you are a MSW social worker working in a health care setting with at least 50% of your caseload 65 years of age and older. The purpose of this study is to better understand the extent to which geriatric social workers are aware of and incorporate Complementary and Alternative Medicine (CAM) into their current practice and the factors that facilitate or inhibit their use of CAM. Your participation in this study will take about 60 minutes.

2. What you will do:
Participants in the study will answer interview questions during an individual face to face or phone interview or via a small focus group. All participants are welcome to learn about the survey findings and can contact the researchers after May 2016 for results.

3. Potential benefits:
You will not directly benefit from your participation in this study. However, your participation in this study may contribute to the strength of our understanding of geriatric social workers awareness of and incorporation of Complementary and Alternative Medicine (CAM) with their social work assessment and social work practice.

4. Potential risks:
There are no foreseeable risks associated with participation in this study.

5. Privacy and confidentiality:
The data for this project will be kept confidential. Data will be coded and a key will be maintained separately. Information about you will be kept confidential to the maximum extent allowable by law. The data will be stored in locked file cabinets and on password-protected computers in locked offices until the completion of the project. We will store the data for three years. Only the two researchers on the study will have access to the data. The results of this study may be published or presented at professional meetings, but only in the aggregate and the identities of all research participants will remain anonymous.

6. Your rights to participate, say no, or withdraw:
Participation in this research project is completely voluntary. You have the right to say no and you may change your mind at any time and withdraw. You may choose not to answer specific questions or to stop participating at any time.

7. Costs and compensation for being in the study:
Each participant will receive either a $20 giftcard for participating in the study.

8. Contact information for questions and concerns
If you have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report an injury, please contact the researchers, Professor Amanda Toler Woodward at Michigan State School of Social Work, 222 Baker Hall, East Lansing, MI 48824; phone: 517- 432-8702; e-mail address: awoodwar@msu.edu or Sheryl Groden at Michigan State School of Social Work, 22 Baker Hall, East Lansing, MI 48824; phone: 510-295-5865; e-mail address: grodensh@msu.edu

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study, you may contact, anonymously, if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax-432-4503, or e-mail irb@msu.edu or regular mail at 202 Olds Hall, MSU, East Lansing, MI 48824.

9. Documentation of informed consent:

By clicking 'next' to continue with the survey you acknowledge that you voluntarily agree to participate in this research study.

Appendix F: Interview Questions

Part one:

'Tell me about your current job. Client population. Demographics. General description of area served.', 'How many clients are on your caseload?', 'Are there practice guidelines you must adhere to? For example, does your agency require you to use specific evidence based practices?, 'Please describe what tasks you perform in your job.'

'How long have you been at this job? Previous positions?'

'Is there a type of social worker you would identify yourself as? Medical SW? Clinical SW? Geriatric SW? Something else?'

Part two:

'Does your social work assessment tool ask clients about dietary supplement and herbal therapy use?', 'Do you know which health care provider inquires about dietary supplement and herbal therapy use? 'Does your social work assessment tool ask clients about CAM use?', Do you ask clients if they've shared CAM information with their primary care physician or other medical care providers?, 'Does a client's age influence your decision to either assess for CAM or explore a client's interest in CAM?', and 'Is there anything about your clients cultural background that might either facilitate or hinder your asking questions about CAM use?'

Respondents were next asked a series of questions regarding social worker practice and CAM, including 'Do you include any of the therapies (refer to list) in your

own social work practice?', 'If yes, what is your training for that using that particular therapy?', **'**Under what circumstances do you discuss CAM to clients?', and 'In your experience, why do clients choose CAM?'

Respondents were asked a few questions addressing attitudes towards CAM: 'Do you personally use any CAM treatments?', 'Does your choice to use CAM influence your attitude towards client use of CAM?', 'Is there an official position about CAM therapies at your professional institution?', and 'Does your institution support or endorse CAM?'.

Respondents were asked a few questions addressing where they learned about CAM: 'What year did you get your MSW?', 'Do you have a BSW or another undergraduate degree?', 'Have you been practicing SW since you completed your MSW?', 'What School of Social Work did you attend?', 'Did your School of social work offer any coursework in CAM?', 'If yes, did you take any courses and if so, what?' 'What other educational opportunities or exposure have you had to CAM?'

Demographic questions were asked at the end of the interview, including age, religion and race/ethnicity of respondent.

Question regarding state licensure asked **'**Does your social work license require any pain management coursework? If yes, do you recall if CAM was included in pain management courses you've taken?'

Appendix G: Check-list of CAM Practices (1)

CAM practice	Are you familiar with this CAM practice?	Which of these CAM modalities do your clients use?
Acupressure		
Acupuncture		
Aromatherapy		
Art therapy		
Ayurvedic medicine		
Biofeedback		
Chiropractic		
Crystal Healing		
Dance Therapy		
Dietary supplements		
Drumming		
Exercise		
Faith healing		
Fasting and juice therapies		
Flower remedies		
Folk medicine		
Healing touch therapy		
Herbal therapy		
Homeopathy		
Humor therapy		
Hypnosis		
Guided imagery		
Laetrile		
Light therapy		
Macrobiotic diet		
Marijuana/Medical Marijuana		
Massage		
Meditation		
Mindfulness Based		

Stress Reduction (MBSR)		
Music/Music therapy		
Native American Healing		
Naturopathy/natural medicine		
Prayer/spiritual practice		
Reflexology		
Reiki		
Relaxation techniques		
Self-help books		
Sound therapy		
Special diet		
Spiritual healing		
Support group		
Tai chi		
Therapeutic touch		
Traditional/Chinese Medicine		
Visualization		
Vitamins		
Water Therapy		
Yoga		
Other:		

List of CAM practices (2)

CAM practice	Are you familiar with this CAM modality?	Which of these CAM modalities do your clients use?	Which of these CAM modalities are offered at your place of employment?
Acupressure			
Acupuncture			
Aromatherapy			
Art therapy			
Ayurvedic medicine			
Biofeedback			
Chiropractic			
Crystal Healing			
Dance Therapy			
Dietary supplements			
Drumming			
Exercise			
Faith healing			
Fasting and juice therapies			
Flower remedies			
Folk medicine			
Healing touch therapy			
Herbal therapy			
Homeopathy			
Humor therapy			
Hypnosis			
Guided imagery			
Laetrile			
Light therapy			
Macrobiotic diet			
Marijuana/Medical Marijuana			
Massage			
Meditation			
Mindfulness Based			

Stress Reduction (MBSR)			
Music/Music therapy			
Native American Healing			
Naturopathy/natural medicine			
Prayer/spiritual practice			
Reflexology			
Reiki			
Relaxation techniques			
Self-help books			
Sound therapy			
Special diet			
Spiritual healing			
Support group			
Tai chi			
Therapeutic touch			
Traditional/Chinese Medicine			
Visualization			
Vitamins			
Water Therapy			
Yoga			
Other:			

Other CAM modalities described in interviews:

Appendix H: Sample Field Log

CAM interview with (#17)

December 22, 2014

Interviewee #17 works at a dialysis center. The interview took place in her office, right outside of dialysis center. Social worker asked to not close the door in case a client needed her. Interrupted once or twice. Interview X is a social worker at a dialysis center in Honolulu. Transplant from the East coast. Previous work experience was in SNF and dialysis. Very knowledgeable about CAM practices for herself. Stated she believed her clients used very little CAM. Attributed CAM use to a high level of education. Stated her patients were low-income, many illiterate, many with limited English profiency. Did not inquire about CAM use. Used very little CAM modalities in her own practice.

Reflection:

I had such an adverse reaction to social worker's comments regarding patient use and CAM. The Social worker made snide remarks regarding patients level of literacy and education. SW also appeared burnt out. Pay attention to researcher reaction to limit bias when coding.

Follow-up questions:

Do they dieticians ask about herbal therapies?

CAM interview with SW (# 18)

December 30, 2014

Interviewee #18 is Director of Social Services at a life care community in Honolulu, in an affluent neighborhood. X has worked at for almost 4 years and has a background in medical social work, both dialysis and in-patient. X was professional, as well as friendly with a good sense of humor. X is originally from Hong Kong and I'm not sure when she moved to the US. She attended college in California and her MSW at UH in the early 80's. She was knowledgeable about CAM, but mentions she does not include any questions regarding CAM in her psycho-social assessment. In her setting it is nursing and dietetics who inquire about herb and supplement use. She said a number of residents take supplements and she also received calls from potential rehab guests who are concerned they cannot continue their supplements while in rehab. All information is reviewed with nursing and the dietician** who will write orders for supplements if approved by the doctor.

X mentioned she has little to do with residents in assisted living or independent living, except at admissions, or if they are transitioning to a higher level. She did not have a clear sense how many CAM modalities were used by this population, except that they do have yoga and tai chi classes on-site and a massage therapist.

Reflection: Interesting interview. A social worker with excellent sense of humor. Appreciated her comments on social work profession wearing many hats.

Follow-up questions for X or other interviewees

**What do we know about dieticians inquiring about CAM supplements and herbs? This would most likely to apply to SNF and dialysis? Where else?

CAM interview with SW (# 19)

January 2, 2015

Interview took place in SW office. SW office was located in back hall from dialysis center, not easily accessible by patients. Interviewee #19 has been practicing SW for almost 20 years. Very knowledgeable and dedicated to dialysis SW. Part Hawaiian and very knowledgeable about the different cultures served at her dialysis center. Had attended medical school and decided it was not for her. Grew up in Hawaii but lived on the mainland.

Reflection: Great interview. SW was super passionate and excited about her work. Cultural competency: is it because she is from the culture? Such a contrast from interview #17.

CAM interview with SW #20

January 2, 2015

Interview took place in conference room in front of out-patient hospice office. Bright. Beautiful art work – hand casting. I was late for interview – got very lost and phone GPS took me to the wrong part of town. I called SW so she knew I was running late, but I was frazzled when I arrived and she had limited time for interview. Rushed through interview. SW was transplant from the West coast. SW not ask about CAM directly but CAM on her radar. SW was interested in and knowledgeable about the culture.

Reflection: Make sure to get to interview on time! Lose credibility when you are late. Interesting interview. Cultural competency does not have to be from the same culture – but professional needs to be respectful of differences and curious to learn.

Follow up to quotes regarding CAM/herbal therapies: *I mean I don't think people are willing to lie about it. But they're not going to bring it up on their own. (Assessment. Patients not bringing up herbal use).*

CAM interview with SW # 21

January 6, 2015

Interview took place in partially empty conference room (two couches, no tables) on hospital floor near ICU. X is a palliative care social worker at a large hospital in Honolulu. She grew up in Honolulu but has lived on the mainland. X created a new palliative care assessment tool. Works with both older and younger patients. Felt that

doctors often refer to her more when the patient is younger because the physician feels less confident working with a younger patient around palliative issues.

Reflection:

I so enjoyed this interview! Social worker was super knowledgeable about palliative care, interactions with hospital colleagues and CAM. G-d forbid I ever need a palliative care social worker, but I would want her to be it! Pay attention to overt biases in coding based on SW reflections.

Follow-up questions:

Queesies? The name of the peppermint aromatherapy for nausau?

Appendix I: Initial Codes

Initial nodes included the following: Assessment, CAM practice, Cultural Connection, CAM Knowledge, Agency Policy, Social Work Identity, Evidence Based Practice, Personal use of CAM, Baby Boomers, Agency use of CAM, Electronic Medical Records, Types of CAM, CAM use by specific ethnic groups, Social Work demographics, Medical Team Assessment, Barriers, Rephrasing CAM – how to communicate about it, Role of CAM in oncology, Cultural Competency, Self-Care, Medical Marijuana, Folk Medicine, Social Work Education and CAM, Fear of the unknown, Adaptation of CAM for individual care, Ageism barrier, Critical thinking, Definition of CAM, Substance Abuse assessment, Agency acceptance of CAM, Insurance Barriers, Regional differences, Social work acceptance in health care setting, SW university, Social Worker date of MSW graduation, MSW program coursework in CAM, where was CAM learned, Social worker-patient communication regarding CAM, Size of case load, practice setting, social workers as team member, medication assessment, Referals for CAM, Herbal Therapy/supplement use, frequency of herbal therapy/supplements conversations with patients, help with medical decisions, Social worker consideration of CAM use in practice setting, type of setting and population served, Social Worker use of CAM in practice, geriatric primary care, long term care, in-patient hospital, hospice/palliative-end of life care, dialysis, oncology, geriatric mental health, adult day health care, refusal for western medication, cognitive impairment, health care insurance, religion, stigma, social worker openness to CAM, substance abuse, self-determination

Appendix J: Member Check

Sample member-check e-mail, CAM check-list and follow-up on themes/respondent quotes.

Dear x,

I hope this finds you well. I hope you remember me - we met at Cafe Stradda in August for my dissertation research. Another big thank you for your help!

I am finally finishing up the data analysis for this study. I completed 39 interviews with social workers in 4 different regions (Mid-Michigan, Greater Boston, Honolulu and the SF Bay Area) and I so appreciate the time you and the other social workers gave me. My last step for data analysis, before completing the writing of the dissertation, is called member check.

In order to complete member check, I have two steps I need to complete. First, on the attached form I have a list of CAM modalities we talked about and three columns describing what you know about CAM, what your clients use and what is offered at your agency/residence. At the time of the interview I did not ask what was offered at your facility (column 3). Can you please review the list for accuracy, add anything relevant and let know if anything is incorrect?

The second step is to review information I obtained in the interview. There are a few themes that emerged from all of the interviews. I've included a number of quotes from your interview that I would like to make sure that I am accurate quoting what you said. I know the interview was a long time ago so I don't expect you to remember it, but if you can please read the attached form and make sure I am accurately depicting what you reported in the interview, that would be great!

Best,
Sheryl

Sheryl R. Groden, MSW, LCSW
Doctoral Candidate and Clinical Instructor
Michigan State University School of Social Work

CAM practice #38	Are you familiar with this CAM modality?	Which of these CAM modalities do your clients use?	Which of these CAM modalities are offered at your place of employment?

Acupressure	X		
Acupuncture	X	X	X
Aromatherapy	X	X	X
Art therapy	X	X	X
Ayurvedic medicine			
Biofeedback			
Chiropractic	X		
Crystal Healing	X		
Dance Therapy	X	X	X
Dietary supplements	X	X	X
Drumming	X	X	X
Exercise	X	X	X
Faith healing			
Fasting and juice therapies			
Flower remedies			
Folk medicine			
Healing touch therapy			
Herbal therapy	X	X	
Homeopathy	X		
Humor therapy	X		
Hypnosis	X		
Guided imagery	X		
Laetrile			
Light therapy			
Macrobiotic diet			

Marijuana/Medical Marijuana	X	X	
Massage	X	X	X
Meditation	X	X	X
Mindfulness Based Stress Reduction (MBSR)	X		
Music/Music therapy	X	X	X
Native American Healing	x		
Naturopathy/natural medicine			
Prayer/spiritual practice	X	X	X
Reflexology			
Reiki	X		
Relaxation techniques	X		
Self-help books	X		
Sound therapy	X	X	X
Special diet	X	X	X
Spiritual healing	X	X	X
Support group	X	X	X
Tai chi	X	X	X
Therapeutic touch			
Traditional/Chinese Medicine	X	X	
Visualization	X	X	
Vitamins	X	X	X

Water Therapy			
Yoga	X		
Other:			

Assessment (How do you know your clients use CAM?)

"Some clients used acupressure. They will ask me 'Can you let me know when my next appointment is?' With a lot of the activities I'll see them participating in them or they'll show me the art that they did in art therapy. It's beautiful, you know, and I'll see them participating. Some of the activities are done in the main day room and some of them are done in a large conference room. Like with the exercise I'll just be walking through the center and I'll see them participating and having a great time",

"At intake the primary care physician reviews candidates current medications and review what is appropriate for them to remain on, remove or add based on their health conditions. We have a medication nurse that dispenses our clients weekly medications. She fills the medication set, which is a medication box that most of our clients receive. We ask all of our clients to bring in their "medi set" every time they come into the day health center so that if the doctor needs to make an adjustment they can just change it for them immediately and send it home with them. The medication nurse also reviews the medications with the clients as needed. She will explain 'you take this one in the morning, this one in the afternoon, and this one at night.' When our clients bring their medication sets to the day health center, the nurse and doctor can can review if they're remembering to take their medications, if they're taking them correctly". If clients are not taking medications correctly, we can send out a home care geriatric aide to their home to help remind them to take their medications. At times clients or their families will ask me questions about their medications, and then I refer them back to the medication nurse, since that is her area of expertise.

> Please confirm: who on your medical team asks the patients questions regarding herbal/supplement use? (not answered)

Client use of CAM

"Acupressure is something I've heard the doctors say "this participant really thinks it could help them so I've prescribed a few months of weekly acupressure" and we'll see if that helps."
(other CAM checked on list above)

Personal use of CAM

"I love massage, exercise and meditation. I find that exercise helps me be a more grounded person. I really like Zumba, I don't know if that's dance therapy. I've used self-help books in the past and they have been helpful. I also have practiced yoga for years. In grad school I was in a first year MSW support group that was really helpful". I've never done Tai Chi but I am interested in trying it.

Cultural competency/considerations

"I know that sometimes clients will continue to use Chinese medicine along with the Western medicine. That's something the social worker can negotiate with the family. Obviously trying to respect their belief system but also saying 'you know this is what the doctor is recommending'",

"Chinese medicine is something that our Asian families use in conjunction with the Western medicine as well."

"I think it's nice to have staff that are also the same culture so they can educate other staff about cultural competency. For example talking about cultural norms and taboos, for example explaining that talking openly about death is 'just not something that's done within this tradition'",

"I have noticed that communication styles and family dynamics vary by culture. I have worked with several Indian families in which the wife was the client and she has deferred to her husband and even if she is still cognitively able to make her own decisions.

"And then also in terms of Latino families sometimes the son will be the decision maker for mother instead of the daughter. It's nice that we have representation within our own staff. It's common to hear staff speaking Mandarin, Vietnamese, Tagalog or Spanish in the break room."

Medical marijuana

"I know that we don't provide it but we know that some of our clients use it"

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