

Psychologists as Change Agents in Chronic Pain Management Practice: Cultural Competence in the Health Care System

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Psychologists bring great value to health care systems, but our ethnocentrism regarding the medical community often limits our effectiveness as agents of change. Based on experience in developing pain management services within the Department of Veterans Affairs health care system, we discuss cultural issues as central to effective systems change and provide specific recommendations for psychologists aspiring to change organized health care systems, such as the Department of Veterans Affairs. Consideration is given to the misfit of the biomedical model to chronic pain, “physics envy” affecting the authority accorded psychology, and societal stigmatization of psychopathology. A process-based definition of cultural competence is recommended as improving on psychology’s intrinsic group-based notion of culture in engaging the medical community. The systems thinking literature is sampled in summarizing practical recommendations that include identifying features of local medical culture and power dynamics between psychology and medicine that can be modified by engaging stakeholders in an interpersonally effective manner.

Keywords: pain, psychologists, organizational culture, cultural competence

Chronic pain is associated with a problematic set of issues for the health care system and society. In particular, best practice standards in chronic pain management centrally emphasize biopsychosocial formulation, a paradigm that is only partially embraced currently in health care. Psychologists play a central role in chronic pain management but do not do so easily. While some leading psychologists have contributed valuably to understanding and early adoption of this paradigm and others in general may apply a systems perspective in their clinical practice, most rank and file psychologists have missed opportunities to facilitate system change in this and similar areas of health care. We purport that this failure reflects our lack of training as change agents, lack of identification with the larger health care system, and faulty definitions of culture within the discipline of psychology.

This paper applies a systems perspective informed by anthropologic notions of culture to the

endeavors of psychologists to transform health care systems, based closely on our direct experiences in pain management within the Department of Veterans Affairs (VA) health care system. Chronic pain management as a focus for system change serves as a prototype for other biopsychosocial medical issues and also bears its own unique features. We suggest the adoption of systems approaches to change, emphasizing themes of culture, cultural competency and ethnocentrism in attempting to more effectively facilitate health care system improvements. We relate these ideas to established theoretical paradigms, such as systems change, but we do not comprehensively review this literature, as previous authors have provided excellent comprehensive discussions of these issues (Checkland, 1984; Midgley, 2000). Our intent is to expand thinking regarding health care culture and leadership by psychologists, and to offer practical implications for system change.

Health Care and Societal Responses to Chronic Pain: A Challenge to the Biomedical Model

Several factors make the development of programs and system improvements in chronic pain management inconsistent and difficult.

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Chronic pain is commonly regarded by experts as a biopsychosocial problem (Gatchel et al., 2007), and multidisciplinary treatment of chronic pain is the state of the art (Flor, Fydrich, & Turk, 1992). In particular, development of pain treatment within the VAs health care system is now formally conceived in terms of a biopsychosocial model and a stepped care structural approach to treatment resources (VHA Directive, 2009-053, Pain Management; Veterans Healthcare Administration, 2009). Though the International Association for the Study of Pain (IASP) offers recommendations regarding the development of multidisciplinary pain centers (Cousins & Loeser, 1990), there is no single standard for their staffing or treatment philosophy. Chronic pain management programs have tended to be developed by local champions with structure and composition largely determined by available interest, resources and expertise, as opposed to any industry standard or even local organizational mandates for what a chronic pain treatment structure should look like. Therefore, individual programs have tended to vary widely in compositions and treatment models. For example, across facilities in the authors' VA health care network, specialty pain clinics are led by psychiatry, anesthesia, family medicine, and palliative care specialists, ranging from single provider to multidisciplinary staffs. Consequently, even during the current evolution of excellent clinical practice guidelines and forward-looking models for treatment in this complex clinical territory, there still is no single standard model for chronic pain treatment programs. In turn, outcome assessment and the empirical study of pain treatment are difficult, as existing pain treatment programs defy valid comparison to one another.

The question of how to structure a chronic pain management program is further complicated because no medical specialty "owns" leadership in chronic pain management. As there is good empiric evidence of the centrality of psychosocial factors (Geisser, 2004) and efficacy of psychological interventions (Hoffman, Papas, Chatkoff, & Kerns, 2007) for chronic pain, it should not be surprising that psychologists often contribute to clinical research and treatment program leadership in chronic pain. However, American medicine has generally operated from a biomedical, rather than biopsychosocial, model in the treatment of pain

(Crowley-Matoka, Saha, Dobscha, & Burgess, 2009), and medical systems do not expect leadership by nonphysicians. As health care providers tend to access new clinical and scientific findings most closely associated with their home disciplines, physicians may be unaware of developing paradigms for pain management published in pain specialty and psychological journals. Physicians often identify anesthesiology as the authoritative specialty in chronic pain, as anesthesiologists are most frequently board-certified as medical pain specialists, though anesthetic procedures play a relatively circumscribed role in chronic pain management. Conversely, VA clinical health psychologists are typically employed by mental health clinical systems, whose core mission often does not include pain management.

Pain is essentially invisible as a symptom, and the complex biopsychosocial impact and maintenance of chronic pain defy understanding within a conventional biomedical disease model. General lack of understanding of chronic pain as a disease entity contributes to its stigmatization in society and in health care, even to the point that services for treating chronic pain appear to have been de-valued. Chronic pain has often been regarded within the health care system as a nuisance medical problem, not quite elevated to the level of recognition as a legitimate disease, and at worst as a symptom cluster representing somatized psychopathology, drug dependence, or antisocial behavior in search of disability funding. Mistreatment because of these skewed characterizations is especially damaging, as patients with chronic pain tend to be high users of health care system resources (Phillips et al., 2008). Patients with chronic pain can be managed effectively, typically through an interdisciplinary, collaborative self-care model of treatment¹ that considers chronic pain to be a lifelong biopsychosocial disease entity. However, there is little evidence of health care systems prioritizing improvement of treatment programs for chronic pain. The National Pain Care Policy Act, which mandates widespread investments in the study and treatment of pain, was introduced in multiple ses-

¹ As noted by Anthony Mariano in the VISN 20 Chronic Pain Education Course, accessible to VA users at <http://vhapugweb3/pain/ChronicPain/index.html>.

sions of congress, passed the House of Representatives in 2009, but awaits resolution of multiple House and Senate versions as this paper is being submitted.

Psychology, Medicine, and Ethnocentrism

Although chronic pain programs are necessarily heterogeneous in that they are reflective of an institution's local dynamics and resources, psychologists and physicians are likely to play predominant roles in determining their development. It is therefore worth considering cultural similarities and differences between psychologists and physicians. At first glance, psychologists and physicians appear to have much in common. Particularly when viewed from the perspective of lay persons, both psychologists and physicians occupy the polar end of a continuum in society, united by their unusual degree of expertise, authority on clinical issues, and professional power. Their clinical authority imparts a unique autonomy and relieves both groups of the burden of honoring alternative rules and alternative cultures to their own. They share an emphasis on science and empiricism relative to other professional disciplines, in which scientific questions are investigated independently of sociocultural factors, which are either controlled or ignored. Both disciplines value reductionism and study of variables, rather than holism that may be more commonly the focus of study in disciplines such as sociology or anthropology.

Despite these similarities, psychologists and physicians are trained quite differently (Kingsbury, 1987). Medicine perceives science as a matter of objective *fact*, uncovered by correct and thorough investigation, whose unique conclusion identifies a singular pathogenesis and thereby an indicated plan of treatment. Psychology perceives science as a *process* by which theoretical relationships among ideas are tested via their real-world measurable referents, in a continually evolving paradigm. Empirical validation is an ultimate test of clinical treatment strategies, but this feature is essentially practical, and competing explanations for the clinical problem are welcome to coexist. Psychology arose as an academic discipline, awarding the doctor of philosophy degree, identifying its holders as scientist practitioners. The medical doctor title is a professional degree held by

clinicians inferred by society as scientific. Physicians are first decision makers and gradually add depth and breadth to their familiarity with clinical concerns as they gather experience. Psychologists are first scholars, often seeing very few patients and spending comparable time in supervision early in their training, and gradually becoming more efficient and decisive as they develop their craft.

There is little exposure of these relatively discrete professional cultures to one another in training, and psychology is clearly a minority subculture within the medical majority culture. Whereas most health professions are trained as dependent practitioners to physicians or trained to roles clearly defined within the medical system (e.g., advanced practice nurses, dentists, podiatrists), even psychologists specializing in clinical health psychology typically only work with physicians late in their training, in selected advanced practicum or internship placements. Similarly, physician trainees' contact with licensed psychologists may be highly circumscribed, with contact limited to psychiatry rotations or selected "psycho-social" topics, such as patient-centered communication. With physicians greatly outnumbering psychologists in the health care system (at the authors' facility the ratio is 18:1), such limited exposure to psychologists likely relegates the discipline of psychology as another ambiguous allied health profession. Even outside of the workplace, all psychologists have personally experienced medical providers, yet most physicians (and their subordinates) have not seen a psychologist professionally.

Given these contrasts, physicians and psychologists have good reason for not understanding one another. It may be a bigger challenge, however, for either group to see themselves as essentially *ethnocentric*. Although psychologists may be acquainted with the largely anthropologic term, it is useful to unpack this complex construct. Ethnocentrism is a process of evaluating other cultural groups based on the norms, values, and beliefs of one's own culture. This process typically happens without the sensitivity or awareness that one's cultural "lens" creates a bias in how others are perceived. Culturally encapsulated majority groups may be particularly at risk for ethnocentrism. These groups can maintain a stance of inherent supe-

riority because they lack the understanding that their own culture-bound worldview is one of several perspectives rather than a universal norm. The end result of ethnocentrism is cultural incompetence, manifesting in prejudice, dysfunctional relational patterns, or outright dismissal of a minority group's legitimacy.

The ultimate responsibility and authority attributed to physicians, the relatively small portion of physicians' universe occupied by psychologists, and the lack of training in alternative worldviews easily explain any tendency for physicians to be blind to their own ways of relating to psychologists. However, the label of ethnocentrism may be more ironic or surprising to psychologists who have long claimed expertise in human behavior and interpersonal interactions, especially with a growing focus on topics such as discrimination and ethnic diversity (Fish, 2000). Consider that many psychologists and physicians may do a relatively poor job in understanding one another, and may be likely to evaluate one another's professional practice based on the ideals of their own discipline. For example, some physicians may discount the data from a consulting psychologist unless it immediately impacts medical treatment, such as the initiation or modification of opioids. At the same time, psychologists may be quick to judge a physician who disregards their contextualized behavioral formulation in favor of relatively simplistic input regarding a patient's likelihood to misuse narcotics. In this scenario, a physician may be driven by their profession's heavy emphasis on diagnostic precision, caution in prescribing a scheduled medication with high abuse potential, and the significant limitations of a 15-min patient encounter. In comparison, psychologists working with more frequent, 50-min sessions may value an evolving case conceptualization that will direct the application of multiple patient-centered interventions. Whereas these well-engrained practice styles may serve their respective disciplines in isolation, the multidisciplinary chronic pain management team is better served by psychologists who are vigilant in applying a culturally informed perspective to understanding their physician colleagues that will enhance their ability to communicate and collaborate effectively for the benefit of the patient and the medical system.

Specific Sociocultural Factors That Broadly Influence the Health Care System: "Physics Envy," Stigma of Psychopathology, and False Alarms

The treatment of chronic pain and the practice of psychology in the health care system also reflect some specific sociocultural issues that have pervasive influence. Jefferson Fish (2000), a clinical psychologist, articulated nicely the a concept of "physics envy," whereby psychologists tend to struggle against a societal scale that assigns ultimate prestige and credibility to physics as the prototypically objective, physical science, and minimal credibility to "soft" social sciences. Psychology aspires to be grouped with biology, seemingly as a way to be ranked among the "hard" natural or life sciences. Psychology is also likely to differentiate itself positively from more qualitative social sciences, such as anthropology. In comparison to psychology, contemporary medicine is overtly linked to "hard" science in its conceptualization of disease as essentially biological, with treatment aimed at curing underlying pathophysiology (Baer, Singer, & Susser, 1997). The issue of what is scientific and, therefore, credible is confused by varying definitions of science among these disciplines. Science is frequently identified more by the subject of inquiry (such as universal biological mechanisms of disease) rather than as a method or process of inquiry that could be applied to a multitude of topics. Thus, although the average clinical psychologist is more highly trained in research methodology and statistics than the average bio-medically trained physician, our larger culture, our legal system, our parents, and often psychologists themselves tend to give more credulity to physicians than psychologists as "scientific" (cf. Weisberg et al., 2008, which demonstrates distortion in favor of accepting scientific findings involving any neuroscience, even if terribly flawed, among all but the most sophisticated consumers). This bias based on perceived "scientificness" influences the behavior of psychologists seeking to influence the health care system and of the health care system in responding to leadership by psychologists. We suggest that quality of life and functional improvement outcomes of treatment, central to a biopsychosocial understanding of pain management, are less

likely to compel system attention than would diminished postoperative complications or improved lab values.

The identity and behavior of psychologists appear further to have been modified by stigmatizing social responses to psychopathology in Western culture. This stigma values biology over behavior and encourages a view of mental impairments as voluntary, reflecting weakness of character, and/or shameful. Only recently was parity in third party payments for mental health (as opposed to medical) treatment legislated by the U.S. Congress, and similar differentials appear to exist through much of the health care system in priority placed on mental health program resources and respect paid to mental health patients. Reflections of this societal stigma can easily be seen within health care (Sartorius, 2002). We have observed that in some sectors of the health care system, program titles have been changed from "mental health" to "behavioral health," presumably a less off-putting and more holistic term, even though "behavioral health" is easily confused with adjacent terms, for example, "behavioral medicine." Patients easily imagine that seeing a psychologist for a pain problem means "the pain is in my head," reflecting a larger cultural association (that a somatic concern meriting "psychological" attention is inherently imaginary or resulting from a controllable mental defect) and sometimes reinforced by explicit or implicit messages from their medical providers in making referrals to psychologists. Psychologists must naturally educate others regarding a biopsychosocial (vs. biomedical or psychopathological) understanding of chronic pain and may feel a need to dissociate themselves from psychopathology to command credible leadership regarding pain management among patients and colleagues.

A third factor that psychologists must consider when addressing how chronic pain is conceptualized and managed within the health care system is possibly unique to chronic pain as a chronic illness. If acute pain is an emergency signal, activating multisystemic alarms to motivate the organism to curtail or prevent further tissue damage, chronic pain is a false alarm and a nuisance discomfort that misleads its sufferers into avoidant actions that can be dysfunctional in the long run. Treatment goals for acute pain are aggressive symptom relief and repair of the

causative injury. In contrast, chronic pain is "managed" without expectation of eradicating pain completely, with top priority placed on disarming the psychological "alarm" reaction to pain and on optimizing functioning as self-dependently as possible as one lives concurrently with residual pain. However, the expectations of many patients and medical providers regarding chronic pain seem to be heavily based in the acute pain model, notably including a linear biomedical solution to a single biological cause. That is, we appear to have implicit confidence in technologic, physical interventions for chronic pain with distant potential to be curative (e.g., surgery) preferentially over biopsychosocial, self-management based interventions with stronger empirical evidence for their efficacy (Hoffman et al., 2007). Among patients, medical providers and health care system decision-makers, there is great danger of misprioritizing medical-surgical approaches over biopsychosocial approaches for chronic pain. Related to our developing discussion of system change, then, there is an inherent challenge for psychologists, as providers with non-medical credentials, to assume leadership in a clinical area that seems to have physiologic bases but actually calls for rehabilitative, biopsychosocial management.

Cultural Competence and System Change in Health Care by Psychologists

Within psychology, there is earnest and growing emphasis in cultural competence and diversity awareness. However, a likely hindrance to progress in this area comes from psychology's tendency to define culture as an attribute of the individual. Psychologists are guided by group-based definitions of culture and identification of cultural variables rather than seeing culture as a process that transcends group membership (Lakes, Lopez, & Garro, 2006). Psychologists identify sources of cultural variability based on racial, ethnic, or other sociodemographic groupings (Cohen, 2009), and much of the energy in the discipline toward multicultural competence has been geared toward knowledge and understanding of specific group and person variables. Emphasis on the study of these variables, typically via nomothetic techniques, accords with a focus on individuals and families as loci of intervention, in

clinical relationships that follow empirically derived rules. Unfortunately, this group-based focus becomes less useful when we consider that not only do individuals simultaneously belong to multiple groups, but that these considerably heterogeneous groups do not lend themselves well to developing typologies. In contrast, anthropologic definitions tend to consider culture broadly as a people's "way of life," comprising language, symbols, rules, and behaviors transmitted over time (McElroy & Townsend, 1996). Culture has also been defined as "transactions between a set of shared values, practices, and traditions" (Tseng et al., 2002, p. 418) framing culture as a dynamic social process. We endorse a definition that may be particularly apt for change agents, regarding culture as "what is at stake in local worlds," or the social interactions of meaning and value in people's everyday lived experience (Kleinman, 1995; Lakes, Lopez, & Garro, 2006). These process-based variations on the definition of culture share the implication that cultural competence results from an interactive social process and situational awareness of cultural realities as opposed to the cataloguing of knowledge on an infinite number of predictive person variables. Shifting psychologists' mindset in conceptualizing culture may enable us to function as health care system activists by seeing the *system as client*. From this perspective, system change begins as a process of discerning precise cultural dynamics, then influencing the system strategically via immersion in its culture, often in nonlinear fashion, without losing one's bearings and identity as a psychologist.

Psychologists have an uncertain foundation from which to embrace this culturally sensitive relationship to the health care system. We have intrinsic value to the health care system, but as we tend to be culturally incompetent regarding that system, we emphasize the wrong assets. Other disciplines (notably social work as a clinical discipline) are trained to identify as agents of systemic change (Wax, 1968). Although there is brief attention to psychologists' competence in outcome evaluation in accrediting standards for training programs (American Psychological Association, 2007), graduate training of psychologists has not consistently emphasized program development, program evaluation, systems theory, and/or medical culture competency. Psychology has tended to market itself

within health care by emphasizing the value of our *unique* skills (e.g., assessment), with some proponents advocating acquisition of *new* skills of obvious value in the existing system (e.g., prescription privileges). Redefinition of our value in terms intrinsic to the dominant culture of the health care system is foreign to many psychologists. It may be challenging for psychologists to accept and define a place within the relatively structured social-professional hierarchy of medicine, to compete with physicians to demonstrate value in health care, and/or to tolerate relatively patriarchal (vs. patient-centered) values still common to many sectors of health care. Further, the skills, leadership, and perspective brought by psychologists to the health care system are often highly effective but invisible. Psychologists may compel power and recognition through visible channels open to anyone in the system (e.g., research grants, advancement to managerial posts) which transcend discipline and minimally require competence in local culture for their authority. Otherwise, psychologists may achieve authority as clinical experts if that expertise is recognizable to the dominant medical culture, but instead, our contributions often come via humble supporting or facilitating roles, for example, advising physician leaders. Analytic or facilitative activity is entirely consistent with our identity and skills as psychologists, and skills in empathy, communication, and formulation around interpersonal dynamics should be a strong suit for psychologists. However, we may be ambivalent about contributing value through "supporting" versus "leading" roles, and psychologist activists often struggle with whether they can be satisfied effecting system change from a largely subordinate position. Elaborated by practical skills, such as running meetings, understanding system rules, procedures and priorities, and ability to interact credibly in terms of the dominant medical culture, psychologists can be valuable and effective agents of health care system change.

General Notions on the Process of System Change

A lack of in-depth exposure to systems theory or systems thinking literature may leave psychologists involved in chronic pain program development feeling ill-prepared to apply this perspective to their local medical settings. We

have found that some of the more accessible literature on the topic comes from community psychology, a subdiscipline with a long history of adopting a systems perspective and strong commitment to social change. Our goal in introducing this discussion is primarily to suggest that adopting a systems perspective—not necessarily mastery of the systems literature—is of foremost value for psychologists acting as change agents. This shift to a systems perspective can reveal the interrelated cultural processes and subsystems that characterize most medical settings that are easily missed if one is guided solely by traditional conceptual models in psychology that emphasize linear, unidirectional processes (Foster-Fishman & Behrens, 2007). Engaging multiple stakeholders to identify and describe adaptive and dysfunctional system components is necessary to uncover both the “deep” (values, norms, beliefs, and assumptions) and “apparent” (policies, procedures, resources, and power dynamics) structures that underpin how health care for chronic pain is conceived and managed (Foster-Fishman, Nowell, & Yang, 2007). Identification of these cultural attributes can be facilitated by psychologists acting as participant-observers conducting key informant interviews (Schensul, 2007), developing graphic displays of system processes (Foster-Fishman, Nowell, & Yang, 2007), and constructing timelines of precursors and consequences of systemic problems (Kreger, Brindis, Manuel, & Sassoubre, 2007). These approaches can be used by change agents to develop contextualized depictions of systems process that uncover root causes of system dysfunction. Intervention for root causes may only require enhancement of current operations (first order change), but enduring change often requires a paradigm shift in how the problem is conceptualized (second order change). If, for example, psychologists have unknowingly assumed a marginalized role in the chronic pain management team, then second order change would target adoption of a biopsychosocial model for understanding and treating chronic pain. Keeping in mind that systems change hinges largely on social change (Tseng et al., 2002), reconceptualizing the management of chronic pain will likely mean altering the status quo by modifying well-entrenched social patterns among psychologists, physicians, and administrators.

Although we have briefly summarized a few formal works addressing key aspects of systems change that we find particularly relevant for psychologists as change agents, the remainder of our discussion is based on our firsthand account as psychologists in chronic pain and medical practice. We offer a dichotomy of system change strategies: (a) explicit, top-down, initiatives endorsed by system leaders, with conscious cooperation by system targets for change, motivated by clear incentives, and (b) induced, gradual, incremental change that may be strategically planned but is accomplished without top-down mandates or incentives and likely involves accommodation by the current culture. The former is the typical form of organizational change assumed by persons in charge, responsible for directing the system, who control the means to motivate and enforce initiatives and are accountable for outcomes. Such changes are not always culture-congruent, though their success is correlated with culture congruence. Pay-based performance measures are a typical example of a seemingly effective means by which health care organizations incentivize system changes of highest priority in the organization’s mission. In accord with much of our earlier discussion, such top-down processes are not the clear norm in the domain of chronic pain management programming, as issues are difficult to measure, of uncertain importance to health care organizations, and/or without consensus on desired solutions.

In contrast and in our experience, pain management systems improvements have frequently depended on more grassroots activism by citizens of the health care system motivated by an intrinsic investment in pain-related issues, without supporting organizational mandate. Under these conditions, we suggest that successful system change can further be seen in terms of two contrasting but additive processes. First, organizational change is *potentiated* by persistent effort on the part of activists, to raise issues to stakeholders and leaders in understandable terms, educate them about implications, present data on options and consequences, and ensure that communication is optimized among necessary agents of change. Especially in under-resourced systems, such activism rarely competes successfully for attention and resources against familiar and prioritized issues that have been associated with tangible consequences for deci-

sion-makers and stake-holders. For example, overwhelmed primary care providers would be foolish to take time away from addressing system-mandated clinical issues on which pay incentives and administrative sanctions depend, to honor new initiatives in education or functional reassessment of a patient with chronic pain, for which there are no such performance incentives. Under these conditions, behavior change can only be accomplished (if at all) by repeated iterations of timely, relevant information, presented in terms recognizable and important to the dominant culture (e.g., cost off-sets), with consequences that shape behavior gradually and consistently in the desired direction and/or transmitted via credible models for desirable practice. Often such initiatives become multi-year campaigns, in which information is repeated or updated, building awareness and familiarity within the culture of the organization, accumulating small incremental steps or building foundations for eventual endorsement by the culture at large. This slow, incremental process demands vision and patience and is sometimes likened to geologic time, suggesting a slow, steady pace as well as a promise of eventual, gradual movement.

Second, there are opportunities to *catalyze* accelerated change. In reality, geologic history is more accurately viewed as long periods of inertia, punctuated by energizing events, for example, volcanic eruptions, earthquakes, and so forth, that yield great change. Similarly, effective organizational activism often depends on perceptive creation and/or exploitation of transient opportunities for accelerated change that shift the terms or create new incentives within the organizational culture. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) has recently placed significant emphasis on pain-related organizational procedures (JCAHO, 2002). This external incentive has induced heightened collaboration across the health care system toward improvements in pain management, often using solutions prepared previously by grassroots advocates but never implemented, because of their cost.

It may be counterintuitive to psychologists that catalyzing change may depend on facilitating distress to make disruption of the status quo worthwhile. We have heard the adage that “fear

trumps love” in organizations, meaning that expenditure of resources is far more easily justified to avert a crisis than to realize an ideal (e.g., higher quality service) in the absence of crisis. Even egregious circumstances often become familiar and normative under conditions in which participants have no control over their aversiveness and have either good reason to persist or are aware of no other option (i.e., learned helplessness). Saul Alinsky, a successful community organizer in civil rights campaigns of the 1960s commented (Alinsky, 1971, pp. xxi-xxii) that individuals do not easily abandon familiar experience for something new. A revolutionary must foster discontent and instill enough questioning of current values to potentiate a willingness or even a passion for change. Reformation occurs when masses of people are disillusioned or hopeless about the existing system, whether or not they have a specific alternative in mind.

Creating incentives to give up the status quo is critical. A competent activist says to organizational leaders “We’re at risk. It’s not working.” to trigger their anxiety and investment in a solution. It is frequently also necessary to communicate “we cannot solve this problem,” to recruit uninvolved agents of the system who control solutions, rather than reassuring leaders that the problem may be solvable under existing circumstances.

Practical Recommendations for Psychologists as Health Care System Activists

We offer the following strategic and practical recommendations for psychologists as change agents, which combine deduction from principles discussed above with our own anecdotal experience. These recommendations are expected to be particularly relevant within large health care organizations, such as the VA, but also for health care systems in general.

- Become competent in the local norms of medical culture. Cultivate mentors within the medical culture. Learn local regulations, procedures, resource issues, power dynamics, and politics that influence decisions and outcomes. Speak in the language of medical providers and build credibility in terms valued by the medical culture, for example, tangible actions and rec-

ommendations, as opposed to theories. Be colleague-centered in formulating strategies. For example, in one clinic, providers are most responsive to informal education by joining them for lunch, whereas another clinic might prefer a formal presentation and hand-out.

- As stakeholders within the health care system typically have different perceptions of system dynamics, different definitions of the problem, different priorities, and so forth, it is essential to not assume a single objective reality for system dynamics and to involve all possible stakeholders in defining issues. Focus groups can be extremely valuable in developing consensual views of problems and soliciting buy-in. For example, a chronic pain clinic designed by specialists may be less successful in changing the culture of the organization and improving overall pain management than a less ambitious opioid renewal clinic developed in concert with primary care providers and other stakeholders to meet their self-identified needs.

- All else equal, a physician with limited or incorrect knowledge will win most times in refuting a knowledgeable and correct nonphysician in the eyes of health care or society. Physician collaborators have difficulty maintaining their loyalty to nonphysicians when challenged by other physicians. Stakeholders must be able to hear from proponents with whom they can identify and who speak their language. Develop physician champions, ideally highly credible within the dominant culture, who will speak for change and visibly support minority spokespersons when their voice is necessary. Routinely keeping the Chief of Staff informed and seeking his or her advice in implementing strategies are obvious and essential examples.

- Especially in trying to evoke gradual cultural change without solid top-down endorsement, sweeping system-wide change rarely works, in our experience. Work first with staff most likely to buy in to proposed changes, or the “early adopters.” Ensure successful outcomes in one sector and then offer them for export. A certain minority of staff will *never* embrace a given change, but they do not have to keep the rest of the system from responding.

- In the absence of valuation for a system change, such as an unfunded clinical program, if

the change is not actively opposed by the system and can be sustained through local effort, it can become accepted over time as normative, especially as staff turnover. Similarly, in the absence of a clear physician authority or champion, chartering a group of collected local experts (such as a Pain Management Committee) can convey immediate authority to its formal representatives and justify input to the organizational hierarchy on relevant issues.

- Leading organizational change or committees requires its own set of administrative skills, which most aspirants learn along the way. Conscientiousness and diligence can command respect and confidence early on, as one is developing these skills. Form partnerships with co-leaders who have complementary skills and knowledge bases, either as mentors or collaborators. In our experience, for example, collaborating nursing and performance management colleagues have often strongly balanced psychologists’ knowledge limitations in clinical logistics and administrative processes, respectively.

- Ensure that you communicate objectives to the bearers of power and resource necessary to achieve them and in a form that they can easily understand. Appeal to organization leaders for support in terms of value/cost to the organization. We accomplished significant movement toward local objectives only after appealing to report to a hospital executive committee (that included necessary leaders), instead of a committee responsible for tracking organizational performance data (whose members had no control over policy).

- Outcome data may be a universal language if they speak in terms that are understood and valued. Producing outcome data typically requires recruitment of expertise and labor resources that can be difficult to come by and whose costs need to be considered as part of strategic planning. Our facility’s central pain-related performance improvement outcome data are collected via laborious chart audits, primarily through the voluntary commitment of Pain Resource Nurses. This resource allows us to use more clinician-friendly means of electronic pain management documentation that improve staff compliance, but at significant cost that the facility may not always be able to afford.

Conclusion

In addition to their direct clinical and scientific contributions to chronic pain treatment, psychologists have a valuable role to play in facilitating health care organizational improvements in pain management. Their effectiveness in this role depends on their fully utilizing familiar interpersonal, conceptual, clinical, and scientific skills while also developing mature skills in cultural competency. We suggest that psychologists must acknowledge their own cultural identity and biases, conceive of the health care system as client, identify and engage core elements of the dominant medical culture, and bridge gaps among individuals and among disciplines to strategically induce successful change in the health care system.

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Correction to Erbes, Curry, and Leskela (2009)

In the original online version of the article “Treatment Presentation and Adherence of Iraq/Afghanistan Era Veterans in Outpatient Care for Posttraumatic Stress Disorder,” by Christopher Erbes, Kyle Curry, and Jennie Leskela, (*Psychological Services*, 2009 Vol. 6, No. 3, 175-183), the copyright for the article was listed incorrectly. This article is in the Public Domain. The online version has been corrected.

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