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Social workers and nurses in labor and delivery units : supportive partnerships or parallel work lives?

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ABSTRACT

Despite increased research on the misconceptions of social work, further investigation is needed to explore the impact of such attitudes on specific practice settings, including their effects on interdisciplinary collaborations. In an effort to help address this gap in research, this study explored the dynamics of social workers' and nurses' interactions using labor and delivery units as a lens. In this mixed method study, 71 participants, comprised of both nursing and social work professions completed an online survey inquiring how each profession views its own roles, that of the other profession, and factors that influence collaborations, if they occur at all. Participants from both groups identified key elements influencing the interdisciplinary relationship. Of all the factors that affect collaborative practice, perceptions of roles seemed to be the most significant. Findings showed that many nurses feel they are able to provide the same services as social workers and typically have more power in the relationship. Also of significance, the results indicated that knowledge about particular skills and/or training of the other discipline may not necessarily support effective interdisciplinary collaboration. Rather, the ability to build genuine relationships with colleagues reduced the potential for hostility because understandings of roles were mutually constructed. However, participants also noted that this is an ongoing process and that these opportunities are declining as a result of the current health care system. Hypotheses for further inquiry and implications for such findings are offered.

SOCIAL WORKERS AND NURSES IN LABOR AND DELIVERY UNITS:

SUPPORTIVE PARTNERSHIPS OR PARALLEL WORK LIVES?

A project based upon an independent investigation
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CHAPTER I

Introduction

"It's so funny, Tim (LCSW) does all the psych stuff – I thought social workers did more, like referrals and resource type stuff."

The previous excerpt emerged from of a conversation I had with a head nurse in a High Risk Obstetrics Clinic, highlighting the lack of clarity surrounding social workers' roles among nurses in a hospital setting. While this quotation illuminates some misconceptions about social work, a likely discrepancy may exist between social workers' perceptions in such settings as pertains to roles of the nurses with whom they share responsibility for patient care. As such may be so, the current research study focuses on interactions in labor and delivery units as a lens to better understand the relationship between nurses and social workers – Is there one? Is there a real disparity in what each profession thinks of the other's roles? And, what are the implications of such disparities, if they exist?

As a result of the recent literature documenting the potentially long-term consequences a negative childbearing experience may have (on both mother and baby), there is an increased emphasis on preventing traumatic births. Evidenced by the research, but something I've also observed firsthand, is the incongruence between expectations versus realities of intrapartum nursing roles; this disconnect is a contributing factor in upsetting childbirth experiences (Harris & Ayers, 2012; MacKinnon, McIntyre & Quance, 2005). In response to these findings, much of the existing literature focuses on the medicalization of childbirth or on the experiences of the

woman, but fails to recognize the multifaceted aspects of these settings, or how interdisciplinary collaboration may improve a mother's experience.

In fact, though intrapaturm nurses and social workers are both distinctively positioned to establish relationships and optimize care practices for childbearing woman, there has been limited investigation regarding their dynamics – and, particularly, interdisciplinary-partnership experiences -- in labor and delivery units. Contemporary research addresses interdisciplinary conflicts but often the studies isolate specific professions, and do not adequately capture the interplay between them. Therefore, a major objective of the current study has been to gather and disseminate information about the dynamics of arguably competitive professions.

Little research acknowledges social work –nurse conflicts, yet early nursing literature indicates that this sense of rivalry is not a new development. In a reprint from *The Visiting Nurse Quarterly* (1911), Ellen La Motte, Nurse-in- Chief with the Tuberculosis Division of the Baltimore Health Department, argued for this combined role based on economic efficiency. She suggested that it was not beneficial financially to have two sets of workers going into homes when -- given additional training -- a nurse was able to carry out both roles (La Motte, 1911).

Though La Matte pointed out economic efficiency in combining two roles, it appears she was also trying to help the nursing profession evolve beyond that of the "physician's handmaiden" via training that prepared the nurse for a broader scope of practice beyond what she received in the hospital-based nursing schools. It should be noted that La Motte wrote this conceptualization specifically with respect to public health nurses; while there may be overlapping personal qualities inherent in professions providing help to others, the training and intended functions of social work and nurses are vastly different, and greatly determined by the setting. Unfortunately, the limited research on the perceptions of social work shows a lack of

understanding regarding the breadth of roles or the specific training and skillsets of the profession. The majority of people perceive social work as it is portrayed in the media. A LCSW recently shared that a client of hers once said, "Oh, don't social workers just give out food stamps and take people's children away?" This flawed and simplistic view of social workers continues to invade public opinion, which is undoubtedly detrimental to the field but has largely been ignored by the profession.

While there is an ample amount of research on childbearing women's expectations of nurse roles, the existing literature relating to social work—or, more precisely, the lack thereof -- suggests that intrapartum nurses, social workers and childbearing women have unclear and potentially conflicting expectations of each discipline, which may contribute to traumatic birth experiences (Cowles & Lefcowitz, 1992; Craig & Muskat, 2013; Egan & Kadushin, 1995; Harris & Ayers, 2012). The current research simplifies the roles and relationships of nurses and social workers, and as a consequence of this narrow approach, nurses' and social workers' roles and approaches to interdisciplinary cooperation/collaboration are not understood. The ambition of this study is to explore and describe such professionals' experiences in greater depth, with a view to enhancing opportunities for interdisciplinary collaboration in the future. In doing so, this study may also serve to improve experiences for childbearing woman.

Finally, it is also my hope that the findings from the present study can benefit the field of social work. Given that the public is the primary consumer of social workers' services, understanding how people perceive the profession is vital to their utilization of such services, as well as the policy positions supported by social workers (LeCroy & Stinson, 2004). By bringing awareness to how social workers are viewed, the community may further appreciate and

prioritize the need to educate people, advocate for the profession, and contribute in the efforts to do so.

CHAPTER II

Literature Review

Social Work in Hospital Settings

The interconnections between illness, poverty, and other social ills are increasingly recognized in health care settings today. To improve outcomes, it's understood that often a person's health cannot be adequately addressed without understanding the individual in a larger societal context. This is a role that, historically, has been filled by social workers whose training emphasizes that perspective (Craig & Muskat 2013). Ida Cannon, the first hospital social worker, wrote about the social complications of physical disease. It was her belief that, "The physician recognizes physical symptoms and seeks for the underlying causes of disease," she said. "The skilled social worker recognizes social symptoms of human distress and also seeks their underlying causes that she may the more wisely help. The services of doctor and social worker then become interdependent, just as the physical and social conditions of the patient himself are interrelated" (Cannon, 1913, p. 1).

Although social workers have delivered services in medical settings for over a century, the environment is rapidly changing -- causing unique challenges for this profession. It is widely known that the current health care system in the United States has a host of issues such as funding shortages, increasing expenditures related to medication and hospital visits, and more patients with complex health conditions using added services. The pressures stemming from

these changes in health care have resulted in hospital social workers' departments increasingly either being downsized or relegated to a case management role.

Since the 1980's, there has been an inadequate demonstration of social workers' potential significance to health care. This, in addition to the loss of government funding, and a lack support for social services by insurance companies, all contributed to social work departments not faring well in resource allocation (Judd & Sheffield, 2010). Legislators concerned by the increasing costs of providing inpatient medical services to a growing population proposed a prospective payment system termed Diagnostic Related Groups (DRGs). Implementing DRG reimbursement systems resulted in the need to discharge patients quickly from the acute hospital setting to ensure full reimbursement for services. While there was still recognition for the clinical contributions that Ida Cannon articulated in 1913, the role of social workers in hospital settings has increasingly become limited to discharge planning and location of material resources for patients and families in need since the 1980s (Judd & Sheffield, 2010).

Impact of reengineering. Hospital systems responded to the continuous escalating costs by introducing a conceptual model of reorganizing in the decade of the 1990s—referred to as reengineering. Changes focused on targeted cost containment by eliminating middle management positions, altering traditional roles and responsibilities of current staff positions to become transdisciplinary, and flexible (Neuman, 2000). This shift in organizational structure once again challenged the roles and responsibilities of hospital social workers. Decentralization, cross-training and standardization of care negatively impacted social work's function within hospital systems in North America (Judd & Sheffield, 2010; Mizrahi & Berger, 2005; Neuman, 2000).

By relying solely on established practices that demonstrated cost-effective measures, the

changes involved in the reengineering of the 90's posed inherent risks to the position of the hospital social worker. Hospital social workers had not regularly produced evidence-based outcomes to substantiate social work roles and interventions within these settings (Judd & Sheffield, 2010). Social service departments deteriorated and the recognition of the importance of specialized skills evaporated, resulting in an escalation of competition between nurses and social workers for roles in addressing the psychosocial outcomes and discharge planning needs of patients (Craig & Muskat, 2013; Egan & Kadushin, 1995; Michalski, Creighton, & Jackson, 1999). At the same time, the onset of managed care resulted in the proliferation of case management departments focused on the need to contain costs.

Some scholars suggest that the undermining of social workers' roles in North America, first caused by reengineering practices, have been legitimized by the medical profession's dominance in terms of power and status (Judd & Sheffield, 2010; Mizrahi, & Berger 2005). Interestingly, while reengineering practices may indicate a significant shift in the roles of social workers working in North American hospitals (U.S and Canada), the literature also shows that interdisciplinary conflict as well as the perceptions of social workers are similar in other countries (Mexico, Israel, Australia), and are certainly not isolated to those who work in hospital settings (Itzhaky & Zanbar, 2014; Craig & Muskat, 2013; LeCroy & Stinson, 2004).

Implications of Perceptions on the Role of Social Workers

Given the hierarchical structure of hospitals, it is easier for doctors to encroach on the domain of social workers than vice versa (Itzhaky & Zanbar, 2014). Yet it is the perceptions and expectations of social worker duties that come from all disciplines, not simply those of doctors, that impact interdisciplinary collaboration, and directly affect the day-to-day functions of a social worker. Payne (2006) argues that the professional identity of social work is created through the

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"negotiation of roles alongside practitioners and service users, where effective relationships contribute to a developing enactment of what social work does, rather than any prescribed or mandated definition" (p. 139). Co-creating social work roles undoubtedly involves the public's opinion of the field and their expectation of interactions. Yet, the need to gather current and relevant information about the public's views of social workers, and the profession in general remains (LeCroy & Stinson, 2004).

   Public perception of social workers. Results from a 1978 survey conducted to examine how the public viewed social work found that there was a growing awareness about the range of social work roles compared to an earlier study in 1950 (Condie, Hanson, Lang, Moss, & Kane, 1978). However, respondents were still only able to accurately identify a negligible number of social work roles. In fact, the number of participants identifying erroneous roles was almost equal to that of those who identified correct roles, with the stereotyped image of "child protector" dominating the majority of the answers. Furthermore, the findings showed that 94% of the sample was reluctant to seek help from a social worker, and this negative attitude only decreased by three percent if a participant personally knew a social worker.

   Despite such troublesome findings, follow up research wasn't conducted until 1995, and even then, the research was specific to the state of Alabama (LeCroy & Stinson, 2004). The 1995 study included 452 adults and intended to measure the public's knowledge of social work in the areas of educational background, credentialing, types of social work settings, types of clients, presenting problems, and the various of issues in which social workers are involved (Kaufman & Raymond, 1995-1996). Surprisingly, yet similarly to the previous study's findings, researchers found that the general attitude about social workers were negative, though the findings could not be extrapolated given the specific sample size. Researchers highlighted that another limitation

stems from the low visibility of social workers because "public and private human service agencies [in the state of Alabama are] not highly professionalized (Kaufman & Raymond, 1995-1996, p. 32). Based upon other studies and recent literature, it seems that the issue of visibility is not just specific to the state of Alabama; rather, it's an area of concern for the profession as a whole.

Further research on the public perceptions of social work has been conducted by comparing the field to other professions with a mental health focus. A study conducted in 2000 explored the public's opinion about clinical psychology, counselors (both masters and doctoral levels), and social workers. Using five clinical mental health case vignettes, respondents were asked to rank their confidence levels in each profession's ability to treat the patients. Results indicated that social workers were consistently ranked the lowest of the four profession, yet social workers were the most common choice for mental health services: 33% of the sample had seen a social worker or knew someone who had (Fall, Levitov, Jennings, & Ebert, 2000). This suggests that in contrast to media influence, personal (seemingly negative) experiences were a major factor for these participants.

In a more recent study entitled, "*The public's perception of social work: Is it what we think it is?*" Craig LeCroy and Erika Stinson (2004) sough to build upon, and examine the earlier findings about the perceptions of social workers. The study surveyed 386 individuals using a random digit telephone survey, asking participants about their knowledge, beliefs, and attitudes about social work. In addition, similarly to a previous survey, respondents were asked to make comparisons between social workers and other "helping professionals" including psychiatrists, psychologists, counselors, nurses and clergy. Unlike in the other surveys, findings from this study are particularly helpful because the sample was reportedly a representative sample of the

United States. As such, the results can be discussed on a national level, though some of the findings are inconsistent with my personal observations, accounts from other clinicians, as well as other literature I've reviewed. Like the previous studies, this quantitative study was unable to capture more of an in-depth understanding because there are no open-ended qualitative questions. Instead, the survey was informed by the previous findings and used Likert scales, true or false and multiple-choice questions. In doing so, the findings may be skewed due to the potential for bias; the options for possible answers were provided by the researchers and can be considered coercive. For example, "appropriate social work roles" had nine possibilities: agent of social change, legal adviser, group therapist, administrator, mental health therapist, prescribe medication, community organize, child protector and psychiatric intern. This question omits many other roles or spaces that social workers navigate in and fulfill; a hospital setting and/or medical social worker were never mentioned throughout the report or the survey itself.

Similarly to the 1978 study, participants in this study again demonstrated many of the same stereotypes: 91.3% identified social workers as a child protector role. Thirty five% of the sample agreed, "social workers have the right to take children away" illustrating the "ongoing public confusion concerning the purpose and power of child welfare workers; "one of the most publicized, portrayed and media skewed roles" (LeCroy & Stinson, 2004, p. 169). Other questions found that only 54.8% of respondents felt that social workers counsel as proficiently as psychologist do and 29.1% disagreed with this statement (despite much documented evidence that professional training of the provider is a poor predictor of therapy outcomes; see, for example common factors research and Consumer Reports,1995). Interestingly, the findings relating to sources of perception about social work were relatively equal with 32.4% identifying a type of media, 30.8% know a social worker, and 35.7 identified personal experience, which

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differ from the other research that suggests media representations are the primary source of knowledge for the general public.

Again, in contrast with other research, this survey found that 92.4% identified that "social workers work with all classes" and 95.8 believe that "social workers can be a great source of comfort in times of need." This data shows that the public is "highly cognizant of that fact that social workers do not solely work with poor people, almost one fourth feel that working with poor people is a primary duty" (LeCroy & Stinson, 2004, p. 168). Lastly, when evaluating social workers in compared to other professions, the "perceived value in the community" of social workers received more (60.8%) "very valuable" ratings compared to psychologist (44.5%), psychiatrists (41.9%), or counselors (58.3%), but less than nurses (89.8%) or clergy (67.7%). Furthermore, one of the most significant findings shows that when "very valuable" and "somewhat valuable" categories are aggregated and compared, social workers fall behind only nurses in terms of perceived value by only a very small margin: 96.3% vs. 99.2%, respectively.

While it's uplifting to note the positive public perception of social workers and nurses captured by the previously cited study, it's important to consider how that may translate in a setting where both professions work, such as a hospital. The similar views (96.3% and 99.2%) regarding the value of nurses and social workers are especially pertinent given the earlier suggestion that nurses and social workers may be interchangeable in a medical setting. The vague overlap between the two professions has significant implications given the previous literature highlighting that interdisciplinary collaboration goes beyond understanding the "various functions" provided by a specific profession. Instead, partnerships are determined based on how people *perceive* the *significance* of the contributions and competence of the other profession (Keefe, Geron, & Enguidanos, 2009; Mizrahi, & Abramson, 2000; Neuman, 2000).

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Perception of roles from other disciplines in a hospital setting. To varying degrees,

physicians and nurses still recognize that social workers' primary competencies in psychosocial

and environmental aspects of cases enhance treatment and improve outcomes (Itzhaky & Zanbar,

2014; Keefe, Geron, & Enguidanos, 2009). Although research is limited, physicians and nurses

have identified critical social work skills, including strong assessment and problem-solving

abilities, in addition to possessing knowledge to positively affect systems and effectively utilize

community resources (Schariach, Simon, & Dal Santo, 2002). Yet, the literature also indicates

that aside from discharge planning, the social workers and their departments poorly articulate

social work roles, and are increasingly less appreciated by other disciplines within hospitals.

Empirical research findings indicate that psychosocial assessment and intervention are no longer

an exclusive fields of social work, but ones that other disciplines partake in as well (Cowles &

Lefcowitz, 1992; Mizrahi & Abramson, 2000).

A 1995 study entitled *Competitive Allies…* investigated rural nurses' and social workers'

perceptions of social work roles in a medical setting. The research found that the both

professions felt social workers' responsibilities should include providing discharge-planning

services. They also agreed that social workers have a role in psychosocial assessment and

intervention, *though not an exclusive one*. Furthermore, nurses and social workers expressed

different opinions regarding the psychosocial focus that should be regarded as the sole domain of

social work or were areas of collaboration (Egan & Kadushin, 1995). The only area in which the

role of the rural medical social worker was clearly defined was in finding aftercare resources for

patients and their families. Given the small sample size (44 nurses and 66 social workers) and the

rural location, this study cannot be generalized. However, the findings highlight the blurred

boundaries of duties and lack of appreciation for the specialized training of social workers.

As expected, findings on interdisciplinary collaboration suggest that the identification of roles, competencies within these roles, and the overlap between roles is pertinent to successful teamwork (Itzhaky & Zanbar, 2014). One particular study sought to examine a newly implemented program in an Israeli hospital. The training program aimed to familiarize doctors with the professional world of social work -- including the guiding principles, goals, and terminology, as well as the conditions under which social workers operate. In doing so, these researchers sought to explore how the course affected doctor–social worker interactions, and whether perceptions of the roles of the two professional groups had changed into a more effective interdisciplinary collaboration (Itzhaky & Zanbar, 2014).

The findings indicate that overall, there was greater cooperation between professionals in the two disciplines after the trainings. However, it's important to note that physicians do not always understand social workers' roles as they relate to patient care and tend to rate their interprofessional collaborations differently than social workers would (Mizrahi & Abramson, 2000). The doctors themselves made little mention of difficulty or friction, with feelings of dissatisfaction expressed mainly by the social workers – that powerful groups are often unaware of the disparities that exist is a pattern often commented on (e.g., Park 2008).

Doctors who spoke of increased collaboration with social workers attributed it to the clear division of roles between them. One doctor stated, " [A social worker] sees the child's relationships, and I see the child's wounds. We seem to complement each other" (Itzhaky & Zanbar, 2014, p. 625). Some physicians stated that cooperation was also a result of their recognition that some issues at hand were not their main specialty, whereas social workers can be considered experts in the field due to their professional training and experience. Contrastingly, a small number of doctors felt the program caused friction and that they no longer needed to

partner with social workers. One doctor stated that "doctors are already at the top of the professional pyramid in the hospital, and the change resulting from the training program gave them even more power [because they were now trained in social work skills as well]" (Itzhaky & Zanbar, 2014, p.626). The power dynamics illuminated by this quotation was a source of frustration for many social workers in the study.

Social work participants also reported that the program added complexities such as overlapping roles, lack of clear boundaries, and even felt a sense of role reversal when doctors considered the psychosocial problems of the child as part of their responsibility, rather than focusing on the medical symptoms. This was "disturbing for the social workers, generating a sense of loss of control and helplessness" (Itzhaky & Zanbar, 2014, p.633).

Social workers' perspectives in a hospital setting. Unlike interdisciplinary studies on the perception of social work duties or collaboration, Judd & Sheffield (2010) intended to capture an understanding of the current (i.e. post-reengineering era) function of hospital social workers from the perspective of social workers. While it's estimated that three-fourths of hospital systems in the United States underwent reengineering (Neuman, 2000), it was not a consideration for this research. Thus, there was no process incorporated within the study to demarcate respondents who were employed by hospital systems that did undergo reengineering activities, or to determine the extent to which organizational change may have occurred (Judd & Sheffield, 2010). Though the absence of delineation may pose a limitation towards better understanding the impact of reengineering, the large sample size of this study is informative and supports existing literature on the current realities of hospital social work.

Participants reported spending less time in counseling or crisis intervention (direct practice) activities when compared to discharge planning (Judd & Sheffield, 2010). In reviewing

their current practices, the participants concluded that, as previous research shows, medical

social workers tend to not fully articulate the exact functions that they perform to

interdisciplinary teams (Mizrahi & Abramson, 1985; Globerman, White, Mullings, & Davies,

2003). Descriptors like "providing support," "counseling," and "working with the family" did

not capture the full extent of their clinical practice. These findings correlate to the previously

mentioned study in Israel: that social work is perceived as a profession, but not as a professional

discipline. As such, the role of social workers in general, and hospital social workers in

particular, remains ambiguous (Itzhaky & Zanbar, 2014). As a response to findings such as these,

Shelley L. Craig and Barbara Muskrat propose that hospital social workers need to clearly define

their roles and responsibilities within the medical teams, to both providers with whom they work

and other individuals involved in health care (Egan & Kadushin, 2004), and to advocate for a

distinct social work domain (Davidson, 1990). Encouraging social workers to articulate their

own roles may provide opportunities to accurately educate and promote the importance of social

work in such settings, compared to feeling a sense of helplessness that appears to be a theme

throughout much of the literature related to this topic.

Findings from their qualitative study: *Bouncers, Brokers, and Glue: The Self-described*

Roles of Social Workers in Hospital, Craig and Muskat (2013) illustrate the complexities

involved in social work and in turn, elaborate on the "descriptors" given in the previous study.

The aim of this research was to gather input from social workers employed in urban hospitals

about their perceptions of the roles, contribution, and professional functioning of social work in a

rapidly changing health care environment (Craig & Muskat, 2013). This is one of the only

studies I've found that managed to capture the difficulties involved in social work, but also, the

opportunities for social workers and the pride involved in their work. The research identified

various themes involved in the role of a hospital social worker: bouncer, janitor, gluer, broker, firefighter, juggler, and challenger.

The task of juggler stems from the pressures of the hospital environment where participants articulated that they were expected to transition between various roles quickly and seamlessly. The notion of bouncer is unusual in health care settings; however, social workers in this study described that they felt that they carried out similar duties, "including crowd control, dealing with behavior problems, or informing families that a patient could not stay in the hospital (Craig & Muskrat, 2013, p.10)." Social workers also stated they felt obligated to "clean up," in the sense that they took care of the less clinical, leftover problems that other profession did not want to address. Most of the participants were not particularly happy with those tasks, but the majority identified that they were aware of the significance of these duties and expressed willingness to continue in these roles. The inclination to take on these tasks may reflect social workers' specific training that considers the person in environment and thinks of the whole picture when providing support.

Social workers also identified that they often had to advocate for patients, both within the hospital team and within the community. They described the ways in which they would challenge the medical model within the hospitals to ensure that all of a patient's needs were addressed, which again is something that social workers are specifically trained in. Though the study reflects previous findings, it differed slightly in regards to direct care practices. Respondents stated that they often acted as "firefighters," needing to deal with "crises that required them to drop everything" (Craig & Muskat, 2013, p. 12). Several identified that this was a role that other professions depended on social workers to fulfill, which pleased them.

Participants described the role of social work as "the glue that holds all of the patients

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and families, the treatment plans, and even the team together" (Craig & Muskat, 2013, p. 11). Being the gluer is described as providing support, while being a broker involves providing more tangible and active negotiation of services. Within this role, social workers described themselves as brokers of information to families and services, particularly in discharge planning and the provision of concrete items, such as clothing.

Interestingly, discharge planning was not a "role that they thought they would be providing on the basis of their social work education" (Craig & Muskat, 2013, p.12). The disconnect between educational training and expectations in the hospital is particularly significant because, as the literature illustrates, discharge planning is seemingly the number one responsibility and specifically identified role of hospital social worker amongst other professions. Because social workers' roles are found to be defined by their interactions with other professionals, partnering during a "lower status role" (such as discharge planning) results in a discrepancy between the complicated self-ascribed roles of social workers, and those assigned by other colleagues (Craig & Muskat, 2013; Davidson, 1990; Payne 2006)**.**

The findings from this study highlight how hospital social workers currently fulfill a wide range of important roles; yet, in a time of dwindling resources, their responsibilities are more focused on meeting immediate needs, with less available time for counseling or treatment planning (Judd & Sheffield, 2010). As funding, reimbursement, and professional expectations continue to focus on service efficiency and best practices, social workers should strive to demonstrate that their contributions are unique to the profession and that their efforts are beneficial to patient outcomes.

Implications of Reengineering and Ambiguous Roles on Labor and Delivery Units

Patient outcomes. The physiological process of childbirth, which the majority of women

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now experience in a hospital setting, may result in varied and unique needs, -- perhaps more so than in any other unit in the hospital given the complex emotional and physical feelings involved in labor and delivery. As Clare Winnicott described, "The social worker starts off as a real person concerned with external events and people in the client's life" and "attempts to bridge the gap between the external world and [her] feelings about it" (as quoted in Kanter, 2004, p. 76). Women and their families hold different views about childbearing based on their knowledge, experiences, belief systems, culture, and social and family backgrounds. Understanding these factors, how they intersect, and how they may affect a patient's birth experience can help inform clinicians' interventions and what would be helpful to a mother during childbirth. Contrastingly, women often do not receive the social supports and assistance that they expect and need in order to avoid PTSD and other adverse psychosocial outcomes. Given the training of social workers, labor and delivery units would benefit by having social workers managing some of the existing gaps that childbearing women require for optimum care.

Significance of a traumatic childbirth experience. Studies highlight that regardless of meeting the specific criteria for PTSD diagnoses, emotions and feelings of distress caused by the birth event are associated with negative outcomes such as psychological distress and ongoing physical pain (Ayers, Joseph, Mckenzie-Mcharg, Slade, & Wijma, 2008). Much of the literature on dissatisfaction with the labor and delivery experiences includes feelings of disappointment, anger and loss, with many woman reporting vivid memories of the traumatic birth experience. In addition, many women identified as feeling depressed, and spoke of feelings of despair and occasionally suicidal ideations (Elmir, Schmied, Wilkes, & Jackson, 2010). Many of the participants in research conducted about a traumatic birth experience reported feelings and memories that affected their ability to care for their babies, and their capacity to establish a close

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bond or connection with their infants and partners (Ayers, Joseph, Mckenzie-Mcharg, Slade, & Wijma, 2008).

As the title of Beck's (2004) study, *Birth Trauma Lies in The Eye of The Beholder* highlights, birth trauma is what women view to be traumatic about their experiences during delivery. Beck found that what women perceive as traumatic may be viewed by nurses and doctors as merely routine procedures. Healthcare professionals may ignore or be unable to recognize the signs of psychological and emotional trauma because of their apparent understanding that birth trauma is a physical injury – leaving out the psychosocial aspects (Beck, 2004). Beck's study, like much of the literature in assessing satisfaction in birth outcomes, focuses on the impact of medicalization, and frames the experience in a dichotomy as "natural" or "medical" birth. In doing so, existing research associates nurses with hospitals/cesareans and midwives with a "natural" childbirth. Brubaker and Dillaway (2009) suggest that this concept of childbirth has "not proven to be meaningful to all women, and the notion of natural or medical childbirth has changed over time" (p. 30). Alternatively, there is accumulating evidence that a woman's subjective view of the event is more important than objective severity (type of birth, pain, etc.) in determining a traumatic response (Harris & Ayers, 2012).

Impact of providers on childbirth experience. A meta-ethnography of 10 qualitative studies on women's perceptions of traumatic birth suggests that women are usually traumatized as a result of the actions or inactions of midwives, nurses and doctors (Elmir, Schmied, Wilkes, & Jackson, 2010). These data support ongoing accounts of women who report high levels of dissatisfaction during childbirth and describe their health care providers as "unhelpful, insensitive, abrupt and rude" (Fraser, 1999, p. 99).

The literature is consistent on the positive effects of social support given by nurses during

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labor. In one study on childbearing women in Taiwan, 60 percent of the participants reported having received only helpful nursing behaviors during labor, and 38 percent reported having received both helpful and unhelpful nursing behaviors (Chen, Wang, & Chang, 2001). Participants identified the helpful ways that nurses supported them as: performing roles of emotional support providers, comforters, information/advice providers, professional technical skills providers, and advocates. Australian researchers MacKinnon, McIntyre, and Quince's (2005) findings on the meaning of a nurse's presence indicate that "women want more than safe passage, they appreciate enhanced passage" via physical presence, emotional support, and advocacy (p. 28).

The limited research on OBGYN nurses primarily focuses on nurses' attitudes towards childbirth and the likelihood of a cesarean birth, rather than ways to offer "enhanced passages." There are very few studies that solely explore the strategies and interventions nurses employ to enhance the labor experience. Martha Sleutel (2000) focused on what strategies and processes nurses used to enhance labor progress in the context of preventing a cesarean birth. The study found that, regarding the nurses' approaches to labor, three subcategories were identified: "I follow whatever the mother's body is telling her to do," "I push the Pit," and "Nursing support techniques" (p. 41). These techniques include encouraging/being positive, including family, giving advice, using different positions, performing physical care, advocating on the mother's behalf. Of significance, through conducting this study, Sleutel also found that "it was not possible to study labor support strategies without uncovering barriers that constrain supportive activities" (p. 43).

Specific barriers include ethical dilemmas as well as nurse-physician conflict and unwilling partnerships. These findings prove beneficial for a topic with little available literature;

however, there are limitations to the study. Data were collected via interpretive interactionism, which leaves greater likelihood for bias on behalf of the researcher. Interpretive interactionism is a methodology where relationships, situations, and interactions are evaluated by the subjective opinion of the researcher. Lastly, only one nurse was interviewed using qualitative questions.

Impact of social worker on childbirth experience. Though social workers may work with childbearing mothers in different settings throughout the pregnancy and delivery, there is very little research on the subject of social workers' impact on a woman's childbirth experience. The scarce literature focuses on social workers' function prior to childbirth, in the context of a birth plan as well as assessing/prevention of a traumatic birth for women who have experienced a sexual assault, but did not specify the impact on the actual delivery experience. The majority of existing studies on social workers and childbirth focus on the interventions of social workers in a postpartum context, after a patient is already experiencing psychological distress (postpartum depression, an upsetting birth, child in the NICU, pregnancy loss, etc.)

According to the National Association for Social workers (2011), "…working in concert with doctors, nurses, and allied health professionals, social workers sensitize other health care providers to the social and emotional aspects of a patient's illness. Hospital social workers use case management skills to help patients and their families address and resolve the social, financial and psychological problems [related to their hospital stay]"(p.1). Working in an interdisciplinary setting, a hospital social worker is evidently "the member of the health care team who offers the person-in-environment perspective, which incorporates all the factors that influence a patient's health care experience" (p. 4). As labor and delivery increasingly occurs in hospitals where health care providers are trained to focus on the medical aspects of birth, in theory, social workers consider the whole person in childbirth. In the context of childbirth, the

role of a social worker could greatly prevent or ameliorate a traumatic delivery and the long-term consequences associated with that experience. Contrastingly, as evidenced throughout this literature review, and also reflected in *The Occupational Profiles on Social Workers in Hospital and Medical Settings* there is an increase in closures of hospital social work departments, with social work staff being reassigned to other departments (such as case management), or eliminating these positions altogether (NASW, 2011).

Though it's imperative to assess for risk factors prior to delivery, there are not always precipitating factors (Ayers, Joseph, Mckenzie-Mcharg, Slade, & Wijma, 2008). While the experiences of childbearing women are helpful in order to provide the best care and reduce the prevalence of traumatic births, perspectives of both nurses and social workers are also pertinent in these efforts. Little research has been conducted on the perception of interdisciplinary roles in labor and delivery units, and the existing literature simplifies the roles of nurses and social workers in these settings. It is within the context of the literature just reviewed that the purpose and methods of the present study were conceived. The methodology chosen is described in the following chapter.

CHAPTER III

Methodology

Though intrapartum nurses and social workers are distinctively positioned to establish relationships and care practices that directly impact a laboring mother's s delivery experience, there has been limited investigation regarding their dynamic approaches and/or how they work together. As two "helping professions," are social workers and nurses competitors or are they able to successfully partner as allies? The purpose of the study reported here was to better understand the relationship between nurses and social workers, specifically in labor and delivery units. By combining an analysis of the current literature on the perception of social work (and the impact of such views), the ongoing structural changes in health care, the prevalence and effects of traumatic birth, factors that impact the birth experience, and social workers and nurses' perspectives on interdisciplinary cooperation, this research intends to provide further insight as to how social workers and nurses perceive the other profession with aim to improve partnerships, and increase maternal satisfaction during delivery.

To explore the relationships between social workers and nurses, this study utilized a mixed methods design by asking participants to complete an anonymous online survey questionnaire via SurveyMonkey. This method allowed me to obtain a quantitative assessment of both nurses' and social workers' perceptions and compare responses. The qualitative questions aimed to gain a more in-depth understanding of these perspectives and factors that impact their answers. The nuances and complexities of these experiences could not be captured via solely quantitative methods. In addition, the online survey enabled participants to be included in the

study regardless of where they are geographically located and may have encouraged participation because of the ability to make participants' responses truly anonymous.

Sample

Inclusion criteria required that participants to be either a registered nurse, nurse midwife, social worker or retiree of one of those professions, and to have worked in a labor and delivery unit for two or more years. In addition, participants were required to be over the age of 21 and speak and read in English. By including retirees, nurse midwives, or any individual who has had at least two years experience in the unit, the hope was to gain valuable information and potentially different perspectives in contrast to responses solely from nurses and social workers that are currently employed in labor and delivery units. However, participants were excluded if they worked solely in Neonatal, Post-partum, Obstetrics, and/or Gynecology, because nurses or social workers in these units do not usually work with women during the process of delivery.

In recruiting this sample, the hope was for the final group of participants to be representative of the larger social worker and nursing populations. Recruitment occurred via purposive, convenience and snowball sampling methods. I initially emailed every state chapter for the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) as well as the National Association of Social Workers (NASW) requesting per mission to post the survey to their listserves. I also made requests to a small number of personal contacts and asked those individuals to pass the survey to others who were eligible and may be interested in participating. (see copies of the recruitment materials used for the study in Appendix B to this thesis report)

Feedback from both NASW and AWHONN chapters varied; some were encouraging and enthusiastic about posting the survey to their listerves; others chapters were willing to help but in a different manner (posting the survey on their twitters or sending it out on "monthly email

blast"); other chapters declined my request or suggested that I contact the National Chapters. The NASW and AWHONN state chapters who responded positively to my initial request were provided with a recruitment email which they then posted to their listerves (see Appendix C). The National chapters for both NASW and AWHONN responded with interest to my request to post my survey, but both have their own lengthy approval processes. Submitting and waiting for approval was not a feasible possibility given the research timeline. However, the NASW gave permission to post the survey on their LinkedIn page.

Though there was an equal number of NASW and AWHONN chapters that agreed to post the survey, the AWHONN is more specific to the intended recruitment population. Therefore, though the NASW chapters posted the survey, it likely did not reach many individuals who met the eligibility requirement of working in labor and delivery units. As respondents began to participate in the survey, it was evident that the number of nursing participants greatly outweighed the number of social work participants. I was concerned about this unevenness, but then learned about the National Association of Perinatal Social Workers (NAPSW) from my supervisor in the NICU, who is a current member. Initial efforts to reach NAPSW members included email requests that went unanswered as well as did my supervisor's attempt to post the survey on my behalf. Eventually I sent an email (Appendix D) to the current chairs of six different committees for the NAPSW. After this correspondence, I received an email from one of Chairs confirming that she would indeed post my survey to the listserve. As expected, posting on the NAPSW, which comprises a high concentration of the target population contributed to a more even representation from both groups. Moreover, this persistent, repetitive recruitment effort was so effective that at the conclusion of my data collection, there were actually more social work participants than nurses.

Data Collection

As previously mentioned, this study utilized mixed methods via an online survey. The responses were encrypted by the SurveyMonkey website to ensure that all identifying data about participants were kept private. The survey did not provide me with any names, email addresses or other identifying data. If identifying information was included in the narrative section, I deleted it from any quoted material. Interested participants who did not meet the eligibility criteria were sent to a page saying "regrettably, your responses indicate that you are not eligible for this study, but I thank you for your interest in this research." Those who met eligibility requirements and signed the consent form electronically continued on to the demographic questionnaire (Appendix F). These questions intended to capture age, race, gender, ethnicity, professional degree, and years in this profession. Following the demographic questions participants were taken to the survey, which consisted of nine questions. The questions included a combination of multiple choice, Likert scale and open-ended questions. The quantitative questions aimed to capture social workers' and nurses' perceptions of roles and responsibilities of their own profession and of the other discipline. The qualitative open-ended questions captured a more in-depth understanding of the complex experiences between nurses and social workers, factors that impact the partnership, and how improvements may be made to affect a truly multidisciplinary approach to childbirth. Participants were not required to answer any questions aside from the consent form. This was done to obtain as many responses as possible regardless of how many questions participant completed. Also, the ethical issue of non-coercion seemed to require that all responses be voluntary, however much that option might deprive the findings of some results.

Data Analysis

The data were analyzed to explore the current relationships between nurses and social workers and get a better understanding of the perceptions of each profession. With the assistance of the Smith College School for Social Work statistical consultant, responses regarding gender, age, race/ethnicity, profession, years of experience in the unit, and personal experience with childbirth were analyzed using quantitative analysis, specifically frequency distributions and measures of central tendency. Demographic data were also analyzed in conjunction with the responses to the qualitative and quantitative questions; again, using descriptive statistics and nonparametric models. Given the sample size and amount of responses from each profession, quantitative analyses were correlational, aiming to explore relationships between the different professions' responses to each of the variables in the study.

The open-ended questions were analyzed through thematic analysis, thus conclusions are interpretative in nature, though also supported by the quantitative results from the study. Open coding was used to denote themes and categories in participants' responses. Axial coding was then incorporated to identify similarities and differences of the themes identified during the initial coding. Lastly, I described connections between the quantitative analysis, the qualitative analysis and concepts discussed in the literature review.

Limitations and Biases

The transferability and generalizability of the data gathered from this study certainly has limitations. Given that the sample size of the entire study is small, the amount of responses from social workers and nurses contributes to the lack of transferability; though only a slight difference the number of social workers compared to nurses skews the findings. The disproportiate amount of responses from social workers and nurses renders the data to be more

representative of social workers' perspectives. Moreover, the individuals I personally recruited (who are also members of the NAPSW) currently work in the same hospital setting as do I, which leaves a chance for bias in their answers. In addition, as a clinical social work intern currently placed in this setting, I undoubtedly have personal biases and assumptions about the questions the research is addressing. Prior to recruiting participants, I asked individuals from both professions to review the survey questions in an effort to limit any sort of biases that may have impacted how the questions were asked; however, even this piloting of the question may not have eliminated bias entirely

CHAPTER IV

Findings

This chapter documents the findings from an online survey exploring partnerships between social workers and nurses in labor and delivery units. Questions were asked via multiple choice, Likert scale and open-ended methods. Participants highlighted varying roles and responsibilities, addressing when partnerships occur, if they seek them out, incidents of both effective and ineffective partnerships, as well as the factors that contributed to those experiences. The most descriptive and pertinent information emerged from the third section of the study. Specifically, identifying the types of interactions each discipline described (brief vs. ongoing), as well as the patterns that emerged regarding when and why partnerships are not effective were most informative. The survey and the ensuing findings consist of three specific sections and are organized accordingly: 1) demographic information, 2) quantitative findings via multiple-choice questions, 3) qualitative data via open-ended questions.

Demographic Data

The demographic data will be described briefly in an effort to summarize the patterns that emerged, and then will be displayed into two tables for ease of visualizing the data. Although 84 people consented to the survey, data from 71 respondents were used for this study, who did not comprise a particularly diverse sample. Of the 71 participants, 100% identified as women and 89% as white or Caucasian. The 11% comprised a combination of Black or African American, Hispanic, Asian, Mixed or biracial responses, with two participants in each category.

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The ages of the respondents were more varied, ranging from 21-60+, and also showed a more even distribution: 28% of the sample were 30-39 years old; 24% identified as 40-49 years old, and 25% identified as in the 50-59 range. An additional question inquired whether subjects have personally experienced childbirth. Sixty respondents said "yes," 10 indicated "no," and one participant skipped this question.

Table 1. Descriptive Statistics of Demographic Data, (N=71)

Demographic	Frequency	Percentage
Gender		
Female	71	100
Male	0	0
Race		
Caucasian	63	88.7
Black	2	2.8
Hispanic	2	2.8
Asian	2	2.8
Biracial	2	2.8
Age		
21-29	3	4.2
31-39	20	28.2
40-49	17	23.9
50-59	18	25.4
60+	13	18.3
Personally experienced childbirth		
Yes	13	18.3
No	18	25.4
No Response	13	18.3

Almost half the sample (47%) stated they've been working between two-10 years and responses showed an inverse relationship: the number of respondents in each category decreased as the range of years worked increased. Twenty three and a half % indicated 11-20 years, 17.4% 21-30 years, and 11.6% for 31-40 years. The average years worked was 19 with the minimum being 2 years and the maximum was 48. There were slightly more participants from the field of social work -- (39) as compared to the nursing profession (31) and one respondent did not fit into

either category. The responses were organized into two categories for ease of analysis, but the

breakdown of responses regarding degrees showed a wide variety. Twenty-five% identified as

Licensed Clinical Social Workers (LCSW) and 24% as Bachelor of Science in Nursing (BSN);

the second most common degree for both professions in this sample were Masters of Social

Work (MSW) 20% and Registered Nurse (RN) 13%. Eleven% classified their degrees as "other"

and wrote in their responses. Another three participants (again 11%) indicated that they have

Masters of Science in Nursing (MSN) degrees; one identified as Registered Nurse Midwife and

one respondent had a PhD. in Social Work. The majority of respondents (6) who chose "other"

were from the social work profession. The two other responses provided in the "other category"

detailed their credentials as "RN BSN MPA NE-BC" and "BA education." The latter response is

difficult to make sense of given the topic of the survey and that it contrasts with eligibility

criteria, but I surmise it may be an additional degree.

Table 2. Descriptive Statistics of Professional Characteristics (N=71)

Demographics	Frequency	Percentage (%)
Social Work	39	55.7
Nursing	31	44.3
Specific Degree		
Registered Nurse Midwife	1	1.4
Registered Nurse	9	12.7
Bachelor of Science in Nursing	17	23.9
Masters of Sceince in Nursing	3	4.2
Masters of Social Work	14	19.7
Licence in Clinical Social Work	18	25.4
Ph. D in Social Work	1	1.4
Other	8	11.3
Year working in the field		
2-10	33	47.8
11-20	16	23.2
21-30	12	17.4
31-40	8	11.6

Quantitative Data

      Significance of labor and delivery experience. Participants were asked to rate the impact of a distressing childbirth experience on a mother's transition to parenthood. The majority of respondents (60%) indicated that there is a moderately high/great impact of a distressing childbirth on mother's transition to parenthood, while 31% felt there is a moderate impact, and only nine% state the belief there is no-to- low impact.

      Interdisciplinary Collaborations. The following two questions asked subjects to indicate the extent to which social workers and nurses partner before a woman delivers, and then after. Interestingly, responses regarding partnering before childbirth resulted in an even bell shaped distribution curve. The median and mean response was "occasionally," with 43% responses providing that answer; 23% said "very infrequently" while another 23% responded "frequently." Lastly, four (5.5%) participants provided "never" while another four provided "almost always" as their answer.

      The responses relating to partnerships after childbirth were less conflicting; with 80% indicating that collaboration occurs "frequently/occasionally." However, the remaining 20% of were evenly split between "very infrequently" and "almost always."

      The following two questions asked each group separately how often they sought out the other profession for assistance when a patient was experiencing emotional distress. Similarly to the data from responses about partnering after birth, the majority of nurses' responses (21) included "occasionally/frequently" as the extent to which they would seek out a social worker. Nobody chose "never," but six participants indicated "very infrequently," and 4 said "almost always."

      Though one participant from the social work group chose "never" as a response, data from this survey showed that social workers had a higher mean response to seeking nurse

assistance (m=4.33) than the nurses did seeking SW help (m=3.42). In comparison to the nursing group, none of the social work respondents selected "very infrequently" as an answer. Also converging from data provided by the nursing group, the most common responses from social participants were evenly split. Of the 39 social work participants, 48% chose "occasionally/frequently" while the other 48% identified "almost always" as answers to seeking members of the nursing staff out.

Narratives in the open-ended question may provide further insight as to the differences in seeking the other profession out. This question is asked in the context of a distressing moment, and it seems that nurses often seek out social workers for indirect care or specifically to help a patient cope with a loss.

Barriers to collaborating .The final multiple-choice question asked participants to rate the impact of five possible barriers. Sixty-four people responded and five opted to provide additional thoughts in the "other" box. Regarding different perception of professional roles, 51.5% of participants felt it had a moderately high/great impact, 32.8% labeled it a moderate impact, and 16% said low/little impact as a barrier to teamwork. Different perceptions of clients needs as a possible barrier had a similar response pattern. The majority of participants (64%) ranked it as having a moderately high/great impact, 28.1% felt it has a moderate impact and 7.8% opted for very little/low impact.

Data from this survey suggest that administrative pressures, funding constraints and scheduling have less impact on interdisciplinary collaboration, though they are still considered barriers. Thirty-nine and one% of the sample felt that administrative pressures have little to low impact, 43.8% stated that funding constraints have little to low impact, though 21.9% rated it as

moderate. Likewise, 43.8% of the participants provided scheduling issues with the same low impact rating, but 31.3% rated it has having a moderate impact.

There were no significant differences in how barriers were rated between social workers and nurses, which suggests that both professions feel barriers relate to interdisciplinary conflict more than systemic issues. These findings correlated with responses provided in the open-ended questions, and will be further commented on in the DISCUSSION (Chapter V).

Demographic characteristics and collaborative data. Based on the information collected from the multiple choice questions, different statistical tests were performed to try generating inferences between partnering and certain demographic characteristics. Given the homogeneity of the sample, the major findings are related to the differences between social work and nursing professions; however, there were significant findings about the timing of partnerships, as well as years of experience in the field.

There was no significant difference found when trying to determine whether a participant's perception of a patient's distressing childbirth had been impacted by her own personal experience. However, a paired t-test was run to determine if there was a difference in the rating of collaboration prior or after birth and a significant difference was found ($t(69)=7.770$, $p=.000$, two-tailed). The mean rating prior to birth was lower ($m=3.00$) than after ($m=3.60$) -- suggesting more collaboration after the birth, which is consistent with responses offered in the open-ended, qualitative portion of the study.

To then determine if there were specific differences in how each profession rated collaboration prior to and after birth, t-tests were performed and significant differences were found in both:

Partnering before birth: t(67)=3.368, p=.001, two-tailed). Social workers had a higher mean response to this question (m=3.33) than did nurses (m=2.60), suggesting that participants in the social work group experienced more collaboration.

Partnering after birth: t(67)=4.413, p=.000, two-tailed). Social workers had a higher mean response to this question (m=3.95) than nurses (m=3.20) suggesting social experienced more collaboration.

No significant difference was found when testing to determine if there was a difference in the perception of collaboration prior and after birth by years of experience (using four different categories). However, there was a correlation when the test was run using the original years in labor/delivery (as a continuous variable), which was how these data were initially obtained before being grouped into categories. A Spearman rho correlation was run and a significant but weak negative correlation was found between years of experience and rating of collaboration prior to birth (rho= -.244, p=.041). This suggests that as years of experience increased, the perception of collaboration went down. There was no significant correlation with collaboration found after birth, though.

Considerable findings from the quantitative data suggest that when collaboration occurs, if at all, timing plays a significant role, as do the different perceptions of professional roles and clients' needs. As previously mentioned, the open-ended questions reiterate these major findings, but also provide a deeper exploration into how each profession views positive or negative partnerships, or why they partner at all.

Qualitative Data

The first open-ended question asked participants to "Please provide an example of when a nurse/social work partnership has been effective? What factors made this experience go well?"

Effective partnerships. Of the 71 participants in the sample, 61 responded to this first open-ended question and all provided comments relating to psychosocial issues. The various responses were further organized into groups reflecting a range of themes and subthemes with some responses applying to more than one category. While comments referenced the psychosocial concerns of patients, four responses also included the importance of "staff morale." Fifteen participants provided specific case examples and the remaining responses were broad such as, "Care coordination as a team for a client with multiple complex psychosocial issues" or "I have had patients who have limited resources, both financial, cognitive and emotional. Social services were able to provide services in these situations." Other answers were broad but also incorporated straightforward examples such as, "There are numerous opportunities and everyone benefits when we have social work support for adoptions, substance use, homelessness and mental health issues" as well as "fetal demise" and "mothers with financial or domestic issues."

Patient related issues. The breakdown of responses relating to instances that necessitate a "partnership" all fell under the broad umbrella of a patient with "psychosocial issues": three adoptions, six child protective services, 14 financial/housing resources, 15 fetal demise, two previous sexual trauma, three neonatal intensive care nursery/high risk obstetrics, two teenage pregnancy, 10 mental health, four pregnancy termination, three traumatic birth, two intimate partner difficulties. These specific examples are also reflected via a Table on the following page:

Table 3. Occurrences of Nurse-Social Work Partnerships

Patient Related Issue	Frequency
Adoption	3
Child Protective services	6
Financial/housing resrouces	14
Fetal Demise	15
History of sexual Trauma	2
High Risk birth	3
Teenage Pregnancy	2
Mental Health	10
Termiantion	4
Intimate Partner Conflicts	2
Traumatic Birth	3

Many of the answers in this section can divided into separate categories of either

support/counseling/direct care practice or community resources/knowledge of a general process.

Though some of the responses fell into a distinct category, others were more nuanced. For

example, there are wide-ranging responses regarding a fetal demise (the most cited issue). Some

subjects only mentioned partnering so that they could help with logistics such as planning the

funeral. Other responses mentioned the grieving process as well as funeral arrangements, and

some comments included multifaceted needs that require both direct care and information about

other resources, such as in the following example:

> The nurse advised me of the situation, explained the mother's mental state (depressed,
> voicing suicidal ideations), medical background, family dynamics, self-image problems,
> and related concerns. I had a good background on [the] patient provided by the nurse. I
> then consulted with the patient and provided ample time to process her grief situation,
> recommendations for support, and additional concerns she presented. After meeting with
> patient, I provided nurse an update … and the plan in place for her [the patient] when she
> discharged the next day. The in-depth information provided by the nurse and updating her
> on my interventions and the proposed plan (for continuity of care) made the experience
> go well.

This example also reflects the most commonly cited theme in terms of factors that contribute to

successful interdisciplinary partnerships: "Effective Communication."

Communication. Eleven participants explicitly said "communication" contributes, while others reflected the theme by writing "input" "feedback" and "providing information." In this particular category, four social work identified respondents correlated the importance of communication with the amount of time spent with a patient. One social worker noted, "Nurses have the most contact with a patient, so I rely heavily on their feedback and perspective to balance the less frequent (and most often in crisis) interactions I have with the patient." Another social worker echoes this idea, "Nurses' input is very helpful because they can observe the mom and baby bonding and interacting for a longer period of time."

Communication is undoubtedly required in many interactions between social workers and nurses, though the type of communication also shows to be important to the overall experience. One subject wrote, "I think mutual respect for each other's roles makes all interactions go well." This sentiment illustrates the second most common theme (respect, cooperation, trust) that contributes to a positive experience while working together. The majority of the responses incorporated such a theme but only a few emphasized or noted specific skills/roles -- which, in contrast, were present in many responses about ineffective relationships. Participants that did mention distinct responsibilities for each profession distinguished the roles by psychosocial need and medical expertise such as,

> Leaning on one another for our strengths. Social work providing counsel/support, nursing providing education on typical postpartum courses" and "combining the psychosocial needs and the medical nursing needs of patients and families when a birth may be high risk.

One participant's response was not necessarily in contrast to the other comments about distinct skills, but she did remark how "Both social worker and Nurse take on responsibility for caring and assessing the mother."

Types of communication. Though not directly asked, responses in this section also revealed ideas about the types of interactions and communications between the two disciplines. The responses can organize in two group: brief, or back and forth communication. The first group captures answers that involve a one-direction exchange of information, including "referrals," as well as "alerting," "identified" "notified." An example of such a back and forth or more complex interaction was offered in: " nurse identified post partum depression, referred to physician who referred to social worker to set up counseling." In comparison, the latter group pertains to responses that include collaboration, working together "hand in hand," in a more ongoing manner.

Both types of interactions were described in responses from each profession, but the majority of responses from members of the social work group fell into the collaborate/ working together category. Their examples tended to focus on social/emotional needs via collaboration and direct care for the patient. Responses from nurses primarily tied to the first category of brief interaction and the content typically pertained to providing patients with community resources. For example, a nurse wrote,

> SWs have access to community resources that are helpful to low-income families. This
> is especially helpful during the discharge process. This type of support is helpful
> because it is offered if we (nurses) ask or there is a consult, and completely out of the
> realm of nurse duty.

In contrast, an example from a subject in the social work group noted "[this] is when a nurse approaches me with concerns about a patient, and we collaboratively evaluate what might be going on for the patient, and identify a plan for how all members of the patient's care team can meet the patient's needs (e.g., "Would the patient benefit from being seen by a psychiatrist? Does the patient benefit from information being communicated in a specific way (verbal vs. written, etc.)? Is the patient facing psychosocial stressors beyond the issues she's facing with

childbirth/parenting?" It's important to note that this social worker begins the example with the nurse approaching her, yet ends her response by stating

> This could also work in the opposite way, in which I as the social worker approach a nurse to discuss concerns and how to best address those concerns/support our mutual patient.

This suggests a sense of equality where both individuals feel they can approach the other, in contrast to later themes regarding power dynamics. In addition, by mentioning the other possible psychosocial needs aside from the obvious concerns, she reflects that in many cases there is not an isolated need, but complex psychosocial issues. This sentiment is shared throughout the data, regardless of the respondent's identified discipline, and was also illustrated in the previous fetal demise example.

Though responses from participants in the social work group reflect more "back and forth," a response from someone in the nursing group also indicated an appreciation of follow up after a brief interaction with a patient. She wrote,

> It goes well when we make early referrals to social work and the communication goes both ways to collaborate care; nurses like follow up on their patients to know the outcome (impact) of their efforts.

While other examples mentioned successful partnerships before a woman delivers, this is the only response that explicitly states the benefit of "early referrals." Interestingly, this is a theme that was commonly cited in the next section, ineffective partnerships, but is only noted by social workers there.

Ineffective partnerships. In comparison to the 61 responses regarding effective partnerships, 56 participants answered the inquiry about ineffective relationships. They were asked: "Please provide an example of when a nurse/social work partnership has not been effective? Why didn't it meet your expectations?" Nine responses included answers such as

"never" and can't think of one" with two of these subjects providing more elaborate answers such as, "In our hospital, we work very closely with the multidisciplinary team and we have one common goal of providing excellent patient care. I don't recall having a negative experience with a SW/nurse partnership."

It was difficult to differentiate responses in this section into "Ineffective partnerships" with "unmet expectations," so they are combined. The pertinent findings in this section center on three themes related to problems in interdisciplinary collaborations. The different categories are evident in both the social workers' and nurses' responses, though they are not numerically matched.

Perception of roles. For both professions, but primarily for subjects from the social work group, topics relating to theme of non-appreciation and misunderstanding of roles contributed to an ineffective partnership, if one occurred at all. One social worker articulated this sentiment writing,

> I think when nurses don't understand our role and think they can do what we do, sometimes they can be invasive and not respecting of space and role.

This feeling of a disconnect and ambiguity of social work roles was also portrayed by a respondent from the nursing field,

> During a C-section, a woman requested that a social worker be present. This doesn't normally happen and I'm not sure it was necessary, given that the pregnant woman's husband was involved. Anesthesiologist and OR nurses provide excellent support and it's not helpful to make the OR more crowded.

Though much of the literature considers nurse and social work roles as caring professions, this narrative suggests that other medical professionals can provide that same care and support; it also introduces the idea that there is essentially some criterion that must be met in order to benefit

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from social work. This notion of being an interchangeable discipline correlates to the theme of feeling unappreciated -- echoed in many of the responses. In fact, many of the narratives related to the overarching theme of roles can be classified into two smaller subthemes: "timing" and "devaluation."

   Timing. Five comments expressing frustration about timing all came from individuals in the social work group. One woman wrote, "When there is blocking by the RN to NOT refer to SW until situation is in chaos" while another social worker expressed that "Nursing often doesn't notify social work until there is a crisis and/or [at the] last minute. More partnership would make for better experience." However, responses from both groups addressed the intersection of expectations and perception of roles, with the timing of a partnership. One subject from the social work captured this sentiment writing:

> When L&D RNs don't contact the social worker at time of stillbirth or neonatal death and don't think parents need more than the RN, I find that families don't get answers re: funeral planning, grief support, guidance re: handling dealing with funeral homes, etc. I am sometimes frustrated by the ego involved with some L&D RNs re: this issue.

A participant from the nursing group similarly mentions time and roles, but with a different understanding:

> Times come to mind where there isn't an understanding of roles, which can be frustrating. Nurses spend more time in labor and delivery rooms with patients than social workers, so we seem to know the patients and their families better. I think it's best to let nurses communicate needs to SW as they arise.

This narrative seems to have a tone of superiority suggesting that nurses know better; and social workers aren't needed unless summoned by nurses, only once nurses deems social work involvement necessary. Regardless of the prevalence among nurses of this statement, any sentiments such as these at all help explain why individual social workeres may feel disrespected and unappreciated, which is the next topic addressed in this chapter.

Feeling unappreciated. Responses from both social workers and nurses correspond with

the theme of "feeling unappreciated" by mentioning being ignored, minimized, and challenged.

One participant from the nurse group wrote that it's difficult to work with social workers

because:

> They do not seem to appreciate nurses, in fact, seem to resent them. When concerns are
> voiced to the social workers, nurses feel that these are minimized and brushed off and
> not taken seriously.

Subjects from the social work group similarly described when a nurse "challenged the SW

assessment" and "disregarding the plan," formed by the social worker. Another social worker

articulates this feeling saying:

> It is not so much an example, but when I talk to a nurse about one of her patients and she
> questions why CSW needs to see her, or states her mood is fine. I do value their
> perception of Mother's mood, but it is so much more than just the time they are in the
> room.

Unlike other comments related to feeling devalued, this quotation highlights consideration for

the other profession's potential contribution.

Unmet expectations. While the majority of social worker responses reflect distress about

roles and respect, the majority of the feedback from nurses suggests that they feel partnerships

are not effective when social workers do not meet professional expectations. In these instances,

mostly nursing-identified respondents referenced specific psychosocial needs (previously

identified in Table 3). For example,

> "Pt. lived in homeless shelter and didn't have any where to go. Had to DC [discharge] pt.
> to go to shelter with two day old NB [newborn], no other options."

Likewise, another nurse felt that social workers were not fulfilling their duties when they "did

not follow up with a family after an infant death. They did not help to set up support and follow

up for after discharge." Other responses from nurses included "When the male SW arrives and is

'just' doing the basic review" and "lack of social worker educated in perinatal issues--was not helpful to mom with mental health issues because only versed in elder care." Four different nurses also commented on the difficulties of not having a specific social worker intended to work solely in a specific unit, as well as not having a reliable social worker on nights or at weekends.

Only a few social worker responses related to the idea of "inadequate job," and they primarily referenced a nurse's lack of knowledge about the patient as the issue. For example, "the nurse relied on cultural stereotypes to explain a mother's concerning behavior." This comment applies to both the concept "inadequate job" as well as "approaches to care," the final theme in this section.

The previous topics relating to ineffective partnerships reflect distinct feelings between the professional groups. Social workers primarily felt that factors related to "roles" contributed to ineffective partnerships, while the majority of nurses suggest it relates to the concept of "inadequate job." However, a fairly equal amount of both nurses and social workers indicated that "different approaches" -- whether it is towards a patient or difference of opinions about a plan -- contributed to a poor partnership. Though it may sound similar to the previous subtheme of role/communication, that category focuses on interactions (or lack thereof) between social worker and nurse; the classification here pertains more to the interface with the patient.

Conflicting views and approaches. Corresponding to the earlier comment about stereotypes, subjects from the social work group feel that nurses are "judgmental." One subject from the social work group commented, "When the nurse is judgmental or perceived as judgmental by the patient, then the patient often feels that the SW will be the same way at first." Related to the theme of judgment but in regards to patient care, one social worker felt that "RNs' plans of care are affected by their opinion and judgment of a client's psychosocial issues." Seven

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of the responses related to the theme of judgment are specifically about substance use in pregnancy. One participant stated that, "Nurses that care for substance exposed infants often struggle with their personal feelings about the mothers," and another expressed,

> If a particular nurse is judgmental about certain patient behaviors or history (e.g., drug use or multiple pregnancies or previous release for adoption, etc.) It can be difficult to provide adequate emotional support unless the CSW is able to educate nurse regarding some of the reasons for such history so that the patient can be well supported.

The basic concept of a patient's ability to change (as in drug use) is an important concept that CSW background provides to that discipline. Responses from nurses pertaining to conflicting opinions include cases where there are different opinions regarding CPS involvement, times when they feel CPS action should have been taken and wasn't, or vice versa. One nurse mentioned, "The removal of a baby -- SW working with DHS used lab tech to get baby out of the room then they went in and told the mother. I felt it was deceitful." Another nurse said,

> The social workers make it difficult when the mother is still a patient with the right to be with the [infant] patient in the nursery, bringing in foster parents at unscheduled times. As a nurse I am an advocate for both of my patients in this dyad. The social workers don't appear interested in the mother -- or the staffing needs of the hospital.

Both social workers and nurses speak about "advocating" or "intervening" on behalf of the client as though they have to protect the patient and are the only individuals able to do so. It appears that when there seem to be "ineffective partnerships" this is often due to the professionals' prioritizing of the relationship with the patient over their interdisciplinary collaboration; though such relationships need not be mutually exclusive or in conflict with the other profession. This finding will be further discussed in the following chapter.

While there are three specific categories to organize the feedback of ineffective partnerships, these ideas are all intertwined with one another. The overall tone of this section is filled with hostility and suggests that it's likely that an ineffective partnership is not the issue, but

a lack of one entirely for some units. Of the 47 responses acknowledging ineffective partnerships, all but four (91%) placed blame on the other profession. Only one respondent mentioned "limited resources and many rules," which is the sole narrative mentioning additional barriers. These data are consistent with findings from the Likert scale questions: "Different perception of clients needs" and "Different perceptions of professional roles" were the highest rated barriers to interdisciplinary partnerships while "Administrative pressures," "Funding constraints," and "Scheduling issues" were rated as having a low impact.

The previous questions in the survey attempted to explore the varied factors impacting and also promoting collaboration; the last section asks the same questions but in a less direct manner.

Suggestions to improve interdisciplinary collaboration. The fewest number of participants, 27, responded to the last open-ended question. In addition to other factors that impact partnerships, participants were asked about any other aspects they believe would be helpful to address. Many responses reiterated themes from the previous questions as well as corresponding suggestions.

Need for education about social work skills and training. Seven responses in this section pertained to the specific training of social workers, how the professional skills differed from nurses' skills and the lack of understanding surrounding the role. Of those seven, four participants proposed providing education around "the scope of social work practice"; in particular, around the skills, services provided, and "when to communicate needs to them." Recommendations also indicated a need to educate patients about social workers' skillsets, so [patients] can advocate for themselves. One subject highlighted that the lack of appreciation for social work extends beyond nurses,

Many other disciplines (RNs, MDs, IBCLCs for instance) have no clue what a social worker really is, or does, or what education we have received. This affects how they utilize us greatly as we are dependent on them for referrals but often they don't understand the job we are doing.

This response contributes to the shared consensus about a lack of understanding about the social work professional, but also identifies why this could be problematic. The comment is evocative of the power dynamics involved in a social work/nurse interaction: what social workers are speaking to in their descriptions of ineffective partnerships -- but are not clearly identifying.

Only one other participant expressed a slightly different take on the matter writing,

"It takes committed teamwork, i.e.: we are all here for the patient, not defending our territories."

Interestingly, she does not specifically mention social work-- but offers the idea that if professions are focused upon their roles they aren't concerned with the patient, or that working as a team is not a priority. Though this comment can be considered in contrast to the earlier suggestions promoting education and distinct roles, it seems the topic cannot be reduced to two separate sides of an argument. Moreover, This conversation is not uniquely between these two disciplines, "chaplain or spiritual care roles can confound the role confusion" as well. In fact, the frustration is analogous to the feelings captured about nurse-social work dynamics "I have had great chaplains and we tag team well together and I have had some that just don't respect role of either nurse or social worker in the spiritual aspect of care."

Additional feedback in this section focused on concepts that have not been addressed in previous responses in this survey, but are topics that are relevant in the context of the existing social work literature.

Funding and structural issues. There were seven comments relating to the structure of employment and a "general need for full time social workers." These responses mentioned how

social workers may be unable to integrate into interdisciplinary teams because of "high caseload covering multiple units" as well as being "imbedded in Case Management departments, but assigned to a service (such as L&D, NICU, etc.)

Other responses highlighted changes such as entire labor and delivery units closing as well as "the increasing pressures on social workers (as a result of changes in health care) to focus on length of stay (getting patients moved along quickly by eliminating psychosocial barriers to discharge)". One participant provided two responses related to this topic of social work positions, but added new specificity. She wrote,

> The lack of qualified Social Workers to work in rural areas of the country. The lack of leadership opportunities for Social Workers to advance in hospital settings compared to RN's.

In every section, the majority of the responses reflect a contrast of the two disciplines regardless of the question asked. The comparison was particularly competitive in the ineffective partnerships portion of the responses. In general, this last section was less personal and addressed larger structural concepts. However, some responses did include specific complaints about the other profession such as "Social workers should have a friendly/collaborative personality. Our current social worker does not look comfortable in her own skin, and is at times very ineffective in her work." Making meaning of the numerous findings identified in this section will be developed further in the following Discussion chapter.

CHAPTER V

Discussion

The purpose of this mixed-methods study was to explore the perceptions and dynamics between social workers and nurses in labor and delivery units with the hope that the data may improve interdisciplinary collaborations and the care provided to childbearing women. Specifically, questions attempted to further illuminate how nurses and social workers in labor and delivery units understand their own roles and responsibilities, that of the other profession, and the extent of partnerships amongst these two disciplines. Although their responses demonstrated the individualized nature of these interactions, there were key findings highlighting a fundamental disconnect between what social workers are capable of and what their current roles entail, as well as how these roles are prescribed. Other major impressions suggest that when partnerships go well there is a synergy, yet there is often little collaboration; some providers seem ambivalent about potential partnerships and at times, even hostile about the other profession. These findings in this discussion are situated within the broad frame of the literature review. The discussion here also includes strengths and limitations of the study, implications for clinical practice, and suggestions for future research.

Major Impressions

Feeling valued. It appears there are qualities that, across the board, support interdisciplinary collaboration. Findings from this study reiterated previous research that identified well-defined roles as an integral part of the effectiveness of interdisciplinary

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collaboration (Mizrahi & Abramson, 1985). Yet, in another study, a researcher found that "

…[while] nurses appreciated that the scope of practice and responsibility was distinct for nurses

and physicians, they still expressed frustration when their opinions were not valued and acted-

upon…. frustration stemmed from a lack of recognition of [the nurses'] knowledge and

experience" (Simmonds, 2010, p. 100). Narratives from social workers in the present study

reflected the same sentiments about a lack of recognition of their own capacities. These

overlapping and consistent findings from both social workers and nurses show that while role

delineation is helpful, what is more important in an interdisciplinary relationship is the feeling of

being appreciated.

The data from the study on nurses and physicians paralleled my findings -- so much so

that many of the individual explanations about negative partnerships could be verbatim

quotations. Although the precise mechanisms were varied, respect was similarly indicated by

being courteous, trusting the other's judgment, and expressing confidence in the other's abilities

(Simmonds, 2010). Similarly, when gratitude was absent amongst the professions, both studies

resulted in nurses and social workers describing feelings of resentment, invisibility and

decreased worth.

Power. While respect, appreciation and acknowledgement are understandably present in

examples of positive collaborations, the power dynamics in this present study are particularly

noteworthy. The social work participants never explicitly name different degrees of power,

though many narratives mention being dependent on nurses for referrals, often not receiving

them until it's too late. These findings correspond with much of the literature examining

intrapartum interprofessional relationships, emphasizing the negative encounter and power

imbalances within these relationships (Sleutal, 2000). Given the earlier literature arguing that

nurses can do the same job as social workers, data documenting the limited extent of nurse-social work collaborations in labor and delivery units are not surprising. As a feminist ethics perspective suggests, perhaps social workers and nurses resist partnerships with one another to create agency amongst their specific disciplines in response to the oppressive environment and power differentiation present in many hospital settings (Sherwin, 1992). It's important to consider the intersection of gender in these dynamics, given that both nursing and social work professions are typically considered "women's work."

While the subject of power is becoming more of a focus in interdisciplinary research, the existing literature appears to abridge the subject as simply inevitable and expected, without exploring the full complexity of it. Knowing that the majority of studies portray social workers as having little agency, I was optimistic that findings from the current study might provide additional insight into the multifacetedness of this issue and/or challenge this dominant narrative. The intense feelings captured by the present study were not anticipated. The anonymous and online aspects of the survey may have encouraged participants to use it as an opportunity to vent their frustration; anger was palpable in the responses from both disciplines, but more so from social workers. Likewise, in an earlier study on interprofessional relationships between doctors and social workers, feelings of dissatisfaction were expressed mainly by the social workers. It's clear that degrees of satisfaction in partnerships often correlate with one's level of power in the relationship; perhaps social workers feel more disenfranchised or disempowered as compared with nurses.

Social workers articulated their frustrations in the context of this research -- where specific questions are asked -- yet generally these feelings are not communicated. Despite my wariness, it seems that social workers have indeed internalized some of the helplessness well

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documented in earlier studies, and feel they cannot express their feelings due to the expected

reactions of the upper power echelons. The inherently sado-masochistic dynamics of many

hierarchies are often subtle and are normalized, which contributes to how social work roles are

prescribed by both providers and patients.

Roles and responsibilities. Despite coming from different settings, the study

"Competitive Allies" conducted in a small rural hospital proves relevant and consistent with the

dynamics reflected in this current study. Both studies had a small sample size, but captured the

blurred professional boundaries, as well as the same misunderstanding of expectations and

responsibilities for nurses and social workers. The data also echo the findings from "Bouncer

Brokers and Glue," which took place in a large metropolitan hospital, focusing solely on social

work perspectives. Both studies suggest that various tasks have different levels of status and

power. The narrative subtly reflects the conscious and unconscious competition involved in

some tasks as compared to others (e.g., discharge planning.) Unlike "Bouncers, Brokers and

Glue," this study found little mention of the satisfaction and support social workers provide to

other professions, such as being the glue to the entire interdisciplinary team, or providing support

to a nurse who wants to debrief/process a particular case. Instead, both professions demonstrated

a general understanding that the provider-patient relationship was more important than

professional relationships.

Moral responsibility. Embedded in the data was a sense of moral responsibility that was

integral to potential collaborations. Participants from both "helping" professions enacted their

responsibilities in ways that they believed would ensure healthy outcomes. Furthermore, the

dualism in the responses illustrated the belief that there was a "good" and a "bad" course of

action; participants would "intervene," "advocate," or at times, just ignore suggestions in order to

manage a patient's care and ensure the "best outcome." Certain situations such as substance using mothers and Child Protective Services involvement appear to enhance these feelings of moral responsibilities more than others. It seems such feelings of responsibility and conflicting opinions about the plan of care stem from both personal and professional identities -- contributing to experiences of frustration when there is a mismatch.

These emerging themes are ones I have not previously encountered and provoked me to further explore the topic. Most of the published literature to date is within the field of nursing, quantitatively measuring the nature and extent of moral distress. However, other research indicates that moral distress is a concern for a variety of health care providers including nurses, pharmacists, social workers, physicians, and health care managers in a wide range of acute and community health care settings (Pauly, Varcoe, & Storch, 2012; Ulrich, O'Donnell, Taylor, Farrar, Danis, & Grady, 2007). There are many causes of stress in health care work, but moral distress is specifically associated with the ethical dimensions of practice and concerns related to difficulties navigating practice while upholding professional values, responsibilities and duties (Simmonds, 2010; Varcoe, Hartrick, Pauly, Rodney, Storch, Mahoney, & Starzomski, 2004). The notion of moral distress, despite being understood differently in various studies, is important to consider because of the implications it has for interdisciplinary interactions. Studies show that experiences of moral distress contribute to emotional distress (e.g., anger and frustration), withdrawal of self from patients, unsafe or poor quality of patient care, and decreasing job satisfaction (Oliver, 2013; Pauly, Varcoe, & Storch, 2012; Hamric, 2010).

Developing relationships. Confusion and widely inconsistent professional expectations are indeed problems that need to be addressed within hospitals. Yet role clarification is too simplistic of an approach by itself, which is why measurable success has been elusive.

Respondents reiterated findings from existing literature identifying how social work roles are produced via interactions with others, illuminating the power of perception in this process. Though not an initial objective, data from this study placed special attention on the types of interactions that took place, which is absent in much of the literature but important to the construction of roles. Capturing the various types of communications (often one-directional) adds depth as to why the role of hospital social workers remains ambiguous (Itzhaky & Zanbar, 2014).

Many researchers suggest that social workers ought to be more flexible in the development of their professional identity, especially to effectively work in an interdisciplinary setting. With that in mind, it's imperative to note the difference between flexible and ambiguous roles. Hospital social workers are no longer simply spanning different boundaries, but are required to give up much of their professional identity entirely. Findings from the present study suggest that the most influential factor in navigating roles and interdisciplinary dynamics is developing genuine relationships, and in turn trust -- something that is accumulated over time.

Even in intradisciplinary relationships between nurses, to the degree that people had the opportunity get to "know" one another, "share similar expectations and understandings of their responsibilities, and demonstrate reliability and reciprocity in their everyday interactions were all elements of the social-moral connections between nurses" (Simmonds, 2010, p 102). Conversely, feedback from this study indicates that where social workers were once able to build real and meaningful relationships with colleagues, forming a basis for collaborative work, many social workers are now seen as interchangeable, and not appreciated as individual people with unique skills to offer. Participants highlighted that changes in caseload sizes, funding and

employment practices currently prevent many social workers from becoming part of an interdisciplinary team.

While nurses and doctors still primarily function as a general group, there are increasingly fewer hospital social workers that are assigned to more cases, and in some instances, even covering various units at one time. Any opportunity for social workers and nurses to practice alongside one another, develop trust, and social-moral connections has largely dissolved. Consequently, social workers can no longer negotiate ascribed vs. prescribed roles, or build social capital, which is needed in order to operate effectively when power is dispersed across systems (Oliver, 2013).

Many of the issues identified in the previous paragraphs would benefit from adequate management of social workers' departments and interdisciplinary teams within hospitals. The most significant factor preventing hospitals from undertaking and addressing these problems, however, may be that there is no financial incentive – this pursuit would not be reimbursed by insurers -- though ironically, ignoring these problems is likely costly and, in a longer view of economics, would be worthwhile to address.

Labo*r* and delivery units. While the experiences expressed in the narratives may be similar to sentiments in other units, the social workers and nurses in this study were speaking specifically about labor and delivery units. Though the data cannot provide explicit suggestions about the care provided to laboring women, it's clear that the hostility reflected in the findings creates an environment that is not conducive to communication or overall wellbeing. Another point that emerged from the present study's findings suggests that social workers who work consistently in specific units are better equipped to understand the medical issues of a patient, which is valuable for everybody. Having specific knowledge is a significant factor in

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understanding what the patient and family are experiencing, and sharing the same appreciation of the issue with nursing staff is beneficial to successful partnerships.

The current study aimed to capture a variety of interactions including ones during labor and delivery, yet all the responses echoed previous studies of partnerships that occurred before or after delivery, with the majority being after. It seems that social workers are rarely involved before labor and delivery and almost never during, though the timing of partnerships is undoubtedly worthwhile to consider. Though the findings reflecting this are among the qualitative ones, and the sample too small for statistical significance, it's noteworthy that some of the responses pertaining to positive partnerships occurred prior to delivery while all negative experiences occurred post-delivery. The perception of positive collaborations may not necessarily relate to a specific outcome, but correspond to feelings of respect that are more likely to happen if a social worker isn't summoned at the last minute. Given the existing research on women's experiences it seems worthwhile to further explore the timing of social workers' involvement. Perhaps if social workers were involved earlier, preventive and helpful measures would be employed, thereby reducing the likelihood that a mother feels she is in crisis.

Strengths and Limitations

Though the present study's findings are not generalizable due to the relatively small and non-random sample involved, the study collected many in-depth and informative responses from a fairly equal number of social worker and nurses. While the open-ended qualitative questions strengthened the quantitative findings and were in agreement often with existing literature, responses also introduced new topics and themes to consider. However, a drawback of the internet-based study design was the inability to clarify responses for participants, or to ask follow up questions, which clearly the respondents were unable to do either. Additionally, it would have

been useful to gather information related to geographical location, size of hospital and whether it was in rural or metropolitan setting. Though the findings in this study were consistent with other studies in a variety of settings, it would be beneficial to know if and how hospital characteristics can impact interdisciplinary collaboration. Does a smaller setting have more positive partnerships because professionals within them are familiar with one another and have more overlap? Or, do social workers and nurses have better dynamics in large metropolitan hospitals where there is more funding, among other differences with small ones?

Lastly, the reports given by participants in this study did not include descriptions of how racial and ethnic differences among staff members might also influence the level of collaboration amongst partnerships. This omission may reflect a limitation of this sample in that the racial composition of it is so far from diverse.

Implications for Social Work

The results of this study have several implications for clinicians in hospital settings, but also for the field of social work in general. The data inform those who work in hospital settings about the conflicting expectations of social workers versus the realities of their day-to-day roles. It is evident that there is a real disparity in what each of the professions thinks of the other's roles, as well as what social worker participants imagined they'd engage in. Generally speaking, nurses believe they are able to provide the same care as do social workers, and this perception in turn may result from competitive motivations, though maybe not consciously. A quote from one social work response illustrates this:

> No referral until after delivery when coping and emotional issues identified in prenatal record and by patient; nurse indicated she could meet all the needs and [did] not need social work intervention or consultation.

Rather than place blame, it's crucial for individual social workers to take responsibility. While

there are many elements that are out of one's control and are aggravating, faulting others will have little impact on the situation. Acknowledging one's professional and personal strengths will help challenge the notion that social workers are complacent victims and may be helpful to alter the course of prescribed roles. Further, while it is beneficial to engage with other professionals in a flexible, respectful, and polite manner, some dynamics will not change unless space is intentionally reclaimed. Though it may feel counterintuitive, I suggest social workers rethink prioritizing civility over equity in the development of a professional identity. Interdisciplinary care is intended to draw on what is distinct about each profession so the whole becomes greater than the sum of the parts. Preventing the development of a strong professional identity as a barrier to interdisciplinary partnerships is also an important consideration and certainly a difficult one to balance.

The field of social work is obligated to challenge the general perception of a social worker's identity that is largely constructed by the media. A profession that "offers food stamps" or "takes away children" are some examples of the demonizing or minimizing that the media can engage in when characterizing social work. An accurate understanding of social work is imperative towards the continuation of a robust profession. The current misconceptions impact both the demand for social workers as well as the extent of their practice. If this trend continues, it will presumably result in a further suffering of recruitment to the field, a lowering of admission standards to social work schools, as well as professional status of social work jobs, and ultimately leave the public with low-wage, untrained people to handle clients with complex problems (Feldman, 2006; LeCroy & Stinson, 2004).

Finally, if more attention was placed on how we interact with healthcare policies and structures within hospitals, rather than focusing so singularly on individualized behaviors, we could get much closer to both understanding "the problem" and finding a solution.

Future Research

As a whole, this study further underlines the need to explore perceptions of social work as it relates to its own and other professional identities. Research surrounding the perceptions of social work can be used to develop strategies to accurately inform and gain support for the extensive services they provide in a variety of settings.

In the context of interdisciplinary care, guidelines supporting the development of interprofessional relationships do not thoroughly describe the processes for addressing the structural and relational factors that influence the establishment and maintenance of those different relationships. It's important to consider how personal preferences, clinical knowledge and professional experience all impact how providers respond to patients and with one another. While the specific focus of this study did not create a space to explore the other significant characteristics of the participants, the data did illuminate the moral-social dimensions involved in caring professions (both social work and nursing) that are largely absent from social work literature. Further research could explore the ways in which individuals understand their work and attempt to meet their moral responsibilities to their clients, their colleagues, their institutions and themselves; such research is necessary to obtain a better understanding of behaviors and to shape desirable changes.

Teaching and talking about relational work in a way that moves beyond idealistic expectations of either "caring" profession, but acknowledges human limitations is necessary to create the flexibility needed in interdisciplinary teamwork. In particular, raising personal and

professional self-reflection, especially about aspects of one's own motivations (such as

unconstructive competitiveness) – these are important aspects that seem lacking in responses of

most research participants to date.

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Appendix A

Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA
2015-2016
……………………………………………………………………………….

Title of Study: Social Worker and Nurse Roles in Labor/Delivery and Obstetric Settings:

Partnership or Parallel Work Lives?

Investigator(s): Allison Barbey, MSW Candidate, Smith College School for Social Work

……………………………………………………………………………..

Introduction
- You are being asked to be in a research study about the roles of nurses' and social workers during childbirth.
- You were selected as a possible participant because you are 21 years or older, are a registered nurse or social worker working in labor and delivery, speak and read English. You will be excluded in the study if you work solely in Neonatal, Post-partum, and/or Gynecology, because nurses or social workers in these units do not usually work with women during the process of delivery
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
- The purpose of the study is to better understand the relationship between nurses and social workers – Is there one? Is there a real disparity in what each profession thinks of the other's roles?
- This study is being conducted as a research requirement for my Master's in Social Work
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures
- If you agree to be in this study, you will be asked to do the following things: complete a one-time online survey that asks you a variety of questions about your responsibilities, perceptions of other discipline (either social work or nursing), and whether you perceive that there is interdisciplinary collaboration. The questions should take approximately 30 minutes to complete and are a mix of rankings and open-ended questions.

Risks/Discomforts of Being in this Study
- There are minimal risks involved by participating in this survey. However, some participants may find it upsetting to reflect on witnessing traumatic birth experiences, or their perceived roles. If during the course of the survey the participants feel uncomfortable or overwhelmed, they have the ability to withdraw at any time. In addition, I will provide information about resources that provide mental health services at the end of the survey.

Benefits of Being in the Study

• This survey offers participants the opportunity to share their professional experiences in caring for women during childbirth or during their child's stay in a Neonatal Intensive Care Unit and may provide participants with new insights into the manner in which they work. A more clear understanding of this topic will help society understand the challenges of intrapartum nursing and social work, which may also benefit participants. I will be unable to offer compensation to participants in the proposed study.

• This research may also provide insight as to how social workers and nurses can better partner in an effort to increase maternal satisfaction during delivery.

Confidentiality

• This study is anonymous. We will not be collecting or retaining any information about your identity.

• Your participation will be kept anonymous. Survey responses will be encrypted by SurveyMonkey to ensure that the data are kept private. The survey will not provide me with names, email addresses or other identifying data. If you do inadvertently include potentially identifying information in your narrative responses, I will delete or disguise it. The data gathered will only be accessible by myself as the researcher, my research advisor, and the Smith College statistical analyst. All date will be stored with a password on secured servers or computers.

• All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

• I am unable to offer any financial payment for your participation.

Right to Refuse or Withdraw

• The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* before you submit your responses to the Internet survey without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely as noted above, before you submit the survey. If you choose to withdraw, you may do so by simply exiting the survey without submitting it and your responses will be erased. . After you do submit your survey, your information cannot be withdrawn, as I will have no way to distinguish your responses from those of other participants, and they will be included as part of the thesis report, as well as other presentations or publications of the findings.

Right to Ask Questions and Report Concerns

• You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about

the study, at any time feel free to contact me, [*xxxxx xxxx*] at [*xxxxy@smith.edul*] or by telephone at [*xxx-xxx-xxxx]* If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

………………………………………………………………………………..

Name of Participant (print): _____
Signature of Participant: _____ Date: _____
Signature of Researcher(s): _____ Date: _____

Appendix B

Listserve Request

Hi _____

My name is xxxxx and I am a master of social work (MSW) candidate in clinical social work at Smith College School for Social Work. I'm currently conducting research for MSW thesis and I am writing to ask for your help by posting my survey on the AWHONN (or NASW) list serve.

I am exploring how registered nurses and social workers who work in labor and delivery units, understand their own roles and responsibilities, that of the other profession, how they partner, if at all, and what aids or barriers to partnership may exist.

My second year field placement is in both a hospital NICU and High Risk Obstetrics settings. In both those settings I've worked with mothers and heard countless accounts about upsetting birthing experiences and their consequences, which piqued my initial interest in this topic. Learning more about the nursing care and social work care complexities involved during labor and delivery may help provide insight as to how social workers and nurses can better partner in an effort to increase maternal satisfaction during delivery.

The online anonymous survey consists of multiple choice short answer questions as well as optional open-ended questions. If you wish to review it, I'm including the link below.

https://www.surveymonkey.com/r/ABarbeymswthesis

Thank you for your time. Please let me know if you have any questions about the study.

Best,

xxxx xxxx
MSW Candidate '16
Smith College School for Social work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix C

Recruitment Post

Hello _____members,

My name is xxxxxx and I'm a master of social work candidate in clinical social work at Smith College School for Social Work. I'm currently conducting research for my MSW thesis and I'm writing to ask for your help.

I am exploring how nurses and social workers who work (or worked) in labor and delivery units, understand their own roles and responsibilities, that of the other profession, how they partner, if at all, and what aids or barriers to partnership may exist.

This online anonymous survey should take between 10-20 minutes. I would greatly appreciate learning from you! If you wish to complete the survey, please click on the link below.

https://www.surveymonkey.com/r/ABarbeymswthesis

If you have any questions, please contact me via my email: abarbey@smith.edu

Many thanks,

xxxxx
MSW Candidate '16
Smith College School for Social Work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix D

Follow Up Request to NAPSW

Hi

My name is xxxx and I am a master of social work (MSW) candidate in clinical social work at Smith College School for Social Work. I'm currently conducting research for MSW thesis: I am exploring how registered nurses and social workers who work in labor and delivery units, understand their own roles and responsibilities, that of the other profession, how they partner, if at all, and what aids or barriers to partnership may exist.

My second year field placement is in both a hospital NICU and High Risk Obstetrics settings. My supervisor in the NICU, xxxx xxx, a member of NAPSW suggested that I reach out to the NAPSW for participants because I have many responses from nurses but I'm having less success recruiting social workers. I emailed Catherine Miller on January 7th, but never received a response. Kathy attempted to post the survey to the listserve on my behalf, but I think something went awry with that process as well. I really appreciate your time and any help you can provide on this matter.

The online anonymous survey consists of multiple choice short answer questions as well as optional open-ended questions. If you wish to review it, I'm including the link below. I'd love to post it to the list serve or elsewhere (open to suggestions), but if that isn't feasible, I'd be grateful if you all wouldn't mind completing it and forwarding it to your personal contacts. It will take between 10-20 minutes.

https://www.surveymonkey.com/r/ABarbeymswthesis

Thank you! Please let me know if you have any questions about the study.

Best,
xxxx
MSW Candidate, Smith College School for Social work

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Appendix E

Human Subjects Review Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

November 23, 2015

Allison Barbey

Dear Allie,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

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Appendix F

Online Questionnaire

Demographics:
1. What do you identify as your gender?
Female
Male
Transgender
Prefer not to answer
Other (please specify) _____

2. What closest fits your age range?
21-29
30-39
40-49
50-59
60+

3. What do you identify as your race/ethnicity?
Black or African American
Hispanic, Latino, or Spanish origin
Asian
Middle Eastern
Native American
Alaskan Native
Mixed Race or Biracial
White or Caucasian
Other (please specify) _____

5. What is your degree?
Registered Nurse Midwife
Licensed Practical Nurse (LPN)
Registered Nurse (RN)
Bachelor of Science in Nursing (BSN)
Masters of Science in Nursing (MSN)
Nursing Doctoral Degree (please specify) _____
Bachelor in Social Work (BSW)
Masters in Social Work (MSW)
Licensed Clinical Social Worker (LCSW)
PhD in Social Work

6. What is the length of time you have been working in labor and delivery? Please round to the nearest year

8. Have you personally experienced childbirth?
Yes
No

Survey Questions:
1) How do you rate the impact of a distressing childbirth experience on a mother's transition to parenthood?
Very little to no impact
Low impact
Moderate impact
Moderately high impact
Great impact

2) To what extent, in your setting, do you see nurses and social workers partnering prior to the mother's birth?
Never
Very Infrequently
Occasionally
Frequently
Almost always or always

3) To what extent, in your setting, do you see nurses and social workers partnering after the mother's birth?
Never
Very Infrequently
Occasionally
Frequently
Almost always or always

4) Nurses only: If you are working with a pregnant patient who is experiencing emotional difficulties during her pregnancy, how often do you seek out a social worker for assistance?
Never
Very Infrequently
Occasionally
Frequently
Almost always or always

5) Social Workers only: When you are working with a patient experiencing emotional difficulties, how often do you seek out nurses' input?
Never
Very Infrequently
Occasionally
Frequently
Almost always or always

6) Please provide an example of when a nurse/social work partnership has been effective? What factors made this experience go well?

7) Please provide an example of when a nurse/social work partnership has not been effective? Why didn't it meet your expectations?

8) Please rate the extent to which these possible barriers may impact effective interdisciplinary care? (1=very little impact, 2=low impact, 3= moderate impact, 4=moderately high impact, 5 = great impact)
- Different perceptions of professional roles
- Different perception of clients' needs
- Administrative pressures
-Funding constraints
-Scheduling issues
-Other (please specify) _____

9) Please comment on anything I have not addressed that could have an impact on interdisciplinary collaboration, or any other aspects of this topic that I have not asked about that you believe could be useful to address.