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Understandings of chronic widespread pain among social workers from municipality job centers in Denmark

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“My private theory is that it’s all in the head”: Understandings of chronic widespread pain among social workers from municipality job centers in Denmark

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Abstract

People with chronic widespread pain (CWP) are often unfit for work, and consequently they are dependent on the municipality job center to receive social support and sickness benefits. The job center’s case management is based on a social worker’s assessment of the citizen’s health condition. This qualitative study investigates social workers’ understandings of CWP. Interviews were carried out with 12 social workers. The results showed that the participants predominantly experienced the citizens’ illnesses as psychosocially mediated—referring to trauma, or a lack of meaning in the citizens’ lives. Only a few participants mentioned possibilities for somatic explanations of CWP.

Keywords

chronic illness, community health psychology, interpretative phenomenological analysis (IPA), pain, qualitative methods

Introduction

Chronic widespread pain (CWP) is defined as pain that is present in most parts of the body and with a symptom duration of 3 months or longer. The pain must have a negative impact on the patient’s level of function and subjective well-being; and a known somatic or psychiatric disease does not explain the pain (Danish Health Authority, 2015).

The classification, assessment, and treatment of CWP are subject to constant debate. Theories of etiology and understandings of the symptoms have alternated throughout history. Possible explanations have been described, such as hysteria by the ancient Greeks, and somatization in the 20th century (Merskey, 1997; Shorter, 1992). Theories from the 1980s and 1990s have connected CWP to childhood trauma, specific personality traits, or psychological difficulties (Ahles et al., 1984; Dailey et al., 1990). The empirical support for these hypotheses is, however, either lacking or contradictory (Seto et al., 2019). According to contemporary understandings neurophysiological processes in the central nervous system (central sensitization) are involved in the experience of pain in CWP. These mechanisms cannot, however, explain the origin and

development of the pain (Bourke et al., 2015; Mendell, 2014; van Griensven et al., 2020).

Chronic pain conditions can have social consequences such as job loss, a poor financial situation, and/or relationship problems. The pain condition may also cause stress, anxiety or depression (Burton, 2012; Creed et al., 2011; Telbizovaa and Arnaoudova, 2020). Research has predominantly focused on CWP as being either a somatic or a psychiatric condition (Bellato et al., 2012; Sommer et al., 2012). However, no sufficient biomedical or psychiatric explanation of the development of the condition has been found (Bellato et al., 2012; Ozgocmen et al., 2006; Sommer et al., 2012). A review by Creed (2020) has pointed out that there could be many possible etiological routes into CWP

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but that more research is needed to identify those routes. However, the study identified some of the strongest risk factors for CWP to be sleep disorders, other pains, and depression. Factors as childhood difficulties, smoking, and overweight were also associated with a higher risk of the development of CWP (Creed, 2020). The uncertainty regarding etiology is mirrored in the practice field by the many different labels for the condition, and by the fact that different psychiatric or somatic diagnoses are possible for patients with the same clinical condition. The diagnostic process is often driven by the professionals' specialty, preferences, and interpretations of the patient's symptoms and situation (Danish Health Authority, 2015; Burton, 2012). These subjective preferences have been shown also to pertain to the social workers in municipality job centers (Mik-Meyer and Johansen, 2009).

Literature on social workers' understanding and conceptualization of pain in general shows that in their assessment of pain rehabilitation they mainly focus on patients' relationships, the conditions at the patients' workplace, and their return to work; areas such as stress management, problem solving, and self-care are overlooked (Larsson et al., 2019). People who suffer from chronic pain often feel delegitimized, stigmatized, and rejected in the community by a systematic disconfirmation of their illness perceptions and by a disbelief of the reality of the pain (Quintner, 2020; Telbizovaa and Arnaoudova, 2020); and they often experience a lack of understanding and acknowledgement in meetings with social workers in the job centers (Schultz et al., 2019). However, there is limited research on social workers' understandings of CWP. These understandings are important to investigate because they can affect the social workers' daily practice and case handling, which in turn impacts the financial situation of citizens with CWP (Järvinen and Mik-Meyer, 2012). The aim of this study, therefore, was to explore how social workers from municipality job centers understand the conditions and the symptoms of citizens with CWP.

Methods

The study was qualitative and based on interviews with social workers from municipality job centers. It was part of a larger project, which also investigated how people with CWP experience their meetings with social workers, general practitioners and hospital staff (Schultz et al., 2019, 2020). During the study, we collaborated closely with a group of social workers; we had a total of 18 meetings with them in order to gain background knowledge of this practice field, and to discuss the findings of the study.

Setting

In the Danish welfare system, citizens who are unfit for work have the right to receive social benefits from the

municipality. However, the citizens are obliged to participate in assessment of their work capacity and to participate in different forms of activation or job training with the purpose of becoming self-supporting. If the citizens cannot return to their previous job function but are assessed to have the capacity to work for 2 hours or more per week, they can be offered a subsidized reduced-hour's job. The social workers at the job center are responsible for the assessment and development of the citizens' job function and for ensuring that the conditions of the legislation are met by both the citizens and the municipality.

Data collection

From January 2016 to February 2017 we recruited social workers from three municipalities in the Capital Region of Denmark, all classified as urban municipalities. The municipalities differed in number of inhabitants and average income per citizen (Danmarks Statistik, 2019; Økonomi og indenrigsministeriet, 2019). The participants were recruited through purposeful sampling to ensure variation in age, and job experience. They were selected by their respective heads of department from the teams that were most likely to work with citizens with CWP. Invitations to participate were sent via e-mail. All participants gave their consent to taking part in the study.

The recruited social workers worked with a broad group of citizens, and citizens with CWP only comprised a subgroup of their daily caseload, which varied from 25 to 100 cases at a time. Our sample consisted of 12 social workers; mean age 51 years (range 39–63); mean years of social work experience 17.8 years (range 1–35). Eleven were female while one was male. All participants were ethnic Danes. The distribution of gender and ethnicity in our sample reflects the distribution in Danish social workers generally.

The first author conducted individual, semi-structured, face-to-face interviews with the participants at their workplaces. The interviews lasted 27–66 minutes (mean 48 minutes). An interview guide was designed beforehand pursuing open-ended questions. The questions focused on how the social workers understood the illness and symptoms of citizens with CWP, their attitudes toward and beliefs about these citizens, which language they used about the condition, and how they experienced their meetings with these citizens including the challenges they experienced in the meetings. The social workers were also invited to recount specific case stories. All interviews were audio-recorded and transcribed verbatim.

Analysis

Analysis was conducted using interpretative phenomenological analysis (IPA). NVivo 11 Pro was used to assist in the coding and analysis.

IPA is developed within psychology research and based on hermeneutic and phenomenological thinking (Langdrige, 2007; Smith and Osborn, 2003). The method relies on data from semi-structured interviews. The interviews do not strictly focus on description but may incorporate questions about the person's attitudes, beliefs and general reactions on a topic (Langdrige and Hagger-Johnson, 2013). IPA aims to explore in detail the meanings of the participants' personal perceptions and experiences in a dynamic and so-called "double hermeneutic" process. This means that the participants interpret an experience or a phenomenon and the researchers interpret the participant's account, thereby engaging actively in the analysis with their own conceptualisation of data (Davidsen, 2013).

The analysis was idiographic with each interview being analyzed individually before looking at general features across the interviews. It involved the following stages: Firstly, each interview transcript was read thoroughly to get an overall impression of the meaning of the text, making notes or memos about thoughts, reflections, and observations. An open coding was then made, where elements of the text were named with keywords or short phrases close to the text, reflecting the content of the participant's account. Here, patterns and themes were drawn out; thereby resembling a thematic analysis, carried out in different rounds. Initial themes were recorded and chunks of meaning were coded as initial themes. Here, we still remained open-minded and tried not to impose our own meaning on the text. The aim was to see the world through the participant's eyes. The process was stepwise, so that the themes reached an increasing level of abstraction in different rounds leading to a list of preliminary themes for each participant. Some themes were clustered, and superordinate themes were identified for each participant. Subsequently, main themes were identified across all interviews forming the basis of the final write-up (Langdrige, 2004; Smith and Osborn, 2003).

In the findings, the quotations are translated from Danish. Data is anonymised and all participants are referred to as *she*, as almost all were female.

Ethics approval

We presented the study to the regional research ethics committee, which replied that, according to *health scientific research projects section 14, sub-section 2*, the project did not need to be evaluated by the committee (4 February 2016). The Danish Data Protection Agency (reference no. 514-0284/19-3000) was notified of the study.

Findings

Most of the social workers expressed that they understood CWP as being induced by psychosocial conditions in the citizens' lives. However, in meetings with citizens they felt obliged to adhere to a professional code of conduct where

they withheld this understanding. This led to the co-existence of personal understandings and a professional attitude. A few social workers expressed a more complex understanding involving bio-psycho-social factors and one social worker with a personal experience of the condition considered the physical component to be influential.

Understandings referring to underlying psychosocial causes

Almost all participants stated that they viewed psychological and social factors as the predominant or the only explanation for CWP. The social workers' understandings of the psychosocial origins of CWP included different circumstances, for example traumatic life events:

Something terrible simply must have happened for some of those people, which means that they are completely, well completely locked and completely have this need to take care of themselves or what could you say. (Social worker 3)

Some social workers pointed to abuse or to poor childhood experiences as contributing factors:

. . . a childhood where you have been in a family where there has been a completely special codex, which you might not have felt you could live up to, and where you have not had a proper childhood (Social worker 9)

According to the social workers, such childhood circumstances could also lead to different psychiatric disorders including functional disorders, which according to the social workers also encompassed CWP:

I think that some get schizophrenia, some get. . . some get PTSD, some get some other psychiatric illnesses, and [some get] the functional disorders. (Social worker 9)

The social workers also mentioned stressful life events such as divorce, children moving away from home, or losing one's job, and too high societal or work-related demands as possible provoking factors. Further, the social workers believed that some citizens had certain personality traits such as perfectionism, neuroticism, or fragility, which they would not accept as part of their life conditions and therefore they converted these personality aspects into a physical condition:

. . . where you have a need to like hide yourself behind some chronic illness to justify that there isn't something wrong with you [mentally or personally]. (Social worker 8)

There are not many who like to say: 'I have an avoidant, fragile personality structure', or something. . . They want to have something which is tangible, well people can see that I walk poorly or something like that, right. And then it turns into the physical symptoms. . . I think. (Social worker 12)

Many participants stated that their experience was that the citizens' illness was rooted in several of these circumstances or conditions being present at the same time, and that this was causing the pain symptoms. Many participants also mentioned that they believed citizens might gain some advantages from having pain symptoms and possibly getting a diagnosis, and that this could contribute to the maintenance of their symptoms. The participants described such advantages as being exposed to lowered demands from others, receiving a higher degree of care and attention from friends and family members, and obtaining legitimacy for withdrawal from work and activities in general:

. . . you might gain something from having a disease. Because well, even though you don't have the diagnosis, then this thing about you having pain, you know, get some care from others and things like that, right. . . people might have missed something in their life or something like that, right. (Social worker 2)

Many of the social workers stated that they did not consider that the citizens with CWP were usually conscious about such advantages; therefore, the social workers did not express a belief that the citizens had a deliberate strategy for gaining the advantages. If participants were asked about their experience of the influence of physical reasons on the development of citizens' CWP, most of them quickly evaded the question by keeping to psychosocial explanations with comments such as: "But I think that it often sits, eh, that it is the mind that comes into play" (Social worker 2).

More complex understandings

Only a few participants expressed a more nuanced view including different influential factors along the bio-psycho-social spectrum as the explanation of CWP. These participants, however, attached different importance to the different elements.

A few participants believed that the citizens' CWP symptoms could involve a biological component and be a combination of a physical and a psychological illness as expressed by this participant:

They do not just have one type of illness. It is not either a physical or a psychological illness. They almost always have a combination. (Social worker 7)

Other social workers explained that they considered that the citizens' symptoms were influenced by both biological, psychological, and social factors as expressed in the bio-psycho-social model. Nevertheless, according to a social worker, the absence of biological findings often led to the citizens getting a psychiatric diagnosis in the health care system. In her view, the bio-psycho-social model, therefore, would rarely fit in everyday practice, because the "bio" part was usually missing.

Along the bio-psycho-social spectrum, some participants expressed that the citizens' social circumstances could be a maintaining factor for their physical symptoms:

Because if there are other things, well, if you have no place to live, a husband who drinks, the kids are sick, whatever, then it doesn't do something positive for some chronic condition in your body. Well, so it is very important to be attentive to whether there could be other barriers, which do not improve the chronic pain. (Social worker 1)

A contrasting understanding based on personal experience

Only one social worker explained the symptoms of CWP as primarily caused by physical factors. This social worker had a personal experience of chronic pain, and had experienced psychosocial explanations from others which she found to be judgmental. She tried to oppose such understandings:

A chronic pain problem can hit us all. It is not something you invent because you are mentally ill, or because you need attention, or you don't want to bother with work. (Social worker 5)

This social worker experienced that while psychological and social problems were a common consequence of living with CWP they were not the cause of the condition. She was optimistic about future improvements in a biological explanation model:

More (people) might get better help concurrently with improvements in the diagnoses. We constantly get more knowledge, we become better at scanning, our x-rays are also getting better and so on. Our pain relief, for those who get that, is also getting better and in that way, luckily, there is hope. (Social worker 5)

No other participants mentioned improvement of future methods to explain CWP symptoms.

The co-existence of personal understandings and a professional attitude

When the participants presented their understandings of CWP as having psychosocial explanations, they also stressed that this was their personal understanding, which they did not disclose in the meetings with the citizens. One of the participants highlighted that: "We could never, ever dream of saying to people, 'I don't believe that you have pain, I think that it is located somewhere else'" (Social worker 10). The social workers explained that due to the professional code of conduct they were obliged to have an acknowledging attitude toward all citizens at the job center. This could lead to a "double-understanding" which one social worker described

as follows: “Well, I have a *professional* understanding, and I have a *personal* understanding” (Social worker 11). The majority of social workers expressed this divide between a professional and a personal understanding. Moreover, their narration of their personal understanding was rich in detail, whereas they described their professional understanding in general terms. The social workers said that they tried to use acknowledging words and to act in accordance with professional ethics in their meetings with citizens. They experienced that there was an increasing attitude in the professional system that the citizens’ pain symptoms should be acknowledged. However, the social workers expressed that behind this professional attitude they still had the perception that the condition was psychological:

Well, I experience that there is an increasing acknowledgement that this is not imagination, that being said, my private theory is that it’s all in the head. But no matter what, this pain exists, and it is of importance for the people sitting in front of us. (Social worker 9)

The social workers’ psychosocial understanding that CWP was induced by psychosocial factors often implied that they thought that people with CWP had a personal responsibility for their symptoms and their life situation due to their priorities in life: “You want it all, but there is too little space and time for it. And then, it all falls apart” (Social worker 6).

Varying degrees of acknowledgment

The social workers expressed varying degrees of acknowledgement of the citizens’ condition. Although they expressed a predominantly psychosocial understanding of the condition, some participants said that they believed that the citizens felt sick:

There are many prejudices and you can probably discuss for eternity whether something is really wrong with them, or if it is something, they think is wrong. I just have to say that the citizens I have, who have these conditions, they are sick. You may not medically, functionally, socially, or psychiatrically be able to explain completely why they are [sick], or completely believe that they are, or suggest any treatment. But the reality is that they are [sick]. (Social worker 4)

Other participants showed their acknowledgement of the citizens’ problems indirectly by telling about the citizens’ disabilities and struggles with symptoms, for example, that the social workers realized that it could be difficult for the citizens to manage daily household tasks.

Still others acknowledged that the citizens had pain, but thought that the symptoms could be induced by some psychosocial “contagion”:

It is the same symptoms the citizens complain about. But you can read anything online and well, you have to point at some

trigger points. But I could also figure out that I have to say ‘ouch’, right, if I had read about [the diagnosis and symptoms]. And (. . .) Well, with your brain you can, I nearly said, you can provoke anything from paralysis to blindness. So, of course, you can also have pain. (Social worker 6)

However, some participants said that if citizens’ subjective complaints were not documented biomedically they tended to disregard the citizens’ experience of pain:

If, from a purely medical point of view, you can’t document and explain why the citizen has pain, then you kind of tend to put the citizen’s experience of their pain aside. (Social worker 11)

The participants experienced that it could demand a personal effort to take the citizens seriously and acknowledge their symptoms:

It’s hard, sometimes, to take them seriously. That’s something which characterises this group in comparison to other groups. You have to fight a bit more with yourself to take it seriously. (Social worker 8)

That some participants spontaneously recollected belittling statements from colleagues, such as: “*Arh, this fibromyalgia that is just some nonsense*” (Social worker 5) was also a sign that skeptical attitudes to citizens with CWP existed among the social workers.

Participants, who talked about their struggle to believe the citizens, often distanced themselves from their own utterance by describing their view in the second person. They used words such as “you” instead of “I,” often in combination with modifying language, such as “you tend to” or “sometimes you.” Some participants said that especially regarding this group of citizens, the frames and conditions of their job and their workload challenged their personal interaction with the citizens and hampered the development of an empathic relationship, because they were difficult to fit into the demands of the legislation.

Discussion

The majority of the social workers expressed an understanding of CWP as being induced by psychosocial factors in the citizens’ lives. However, the social workers described the co-existence of their personal understandings and a professional attitude. Due to professional ethics they kept their psychosocial explanations as personal theories, which they did not present to the citizens. In the meetings with citizens, the social workers stated that they applied a professional understanding, which they described as acknowledging and in accordance with professional ethics. However, this professional “understanding” seemed more like a code of behavior detached from the social workers’ personal beliefs and basic understandings of CWP. A few participants had different understandings of CWP than the rest. These

participants suggested that there were other contributing factors including biological factors or that CWP was to be understood in a more dynamic way by integrating physical and psychosocial components.

The social workers' psychosocial explanations mainly echo a psychogenic understanding of symptoms. According to this understanding, there is a linear causation between psychological, social or emotional difficulties, and the origin of physical symptoms. This understanding is based on a dualistic thinking, where the body and mind are seen as separate units (Grassi et al., 2019; Lipowski, 1984). Similar understandings are found among general practitioners, where the lack of detectable biomedical causes has led to social explanations of CWP symptoms (Mik-Meyer, 2015; Salmon et al., 2004, 2006). Another meaning of the word psychosomatic endorses a more holistic view that does not involve a separation between body and mind, and acknowledges emotional symptoms as being part of many bodily diseases (Fava and Sonino, 2010; Grassi et al., 2019; Lipowski, 1986). Such a holistic view was only mirrored in a few of the social workers' understandings.

The Danish neuropsychologist Ehlers (2000) claimed that illness without a proper somatic explanation, such as CWP, was a conversion of the person's mental state into bodily symptoms (Ehlers, 1999, 2000). In the book *Life's Troubles*, she argued that feelings of loneliness, remorse over a loveless life, or feelings of inadequacy over not being able to live up to one's own expectations could cause medically unexplained symptoms, including CWP, because it is not culturally acceptable to seek help or take sick leave due to existential or social problems (Ehlers, 1999, 2000). Ehlers' understanding of CWP symptoms as culturally embedded "life troubles" seems to have been adopted by many of the participants. However, it has proven difficult to establish empirical support for the theories and hypotheses about psychosocial burdens and suggested unconscious motives for symptom development in CWP (Henningesen, 2015; Malin and Littlejohn, 2012; Merskey, 1997; Seto et al., 2019).

The social workers described the possible advantages of having pain and possibly being given a diagnosis as a factor that could potentially maintain the condition. This is in line with descriptions of secondary gains of illness and compensation neurosis (Hall and Hall, 2012; Shorter, 1992). The social workers' explanation of personality traits such as neuroticism and perfectionism as the foundation of CWP conditions also corresponds to explanations found in literature (Naylor et al., 2017). However, people with pain, irrespective of cause, have shown slightly greater neuroticism compared with healthy controls. Thus, higher neuroticism is also the case for pain with known etiology, such as rheumatoid arthritis (Malin and Littlejohn, 2012; Seto et al., 2019; Torres et al., 2013). When comparing patients with different pain types, no specific personality traits were found for CWP (Malin and Littlejohn, 2012). Modern

health psychology views personality and life history as influencing the expressions of and reactions to illness, but these factors are not considered the cause (Malin and Littlejohn, 2016; Seto et al., 2019).

The social workers included varying degrees of acknowledgement of CWP in their explanations. They said they were obliged to show acknowledgement of the citizens' illness to maintain their professional ethics. At the same time, they were obliged to validate or document the symptoms according to the legislation of the welfare state (The Danish Agency of Labor Market and Recruitment, 2019). This put them in a paradoxical position between showing acknowledgment and questioning complaints, as also described by Järvinen and Mik-Meyer (2012). This might contribute to the social workers' two-folded understanding and varying degrees of expressed acknowledgements.

Järvinen and Mik-Meyer (2012) have shown that, from the point of view of the job center, patients can be legally ill if they have a physical illness. However, in the absence of a physical illness, the social worker must motivate the citizens to take personal responsibility, initiative, or control of their lives to fight psychological issues. At the same time, Mik-Meyer and Obling (2012) have shown that general practitioners' evaluation of the legitimacy of the sick role in patients with medically unexplained symptoms often relies on an evaluation of the patients' social background and personality. If the patient has a problematic social background and a problematic personality, the general practitioner is more likely to try to accommodate the patients' complaints and the rights of a sick role. The social workers' focus on biological factors and the general practitioners' focus on social and psychological factors show a swapping of roles in their negotiations with patients of what it is to be a patient. This stresses the need for a more holistic understanding that could be shared among different groups of professionals (Mik-Meyer, 2010).

One of the social workers referred to the bio-psycho-social model in her explanation of CWP. This model was described by Engel in the 1970s, and introduced a broader definition and understanding of disease which also included psychological and social aspects (Engel, 1977, 1980). However, the social worker stated that this model was almost impossible to apply in practice because in municipalities, as well as in general practice and somatic hospital departments, the etiology of illness is perceived as *either* somatic *or* psychiatric. The structures of the health system and the social care system are not designed to consider multiple interrelated factors concurrently.

The social workers' explanations for CWP did not include any understanding of the physiology of chronic pain as for example disturbances in the central nervous system (Bourke et al., 2015; Mendell, 2014). One social worker with a personal experience of CWP, however, seemed to show a particular awareness of citizens with CWP and believed that the symptoms of CWP had a

physical origin. Her “case” was an interesting exception to the overall picture and calls for further exploration. A previous study from British general practice suggests that general practitioners who have experienced significant illness may become more engaged in their patients both practically and emotionally (Fox et al., 2009). Some social workers also considered that the job conditions in the social care system counteracted an empathic approach to the citizens. This has also been suggested by Järvinen and Mik-Meyer (2012) in regard to the Danish social care system.

The dualistic categorization of symptoms that was expressed by most of the participants in this study is common practice in both health care and social care systems (Burton, 2012; Järvinen and Mik-Meyer, 2012). Both in the literature and in clinical practice, it is an ongoing challenge to embrace a multidimensional understanding of CWP where physical, social, and psychological components are complexly interwoven. The narrow understanding of pain expressed by the social workers could call for educational strategies applied in job centers with the aim of nuancing the social workers’ understandings and explanations of CWP and increase their empathy. This could be practiced as traditional education from specialists on pain mechanisms, current understandings of etiology and risk factors, and the lived experience of pain. More knowledge might facilitate a more nuanced language, and give the social workers a better ground for communication with citizens with CWP. In Denmark, education of selected social workers in specific job centers (in other regions than the participants are recruited from) has been initiated in order to train these social workers as ambassadors for CWP disorders. In the role as ambassadors they are expected to pass on knowledge on CWP in their workplace, and contribute to a change in the work culture in relation to CWP. These initiatives have only been carried out as pilot projects (Clinic for Functional Disorders, 2020). In Denmark, there has also been a reorganization of treatment offers to patients with CWP, where departments for these conditions, which were previously located in psychiatric centers, have been closed and new interdisciplinary departments have been established in the somatic health care system (Center for Complex Symptoms, 2020; Danish Health Authority, 2018). These initiatives have not yet been evaluated.

Limitations

The study has some limitations to consider. The results only reflect the social workers’ point of view in one region in Denmark and the sample of participants was small. This limits the transferability of the results. Nevertheless, our findings seem to correspond with results from other qualitative studies (Järvinen and Mik-Meyer, 2012; Steihaug et al., 2017), and therefore they might be transferable to other municipalities in Denmark and possibly to other countries with comparable social care systems. However,

further research could investigate if the understandings of our participants are shared by the larger population of social workers.

The study was based on qualitative interviews focusing on the participants understandings, beliefs, and experiences. In order to gain further knowledge on how diverse understandings, degrees of acknowledgement, and rehabilitation strategies actually play out in practice, future research could employ observations of meetings and interactions between social workers and citizens with CWP.

The authors have different professional backgrounds. All authors tried to be aware of their pre-understandings during data collection and analysis, and the analysis was critically discussed among the authors.

Conclusion

The social workers from municipality job centers primarily explained CWP using psychosocial factors such as “life’s troubles”, childhood trauma, neglect, personality traits, and psychiatric illness. Few social workers revealed understandings that were more complex and explanations deriving from pain physiology such as malfunctions in the central nervous system were not presented. One participant with a personal experience of the condition had a more physical explanation and she, among a few others, thought that the social care system led to lack of empathy in the relationship with citizens. Nevertheless, to act in accordance with professional ethics, the social workers adhered to an acknowledging code of conduct in meetings with citizens. However, being obliged to document citizens’ symptoms forced the social workers into a paradoxical position between showing acknowledgment and questioning complaints. Initiatives with education of social workers in general, or for some selected social workers who could act as ambassadors in each job center might overcome some of the challenges, and nuance the social workers’ understandings and communication regarding CWP. Interdisciplinary clinics to assess the conditions of people with CWP could be another possibility to counteract the dichotomous view of professionals.

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