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**CHRONIC PAIN AS THE RESULT OF TRAUMATIC INJURY:  
A GROUP COUNSELING MODEL FOR SURVIVORS**

**BY**

**Corianne S. Woodard**

**B.A., University of New Hampshire, 2007**

**THESIS**

**Submitted to the University of New Hampshire  
in Partial Fulfillment of  
the Requirements for the Degree of**

**Master of Arts**

**in**

**Counseling**

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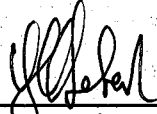
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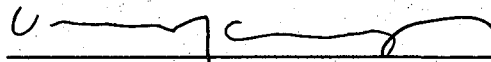
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*I also have overflowing appreciation for those who have knowingly or unknowingly served as members of my support system in my own journey toward health following traumatic injury.*

## ABSTRACT

### CHRONIC PAIN AS THE RESULT OF TRAUMATIC INJURY: A GROUP COUNSELING MODEL FOR SURVIVORS

By

Corianne S. Woodard

University of New Hampshire, May, 2009

*Millions of Americans live with chronic pain as the result of traumatic injury. These individuals face countless challenges as they attempt to cope with daily pain and grieve the many losses caused by their injuries. The physical and emotional stresses associated with chronic pain and traumatic injury place these survivors at significant psychological risk and contribute to the perpetuation of their chronic pain. Group counseling with a grief model emphasis is a cost effective way to meet the specific needs of survivors living with chronic pain. These needs include: the establishment of a social support system, an opportunity to grieve losses since the injury, the development of self-care skills, and the learning of skills and strategies to move through pain and grief toward empowerment and self-esteem. An eight week psychoeducational support group is described.*

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## CHAPTER I

### INTRODUCTION TO STUDY

*Few things are more traumatic than having a once capable body rendered disabled by traumatic injury. When combined with chronic pain, the stress of these injuries puts survivors at significant psychological risk (O'Donnell, Creamer, Pattison, & Atkin, 2004). Much attention has been paid to the physical recovery of these survivors, but significantly less emphasis has been placed on emotional and psychological recovery following an injury (Ferguson, Richie, & Gomez, 2004).*

*The loss of a body part, a physical ability, or the luxury of good health triggers a mourning process that mirrors that which is experienced when a person loses a loved one. Chronic pain and daily challenges serve as constant triggers for this grief and despair (Livnch & Antonak, 2005)*

*Appropriate group counseling with a grief model emphasis may provide these survivors with the support necessary to travel toward physical and emotional healing.*

#### **Purpose of Study**

*This research has generated a group counseling model that meets the needs specific to individuals living with chronic pain as the result of traumatic injury. The goal is to ensure that the mental health community is*



*prepared to deal with the emotional and psychological recovery of those who survive traumatic injuries and are left living with daily pain.*

*This theoretically supported model for providing group counseling to survivors of traumatic injury creates structure for group facilitators, and it ensures a high quality of specialized care for group participants. A complete rehabilitative model would also increase the ease with which these groups could be run, therefore increasing their frequency and accessibility. Further empirical studies could evaluate the effectiveness of these groups and measure participant outcomes.*

### **Rationale for Study**

*The Center for Disease Control and Prevention lists physical trauma as the leading cause of death and disability in Americans under age 45 (CDC, 2008). Our current military involvement has also greatly contributed to the frequency with which individuals sustain these injuries. The United States Department of Defense (2008) reports that as of December 6, 2008, 33, 476 service members have been wounded in action in Iraq and Afghanistan. More than half of those injured were under the age of 25.*

*Congress has named the time between 2001 and 2011 the Decade of Pain Control and Research (National Pain Foundation, 2008), yet the American Academy of Pain Management (2008) still calls chronic pain a "silent epidemic," as over 50 million Americans live with chronic pain, and only about ten percent of these individuals see a physician or other healthcare*

*professional for their pain each year. This means that pain in our country has been under treated and millions of Americans live in pain on a daily basis.*

*Chronic pain has been called the most costly health problem in the US. Increased medical expenses, lost income, lost productivity, compensation payments, and legal charges have significant economic consequences as a result of chronic pain (Yale Medical Group, 2008). Anxiety and depression are the most frequent psychological reactions to chronic pain, and they increase the negative impact on quality of life by affecting sleep, socialization, concentration, and ability to work (American Academy of Pain Management, 2008).*

*With many individuals suffering so deeply from chronic pain, there is a clear need for support for these individuals. It has also become increasingly clear that traditional medicine cannot meet the complex needs of this population alone (Brown, 2008).*

### **Definitions of Terms**

#### **Traumatic Injury**

*A traumatic injury is one resulting from abrupt exterior causation such as motor vehicle accident, fall, assault, or other impact. Injuries are serious and may be life-threatening. This does not include health issues that result from disease processes or age.*

#### **Survivor**

*For the purposes of this study, survivors will be considered individuals who have sustained traumatic injuries. They may or may not experience*

*chronic pain, and they may or may not choose to participate in group counseling or support groups.*

### *Group Counseling*

*A group of people with a similar set of goals or concerns who work with a counselor or facilitator to collectively and individually achieve growth by sharing feelings, experiences, and solutions in a supportive environment (Corey & Corey 2006).*

### *Pain*

*The American Academy of Pain Management (2008) defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage.”*

### *Chronic Pain*

*Chronic pain is intermittent or continuous discomfort that lasts for months or years. The pain may be related to illness, injury, or an unknown cause. This differs from acute pain which is directly linked to illness or injury and is generally resolved once the underlying condition has been treated (Yale Medical Group, 2008).*

### *Research Assumptions*

*For the purposes of this study, it has been assumed that:*

- (1) Pain is a complex physically, socially, and psychologically influenced experience.*
- (2) Living with chronic pain is an unpleasant experience that individuals will seek to avoid.*

- (3) *Those who make reports of pain and chronic pain are genuinely experiencing it.*

### **Limitations of Study**

*This study has generated a model of group counseling designed to meet the needs of individuals living with chronic pain as the result of traumatic injury. However, limitations of the study and model include:*

- (1) *The group counseling model has not been empirically validated nor has its effectiveness for use with survivors of traumatic injury been evaluated.*
- (2) *The model attempts to address psychological reactions to physical trauma, but it does not constitute treatment for individuals with PTSD.*
- (3) *This model may not be appropriate for individuals with moderate or severe traumatic brain injuries depending on their abilities in the areas of insight, cognition, and memory.*
- (4) *This model cannot meet the needs of active substance abusers and would therefore be inappropriate for such persons.*
- (5) *As with any group counseling model, appropriate facilitation and pre-group screening would be required to ensure safety and well-being of participants.*
- (6) *This group counseling model is not meant to replace ongoing medical treatment for chronic pain.*

## CHAPTER II

### REVIEW OF THE LITERATURE

#### Traumatic Injury

*The psychological risk associated with experience of a traumatic injury is well documented. The mechanism of injury has the potential to be emotionally traumatizing given that these injuries may occur in the context of armed conflict, terrorist attack, natural disaster, assault, or accident (Wain & Gabriel, 2007). Survivors of traumatic injury are also unique in the sudden onset of their physical maladies. In typical disease processes, individuals have time to adjust to small deteriorations in health and physical ability as an illness progresses. In cases of traumatic injury, the survivor is faced with a body significantly unlike that to which they are accustomed with no period of mental or emotional preparation for this change. The necessity for adaptation can be unspeakably jarring to the survivor as many may have enjoyed perfect health and been completely able-bodied prior to their injuries. It is common for the individual to process this experience as a psychosocial crisis as stress levels are heightened by threats to bodily integrity, safety, independence, autonomy, fulfillment of roles within the family and community, and economic stability (Livneh & Antonak, 2005).*

*Traumatic injury can have devastating effects on the body image and self-concept of survivors. Many survivors are left with bodies that have*

*undergone significant changes in physical appearance as a result of their injuries. These changes may include burns, amputations, scars, or other disfigurements. Alterations in functional abilities such as paralysis, decreased range of motion, or reduced strength may also change the ways survivors think and feel about their bodies. This may result in very negative or distorted body perceptions which then contribute to a negative sense of self. For individuals who have visible injuries or disabilities, this is often exacerbated by society's desire to label individuals based on appearance. When others identify the survivor as "disabled" before gathering any other information, they are focusing on appearance rather than identity. The survivor's already insecure sense of self creates an environment in which the individual accepts the disability as the most significant aspect of his or her identity. Sadly, some survivors find that they are unable to maintain a true sense of self because it is slowly eroded by their own negative self-perceptions and similar encounters with others (Livneh & Antonak, 2005).*

*This process of identity adjustment appears to be especially difficult for some men as they are forced to alter their ideas about what it means to be a man as a result of their injuries. In a study involving male survivors of spinal cord injuries, participants noted their injury's impact on their sense of safety, sexual encounters, and body image. The injury and resulting disability violated social understandings of masculinity and the male survivors developed poor self-perceptions due to their negative associations with disability and dependence. (Ostrander, 2008).*

*In a longitudinal study designed to identify the prevalence of psychiatric morbidity following severe injury, O'Donnell et al (2004) assessed survivors of traumatic injury for anxiety disorders, mood disorders, and substance abuse disorders for a year following their injuries. They found that over twenty percent of survivors met criteria for a psychiatric diagnosis up to one year post-injury. Post-traumatic stress disorder (PTSD) and major depressive disorder were the most frequent diagnoses, and more than ten percent of survivors met criteria for both diagnoses. These findings represent the frequency and persistency with which psychopathology occurs in survivors of traumatic injury. They also demonstrate the need for appropriate mental health support during short and long-term recovery processes.*

*Research has shown that many survivors begin to experience emotional strain and may benefit from psychological interventions prior to entering the recovery phase. In a study investigating limb reconstruction necessitated by traumatic injury and the associated psychological distress, variations in distress during and after treatment were accounted for by variance in the patient's coping skills, social support, pain, and extent of disability. These results suggest that both medical and psychological interventions have the potential to reduce distress and increase well-being in survivors at many stages of treatment (Scott, 2001).*

*The importance of social support for trauma survivors is well documented. Bonanno, et al (2007) identified access to social support as a primary social and contextual protective factor associated with psychological*

*resilience following physical trauma. Ozer, Lipsey, and Best (2003) also concluded that post trauma social support increases the likelihood of positive outcomes and decreases the likelihood of the development of PTSD following physical trauma.*

### **Chronic Pain**

*Until very recently, pain was always conceptualized as an experience caused either by a signal of physiological ailment sent to the nervous system or as a mental representation of a disordered personality or some other form of psychopathology. This biomedical model focuses on the separation of mind and body and therefore fails to address the complex connections between physical pain and psychological factors (Brown, 2008).*

*Under the biomedical model, pain without a known medical cause or pain that does not respond to traditional treatments is considered somatic, or psychogenic in nature. Following this model therefore requires practitioners to operate under the assumption that medical science is advanced enough to successfully identify and treat every biologically based condition that produces pain. Though this is a limiting approach to dealing with incredibly complex organisms operating within even more complex environments, this way of thinking about pain continues to saturate a variety of healthcare fields (Nicholson & Martelli, 2004).*

*The biomedical approach contributes to the frustration that is so frequently experienced by sufferers of chronic pain when they seek treatment. Many physicians who are unable to explain or effectively treat*



*pain have been trained to determine that the pain is somatic in nature. They may also state that the pain reported by the patient is disproportionate to the apparent cause despite the fact that no means exist to objectively measure pain. Pain, like depression, is a subjective experience and must be treated as such (Brown, 2008).*

*An integrative approach strays from the mind-body dualism of the biomedical model and considers the whole person when seeking to conceptualize pain and chronic pain. In this way of thinking, pain is never just a physical problem or just a psychological problem. Rather, there are always physical and psychological components to pain processes. Thus, under the biopsychosocial model, chronic pain is considered a biological impairment complicated by psychological effects. The individual's experience of pain is unique as a result of biological variations, such as tissue damage, nervous system connections, and cell replication, and as a result of psychosocial factors, such as personality, temperament, family, and culture (Brown, 2008).*

*The concept of the "terrible triad" of pain assists in illustrating the numerous forces that cause and maintain chronic pain processes. When pain is severe and constant, it interferes with enjoyable activities, occupational responsibilities, and other activities of daily living. Chronic pain sufferers may become preoccupied with their pain and become depressed and irritable as a result of their discomfort and limited abilities. Depression leads to sleep disturbances which cause fatigue and increase pain. The pain completes the*

*perpetuating cycle by causing depression, insomnia, and ultimately more pain (Yale Medical Group, 2008).*

*The perpetuation of chronic pain and the frustration of countless failed attempts to manage the pain have the potential to lead sufferers to frustration and feelings of helplessness. If frequent failures at pain management are combined with a perception of limited or no control over the pain, Learned Helplessness Theory (1978) states that many of these individuals will cease to make efforts to avoid the pain. Just as the dogs in early Learned Helplessness experiments laid down in submission rather than continuing to make ineffective attempts to avoid electric shocks, individuals living with chronic pain often surrender to what they see as an impossible battle against daily pain. Learned Helplessness in humans presents as clinical depression and related mental illnesses. When individuals are able to maintain some sense of control over their circumstances, they do not see themselves as helpless and their obstacles as insurmountable (Abrahamson, Seligman & Teasdale, 1978). Within this line of thought, survivors who perceive themselves as having some level of control over their pain will not surrender to their pain as readily as those survivors who see themselves as helpless.*

### **Group Process and Dynamics**

*The benefits of therapeutic groups have been widely recognized in mental health literature, and group formats have been used with increasing frequency in recent years. Research has shown that recovery after injury*

*must involve extensive psychosocial healing (Ferguson, Richie, & Gomez, 2004), and the variety of group types provides the opportunity for selection of a style that most adequately meets the needs of the population to be served.*

*Support groups are made up of individuals with a similar issue or group of issues to be addressed. They are most routinely utilized by otherwise healthy individuals who experience particular difficulty with a burdensome problem. Support groups may be facilitated by the members as peers, in what is often called a self-help support group or a peer support group, or they may be led by a trained therapist or counselor in a professionally operated support group (Corey & Corey, 2006).*

*In professionally operated support groups, a greater number of clients may be seen simultaneously by fewer clinicians than would be possible in cases of individual counseling. This utilizes fewer agency resources and provides a cost-effective method of service delivery. By saving the agency money, the group format makes it possible to reduce the cost to clients, thereby making treatment more accessible and realistic for many (Nash, 2004). It has also been proven that support groups may be more effective than individual counseling in many cases (Stroebe & Schut, 1999).*

*Support groups provide a sense of community that is often lost as a result of the disability that sometimes accompanies chronic pain. Survivors may feel isolated as they cope with traumatic loss and chronic pain. This can become an issue for survivors as they deal with mobility issues, mood and sleep disturbances, and decreased self-confidence.*

*These individuals have often lost their social networks due to an inability to work. They may have lost touch with friends due to long hospital stays or the fact that they are no longer able to participate in many of the recreational activities that they once enjoyed. Some survivors report that friends stay away following an injury because it is simply too hard to for them to see the survivor looking differently or struggling with things that they once did with ease (Bradford, 1999).*

*In addition to the loss of their physical abilities, or changes in their physical appearances, many survivors deal with the loss of roles within the family and community. Support group work attempts to counteract this isolation by assembling people with similar issues to enforce that survivors are not alone in their difficulties.*

*Survivors of traumatic injury must find a way to live in a world where physical ability is the norm. They may be unable to do things that they once enjoyed, and they must learn new ways to do everyday tasks. Each of these changes is experienced as a loss. Groups provide a unique opportunity for survivors to share these experiences in the company of others who have experienced similar losses. The group enables discussions that might not be possible or comfortable amongst the general population where such shared understanding is not present. This aspect of group dynamics has been shown to create a growth-promoting environment that is capable of stimulating more rapid recovery for participants (Bradford, 1999).*

*Groups also provide an opportunity for members to share coping strategies and helpful resources. Frustration is common as patients struggle to navigate through the medical system. This frustration grows as they experience daily pain, limited abilities, insensitive physicians, and grim prognoses for recovery. These reactions interfere with the patient's ability to manage pain, create coping mechanisms, and gather assistive resources, but a supportive group atmosphere combined with appropriate psychoeducational information can aid survivors in each of these areas (Arthur & Edwards, 2005).*

### **Chronic Pain Rehabilitative and Treatment Practices**

*For many years chronic pain treatment operated under the assumption that pain becomes chronic due to psychological causes. From this view, chronic pain was treated using behavioral science rather than medical science or an integration of the two. Theorists explained that chronic pain (especially idiopathic pain) is the result of pain behavior that has been reinforced by environmental influences. The concept of contingency management seeks to extinguish pain behavior by withdrawing factors that reinforce it. Unfortunately, this means that expressions of pain or complaints of discomfort must be ignored if they are to be eliminated in order for well behaviors to be reestablished (MacDonald, 2000).*

*Strict behavioral or contingency approaches to pain leave no room for the voice of the individual who is suffering. Rather, they are founded on the belief that the patient's experience of pain is a learned behavior that can be*

*cured once it is simply replaced with more appropriate and accurate behaviors. This approach is in contrast to more contemporary research that repeatedly highlights the importance of trust, empathy, respect, and empowerment in treatment of chronic pain patients (Seers & Friedli, 1996).*

*Along with the validation of patient experiences, there has been a significant shift in treatment and rehabilitative practices in recent years toward multidisciplinary pain programs. Multidisciplinary rehabilitation programs and other mental health interventions have been in existence in medical settings for over 30 years, but only recently have they become widely accepted. The literature shows that such treatment which incorporates a variety of disciplines is more effective than any other form of treatment for chronic pain. They have also been found to be a more cost effective and less invasive alternative to a variety of medical procedures aimed at pain management (Townsend, Bruce, Hooten & Rome, 2006).*

*Multidisciplinary pain management and rehabilitation teams may include neurologists, orthopedists, physiatrists, physical therapists, occupational therapists, nurses, psychologists, counselors, social workers, case managers, pharmacists, dieticians, and/or vocational counselors. In this collaborative approach to pain rehabilitation, practitioners are competent within the scope of their expertise in addition to having an understanding of comprehensive pain management (Townsend, Bruce, Hooten & Rome, 2006).*

*Recent legislation and national initiatives have drawn attention to the importance of pain care in the US. In late 2000, Congress passed a law*

*declaring the ten-year period that began January 1, 2001, as the Decade of Pain Control and Research. Then, the National Pain Care Policy Act of 2008 was designed to address barriers to pain relief by improving pain care research, education, training, access, outreach and care. The bill also demanded that the Secretary of Health and Human Services develop and implement a national outreach and awareness campaign to educate consumers, patients, families and other caregivers on the significance of pain as a national public health problem; risks to patients if pain is not properly assessed and treated; availability, benefits, and risks of treatment and management options; importance of having pain assessed and treated; the role of pain management specialists; and resources that are available to patients and other consumers to help in dealing with pain (National Pain Foundation, 2008). With increased resources, advances in technology, new theoretical approaches, and national dedication to the cause, it appears that this may be a revolutionary time in the area of chronic pain management and rehabilitation.*

*Though major advances have been made in the area of pain management, there is still much to be done. The lack of effective chronic pain management resources currently available is evidenced by the millions of people who continue to live with daily pain. For many sufferers, typical pain medications have limited effectiveness (Nash, 2004), and comprehensive pain treatment programs are inaccessible due to location and cost (Bradford, 1999). A clearly defined and theoretically grounded group counseling model*

*would provide clinicians with the framework necessary to provide survivors of traumatic injury with an affordable addition to their chronic pain treatment.*



## CHAPTER III

### THEORETICAL CONSIDERATIONS

#### Pain and Disability

*Rodin et al.'s (1991) three-phase approach to working with medically impaired individuals seeks to limit depressive symptoms by encouraging clients to grieve and mourn losses associated with their injuries, by exploring opportunities to find meaning in client experiences, and by training clients to reframe daily challenges to experience empowerment and a sense of mastery over their symptoms.*

*Hendler's (1984) four-stage response to chronic pain parallels Kubler-Ross's (1969) description of the stages of dying. In Hendler's acute pain state (zero to two months), the individual fully expects to get well and is generally without psychological changes. During the second stage of pain response (two to six months) the individual becomes anxious as a response to the continued pain. Once pain has become chronic and persisted beyond six months, the individual begins to feel depressed with the realization that the pain may be permanent. This is the third response stage. Hendler states that the fourth stage may take from three to twelve years from the onset of pain. In this stage, the individual reconciles with the permanency of the pain and seeks out accommodations and lifestyle changes to better cope with it.*

## Grief

### Stage Theory

*Bowlby's (1961) mourning theory suggests that grief is a predictable pattern of responses to a loss or death. He explains this universal pain response through the lens of human attachment. He goes on to say that grief is an instinctual reaction to separation from that which we have become accustomed.*

*Survivors of traumatic injury must deal with the loss of many things to which they have become accustomed. Among other things, they may have lost independence, mobility, and/or comfort. These luxuries are often taken for granted by those who have them, but they are sorely missed once they have been lost.*

*Kubler-Ross's (1969) work with death, dying, and grieving proposes that when dealing with death or loss, individuals go through a series of stages in which one feeling or emotion is predominant. She identifies the stages as: denial, anger, bargaining, depression, and acceptance. When confronted with a significant loss, people refuse to believe that it is true; they become angry at specific people, themselves, or the world; they may try to negotiate or bargain some way around the loss or a way to reverse the loss; they become very sad; and ultimately they come to some sort of peace or acceptance.*

*For a survivor of traumatic injury with chronic pain, this process could involve denial of the severity of their injury and the permanency of their*

*pain, anger at the person or people seen as responsible for the injury, bargaining that doctors or therapists will be able to alleviate all pain or reverse the injury if the survivor is compliant with orders, depression and isolation, and finally acceptance of a new identity and a new way of being in the world.*

### *Tasks of Grief*

*Worden (1992) suggests that the grieving process is made up of four overlapping tasks which require the bereaved person to work through the emotional pain of loss while adjusting to new circumstances, roles, and identities. The tasks have been completed when the grieving person has integrated the loss into their life. Emotional attachments to the object or person that has been lost are decreased, and the bereaved person is able to reinvest in the present and the future rather than remaining focused on the past.*

*The first task is to accept the reality of the loss. In traumatic injury and chronic pain, this task may require that survivors receive some education about their condition and prognosis. Talking about the mechanism of injury and the injury itself may also help survivors to let go of denial of what has taken place.*

*The second task is to work through the pain of grief. Many individuals seek to avoid the pain associated with grief in favor of numbing their emotions. Some turn to substances or other addictions rather than working*

*through their grief. Survivors of traumatic injury should be encouraged to acknowledge all of the emotions surrounding their losses.*

*The third task is to adjust to an environment in which the lost person or object is missing. For survivors, this may mean adapting to living in a very different body, or having to find new ways to do things that were once done with ease. Survivors of traumatic injury may also need to find new jobs or file for disability benefits. Gathering of resources is an important component of this task.*

*The fourth task is to emotionally relocate the loss and move forward with life. To complete this task, survivors may need to find new areas of interest, develop new relationships, and find a way to let go of lost pieces of the former self.*

### *Dual Process Model*

*Stroebe and Schut (1999) have more recently explored the effects of both expressing and controlling emotions. The dual process model introduces the concept of oscillating between a grief focus and the avoidance of grief. Both loss orientation and restoration orientation are necessary for future adjustment, so by taking breaks from the overwhelming pain of grief, a bereaved person may be more able to cope with the requirements of daily life.*

*This model supports Kleiber's idea (2008) that survivors of traumatic injury should spend some of their time participating in leisure activities as a*

way to divert attention away from the constant suffering of disability and chronic pain.

### **Cognitive Reframing**

#### **Cognitive Model**

Beck's (1976) cognitive model promotes the notions that feelings and behaviors are influenced by thoughts, and that alterations to our thoughts will result in subsequent changes to our emotions and our actions. The chronic pain literature (Brown, 2008) speaks of the effectiveness of reframing. Survivors who consider themselves "well persons living with pain" tend to have much more positive self-evaluations than survivors who allow themselves to be defined by their pain as "chronic pain sufferers."

#### **Cognitive Behavioral Therapy**

Cognitive behavioral therapy focuses on modifying an individual's beliefs, expectations, and ability to cope with life's challenges. By altering one's automatic thoughts and replacing them with more adaptive (often more optimistic) thoughts, cognitive behavioral therapy is able to impact the emotions associated with specific situations and the behaviors that take place in conjunction with these emotions.

Cognitive behavioral therapy has been used to treat individuals with chronic pain, and it has been shown to be significantly more effective than waiting list controls. Though cognitive behavioral therapy has had positive

*results when used as the sole method of treatment for chronic pain, it is most effective when integrated as a part of a more comprehensive treatment program (Budh et al., 2006).*

## CHAPTER IV

### GROUP COUNSELING MODEL

#### Overview

*By conceptualizing the experience of traumatic injury as a series of losses, this group counseling model addresses the specific needs of survivors through support group grief work which has been integrated with cognitive reframing strategies and relevant psychoeducation.*

#### Goals

*While individual participants may develop personal goals, the overall goals of this group include:*

- 1. To establish a sense of community among participants while fostering support, trust, and connection*
- 2. To encourage appropriate grieving of the losses associated with participant injuries*
- 3. To increase participant empowerment and self-esteem*
- 4. To promote effective self-care practices*
- 5. To improve participant quality of life in relation to traumatic injury and chronic pain experience.*

#### Parameters

*The group consists of eight weekly sessions which run from 6:00 - 8:00 pm. Evening hours allow participants to attend after completing daytime work or childcare obligations if applicable. This time was also selected with*

*consideration that some participants may need to rely on friends, family, and/or public means for transportation to and from the group. Eight weeks allow for adequate processing of experience and fostering of connection, but it is still a brief enough period to be covered by many managed care providers and to require that participants continue to make progress. Groups may range in size from six to twelve adult participants, depending upon demand and the individual needs of participants.*

*Special care must be taken when selecting the location in which the group will be held. The facility must be accessible to individuals with a broad range of abilities and disabilities, and seating should be comfortable and practical for all participants and facilitators.*

*Groups are always co-facilitated by two counselors with expertise in the areas of group work, chronic pain, and traumatic injury. The co-facilitation of the group better equips the counselors to meet the needs of survivors. If one or more group members is expressing intense emotions, one counselor can attend to the situation while the other counselor notes the reactions of other participants or finds a way to engage the other participants. Working in pairs also means there is always a back up if one counselor finds himself or herself having a strong reaction to a survivor's story, experiencing counter-transference, or is otherwise distracted (Corey & Corey 2006).*

*Group members will only be enrolled in the group after careful screening to ensure that they are able to participate appropriately and to be*



*certain that the group will meet their needs adequately. The limitations of the study state that individuals who are actively abusing substances, individuals who have PTSD, or those who have moderate or severe traumatic brain injury are not appropriate for participation, as this group cannot effectively meet their needs.*

*Due to the scope of this group, ideal participants will have allowed four to eight months to pass since the date of their injury. Within this timeframe, it is likely that survivors will have overcome the initial shock of the injury and moved past the denial present in Kubler-Ross (1969) and Hendler's (1984) models. Pain is also considered chronic at this point. Survivors no longer expect the pain to disappear completely, yet they may be years away from the acceptance of it.*

*The group will begin with rapport building in an effort to encourage the development of trust and connectivity among members. Each session will also have a psychoeducational component with emphasis on strategies for coping with loss and pain (Corey & Corey, 2006).*

*Because pain is a complex process with many contributing factors, it is best treated when approached from a variety of angles. Multidisciplinary treatment has been shown to be the most effective approach to managing chronic pain (Budh, Kowalski, & Lundeberg, 2006). This model addresses psychosocial needs of survivors with chronic pain, but its effectiveness is maximized when used in conjunction with medical treatment.*

## Session Content

### Week 1:

*The session opens with a welcome to participants. All complete a centering exercise in an effort to allow participants to become present and remain available for the work to be done. Necessary information will be shared about the facility in which the group is held regarding parking and location of rest rooms. Participants are welcomed to stretch or stand as needed to be most comfortable during the session. It is important that participants feel safe taking steps to accommodate their needs in this setting.*

*The session continues with introductions of the co-facilitators. This introduction may include background information, related clinical experience, and brief sharing of personal experience with traumatic injury and chronic pain if applicable. A brief overview of the group model is also presented. This overview should include the topics to be covered, general session format, weekly homework, and review of meeting times and dates.*

*Confidentiality and its limitations are discussed next. The facilitators explain the significance of maintaining confidentiality for participants and facilitators alike. The facilitators also explain cases in which they will be required to break confidentiality in order to maintain the safety of group members and those with whom they come in contact. Upon completion of this section, the facilitators open the discussion for questions.*

*The second half of this first meeting begins with participant introductions and an opportunity for sharing. Participants are asked to share their names, the events surrounding their injuries, and their current experiences with pain. The sharing of survivor stories is an important component of this group and it has the potential to be incredibly bonding for participants (Corey & Corey, 2006).*

*At the end of the session, participants will be assigned to compile a list of goals that they would like to achieve by the end of their time in the group. Participants will be given a notebook in which each week's homework assignment can be completed. This will allow the work to be kept together for easy self-review throughout the process. Participants are welcome to journal, doodle, or record reactions to sessions and specific activities within these notebooks if they wish.*

*The session ends with a closing exercise which asks participants to close their eyes, breathe deeply, and share one hope for the upcoming week. This allows participants to collect themselves and encourages them to remain hopeful as they prepare to step back into their day-to-day lives.*

*The general format for each session will remain constant throughout the process and will proceed as follows:*

- Centering exercise*
- Homework review and discussion*
- Psychoeducational component*
- Experiential and/or group work component*

- *Assignment and explanation of homework for the following week*
- *Closing exercise*

### Week 2:

- *Centering exercise*
- *Homework review and discussion: Participant goals*
- *Psychoeducation: Introduction of Hendler's four-stage response to chronic pain (1984) and Kubler-Ross's stages of grief (1969)*
- *Group work: Where do you see yourself chronologically and characteristically within Hendler and Kubler-Ross's stages?*
- *Homework Assignment: Explore your denial. What have you refused to believe about your injury and/or your pain?*
- *Closing exercise*

### Week 3:

- *Centering exercise*
- *Homework review and discussion: Denial*
- *Psychoeducation: Introduce Rodin's (1991) three-phase approach to medical treatment and Worden's (1992) four tasks of grieving.*
- *Group work: Address Rodin's first phase (grieving) and Worden's first task (accept the reality of the loss). What have you lost as a result of your injury and/or your pain?*
- *Homework assignment: Compare your present self to the person that you were prior to your injury. Draw pictures or bring photos from before and after if you wish.*
- *Closing exercise*

### Week 4:

- *Centering exercise*
- *Homework review and discussion: Before and after*

- *Psychoeducation: Introduction of Bowlby's (1961) grief theory and revisit Worden's second task of grief (experience the pain of grief).*
- *Group work: Address Rodin's second phase (meaning making). Label the pain of your grief. Is it sadness, fear, anger, etc.? What has this meant for you?*
- *Homework assignment: Revisit your goals from the first week. Amend your list as you see fit and note your reasons for making changes.*
- *Closing exercise*

### Week 5

- *Centering exercise*
- *Homework review and discussion: Updated goals*
- *Psychoeducation: Introduction of Beck's (1976) cognitive model and cognitive behavioral therapy.*
- *Experiential work: Record your automatic thoughts about the appearance, the functionality, and the physical sensations of your body.*
- *Group work: Address Rodin's third phase (reframing and empowering). Share automatic thoughts and reframe those that are negative, maladaptive, or not in alignment with personal and group goals to be more positive, adaptive, and in alignment with personal and group goals.*
- *Homework assignment: How do you take care of yourself? What are you able to do for yourself that is meaningful and enjoyable? Do a demonstration for the group and bring in resources about your activity of choice (contact information, locations of interest, etc.).*
- *Closing exercise*

### Week 6

- *Centering exercise*
- *Homework review and discussion: Self-care and recreation*

- *Psychoeducation: Introduction of the dual-process model of grieving (Stroebe & Schut, 1999) and Kleiber's (2008) research on leisure's role in recovery from traumatic injury*
- *Group work: Address Worden's third task of grief (adjust to a new world). What and whom have been most/least helpful since your injury. Continue sharing of resources.*
- *Homework assignment: Create a list of guidelines or hints that you wish had been given to you in the days immediately following your injury. You may also create a list that you wish had been given to your friends and family.*
- *Closing exercise*

### Week 7

- *Centering exercise*
- *Homework review and discussion: Guidelines and helpful hints*
- *Psychoeducation: Review Rodin's second (meaning making) and third (reframing and empowering) phases.*
- *Group work: Revisit what you have lost since your injury (week 3, Rodin's first phase: grieving). Have you gained anything?*
- *Homework assignment: What will acceptance (Kubler-Ross and Hendler) or emotional relocation (Worden) look like for you? What can you do to work toward these achievements?*
- *Closing exercise*

### Week 8

- *Centering exercise*
- *Homework review and discussion: Acceptance and final task of grief*
- *Psychoeducation: Overview of all theories and models; time for questions*
- *Group work: Revisit personal goals from week 1 and week 4 and group goals. How many of these goals have you reached? How did*

*you do this? What can you do to maintain this progress? What can you do to work toward other goals?*

- *Optional exchange of participant contact information*
- *Homework assignment: Practice self-care*
- *Closing exercise*

### **Post Group Evaluation**

*A questionnaire will be mailed to each participant one week after completion of the program. Participants will be asked to assess whether the group met their individual needs and the extent to which the group goals were achieved. Participants will also have the opportunity to provide written positive or negative feedback.*

## CHAPTER IV

### CONCLUSIONS AND RECOMMENDATIONS FOR FURTHER STUDY

*This eight-week psychoeducational support group model begins to address the needs of survivors of traumatic injury living with chronic pain by incorporating social support, grief work, self-care, coping skills and strategies, resource gathering, and empowerment.*

*In the immediate future, it would be most helpful to conduct actual groups using this model. Participant and facilitator reactions would be invaluable in beginning to assess the model. Post-group evaluations and feedback could also be considered and incorporated into amendments to the model.*

*In addition to participant and facilitator perceptions regarding the quality of the program, it is essential that the effectiveness of the model be empirically validated. While it is supported theoretically, the model will hold much greater significance if statistically qualified.*

*If proven to be associated with significant improvements in participant quality of life, sense of community, empowerment, appropriate grieving, and/or self-care practices, the group model would carry great promise for survivors. The positive impact could be expected to multiply further if the model was to become a component of a complete rehabilitative plan incorporating medical and complimentary treatments.*



*Chronic pain and traumatic injury are startlingly complicated systems that have the potential to wreak havoc on the lives of those whom they touch. When the two are combined, this effect is exacerbated. Yet, with the proper support and resources, many individuals are able to find health and healing in the face of pain and injury. Continued research and awareness will help to make positive outcomes possible for more survivors by bringing this silent epidemic into the light.*

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