WHAT INFLUENCES DO TRAUMATIC EVENTS HAVE ON INDIVIDUALS EXPERIENCING CHRONIC PAIN?

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WHAT INFLUENCES DO TRAUMATIC EVENTS HAVE ON INDIVIDUALS EXPERIENCING CHRONIC PAIN?

A Project

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Division of Social Work
Abstract

of

WHAT INFLUENCES DO TRAUMATIC EVENTS HAVE ON INDIVIDUALS EXPERIENCING CHRONIC PAIN?

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The purpose of this research is to explore influences and identify similar characteristics related to trauma that contribute to chronic pain in individuals. This is an exploratory, qualitative study and was conducted using a Grounded Theory design. There were six respondents who participated, and the research involved interviewing the participants with in-depth, open ended questions, using an audio tape recorder. The participant’s answers were transcribed and categorized into six common themes using open coding. The analysis showed that unresolved historical trauma that hasn’t been treated, can trigger and exacerbate a pain episode. Cumulative emotional stress is common as life’s stresses can overlap and build upon each other. Acceptance is a state that is optimal for chronic pain sufferer’s as it appears that once there is acceptance, a management program can be incorporated with treatment to enhance more quality into a way of life into place. Legacy of poor coping skills often creates a barrier for chronic pain suffers as they do not know how to manage chronic pain correctly. The most challenging aspect of this
exploration was the small sample size of participants, due to lack of time availability of many of health care practitioners.

____________________________, Committee Chair
Robin B. Kennedy, Ph.D

____________________________
Date
ACKNOWLEDGMENTS

I want to thank my mom who is the essence of who I am. Regardless of the abuse she suffered as a child and the mental health issues that resulted, I never doubted her love and belief in me and in all that I could achieve. I also thank her for giving me my little sis. Diana: thank you for your unconditional love.

To my dad: thank you for your words of wisdom and believing in me. To my friends: who have been my family for so long, thank you for your support to complete this journey and for always lending an ear.

To my beautiful new family: Your love, support and acceptance of me has touched me so deeply and has helped me to grow. Each one of you is special and dear to me. Thank you for allowing me to be apart of your family.

To my new husband, my best friend, my rock: Your partnership, kindness, patience and encouragement make me want to be a better woman. I am so lucky to have found you. Thank you. To my dogs Dakota and Marley: thank you for keeping me company for many hours in the computer room, and for bringing joy, tenderness and laughter to our home everyday. Through this experience I was blessed to have met some new friends through school that offered comradery when needed, and some professors that offered guidance and mentorship when needed. For that I am thankful. I cannot thank my colleagues at work enough for allowing me to achieve my degree, by simply understanding the stress, not burdening me with more, and giving me an outlet to achieve it. Thank you from the bottom of my heart.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgments</th>
<th>vi</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>x</td>
</tr>
</tbody>
</table>

## Chapter

### 1. INTRODUCTION .............................................................. 1

- The Problem ................................................................. 1
- Background of the Problem ............................................. 3
- Statement of the Research Problem ............................... 5
- Purpose of the Study ..................................................... 6
- Theoretical Framework ................................................. 6
- Definition of Terms ..................................................... 9
- Assumptions ................................................................. 11
- Justification ............................................................... 11
- Summary ................................................................. 11

### 2. REVIEW OF THE LITERATURE ........................................ 13

- Unresolved Historical Trauma ........................................ 13
- Cumulative Emotional Stress ........................................... 19
- Acceptance ................................................................. 23
- Summary ................................................................. 27
Appendix A. Consent Form ...................................................................................... 56
Appendix B. Interview Questions ............................................................................ 58
References .................................................................................................................. 60
LIST OF TABLES

1. Table 1 Themes ........................................................................................................ 33
Chapter 1

INTRODUCTION

The Problem

“Chronic pain management is a serious health crisis facing the world today” (Grinstead, 2009, p. 1) the numbers of people suffering from chronic pain is a problem that is reaching epidemic proportions. This issue is increasing, and cannot be denied attention any longer. Turk (1999) suggests that chronic pain not only taxes the individual, but the capacities of family, friends, co-workers, employers, the health-care system, and society to provide support and relief as pain management continues to be an extremely challenging problem for the sufferer. Chronic pain is defined as a pain condition that lasts six months or more persistently.

Chronic pain sufferers often feel frustrated and helpless. Challenges of how to function with as little pain as possible is what these individuals face everyday. These challenges alone of simple daily functioning can create an abundance of stress because of feelings of guilt, grief and loss for their condition. Physicians are often unable to identity a specific organic cause for their pain. Treating the pain with medication only, could be a beginning to drug dependency. Treating the pain with surgery can result to side effects or surgical risks. The burden of financial strain is another frustration. “The cost of human pain and suffering experienced by those individuals whose pain condition is either under-treated or mistreated is priceless” (Grinstead, 2009, p. 10).

A traumatic experience in either childhood or adulthood can exert long lasting physiological problems. Trauma can be described as a disordered psychic behavioral state
resulting from severe mental or emotional stress, or physical injury. This includes shock, being upset, disturbance, suffering, pain, or distress; a person may experience these in an array of ways. In practice, it has been demonstrated that counseling and case management helps the client to understand if something has happened to the body, then the person needs to confront the issue mentally and emotionally to figure out how to repair what has been lost.

I am a chronic pain sufferer. For most of my adult life I have struggled with pain, fatigue and depression that accompany fibromyalgia. My mother was addicted to alcohol and prescription drugs for most of my life; leaving me with the emotional pain common among children of addicts that are continually exposed to a chaotic and unsafe living environment. In some way, this childhood situation contributed to my current chronic physical pain condition that I have as an adult. I know other people that have chronic pain, that have shared stories of similar stresses and traumas early in life. I hypothesize that there are an underlying set of conditions which lead some people to develop chronic pain.

Particular sets of circumstances that could underlie chronic pain might be found in the neurobiological, psychological, and/or psychosocial. The research suggests that it takes an average of four years to obtain a diagnosis for these chronic illnesses (Fennell, 2006). These symptoms include debilitating joint and muscle pain, fatigue, migraines, mood disturbance, trouble sleeping because of the chronic pain leading to trouble concentrating, and daily functioning. Chronic pain and related symptoms have
detrimental affects on the physical, emotional, social, and economic well being of an individual.

Background of the Problem

Bravslavsky (2008) states that the medical field has just recently began to acknowledge that chronic illnesses even exist. The connection between pain and suffering are difficult to identify because any number of factors--genetic makeup, family background, or a history of anxiety or traumatic events in childhood--may have contributed to the development of the chronic pain syndrome (Bravslavsky, 2008). As with any other recovery model, getting to the root of the problem is the beginning of the healing process. Although this continues to be a complex and confusing issue, identifying what may have contributed to the physical chronic affect the individual is suffering from could be the way to begin the healing process.

Historically, family violence has been a reactive issue. There are a few organizations that have been established as a primary provider for crisis intervention services to survivors of domestic violence. The implications of domestic violence on children included feelings of shame, which can cause isolation from others due to embarrassment of what is occurring at home. These children can suffer from low self-esteem and may feel responsible and blame themselves. It is also likely that the children are not getting the necessary emotional support from either parent to ensure healthy self-esteem development (Weave Inc., 2008). Many children of domestic violence families have excess responsibility in the home, and unpredictable behavior from both parents can become a burden on the children’s mental health, emotional growth, and well-being.
Furthermore, substance abuse and domestic violence are two societal contributors that can threaten the lives of people. It also adds to the stress of children growing up in such a challenging environment. Substance abusing parents are often under financial stress due to multiple jobs, or not having a job, this can cause stress on all family members. In addition, physical and sexual abuse are a threat to children whose parents are substance abusers because they lose their sense of precaution, and do not monitor their children properly and keep them safe all the time (Boyd-Webb, 2003).

Rubin (2005) states that at least 40 to 60% of women and at least 20% of men with chronic pain disorders report a history of being abused during childhood and/or adulthood. Reports of abuse and trauma are two to four times higher than in the general population of chronic pain sufferers. Reports of more severe or frequent abuse, usually during childhood, and worse if sexual in nature, often develop specific syndromes or combinations of syndromes. These syndromes include posttraumatic stress disorder, fibromyalgia, and other conditions characterized by repression, somatization, and a need for increased utilization of medical care (Rubin, 2005).

“Studies based on psychoanalytic theories have found relationships between pain in adulthood and early trauma such as punishment, rejection, neglect, loss, conflict as well as physical and/or sexual abuse” (Heckman & Westefeld, 2006, p. 64). The methods and measures used in this article were based the following two research questions: 1) Do Trauma survivors have greater levels of symptomatology than non-traumatized individual? 2) What is the association between trauma severity/type of trauma and symptomatology?
Evidence for genetic and environmental links is also a contributing factor to the growing interest in these conditions. If a direct link is proven that a child’s environment growing up does create these physiological symptoms, the medical community might become more aware and interested. This problem could bring more attention to the forefront to help these individuals cope by opening up an entirely new way of treatment.

Statement of the Research Problem

There is a need for medical social workers to be a part of the treatment team for chronic pain management, because there is a lack of understanding about chronic pain and how trauma affects this concern. Active involvement and consultation in research should improve treatment as pain management education expands, and as the issue of chronic pain is brought into greater public awareness. Identifying and addressing the pain, and dealing with the trauma that might have caused it, will help alleviate the stress that continues to plague these individuals. If clinicians would routinely question chronic pain patients about a history of past or present abuse as a mutual level of trust and confidence is gained, the use of treatment may be more beneficial as it would be administered correctly. If the stress isn’t alleviated, a continued cycle of abuse could occur, which in turn affects our society with yet another generation of chronic pain sufferers that may not be able to function. This may include not being physically capable to take care of their families or hold a steady job. This type of stress can lead to child abuse. Improving coping skills and decreasing emotional stress can be an underlying problem which could be identified as repressed or unresolved trauma. Social workers in
direct services can help clients by either facing the crisis or dealing with ongoing stressors that would impair their coping ability (Corey, Corey, & Callahan, 2007).

Purpose of the Study

The purpose of this study is to identify similar characteristics of trauma as it contributes to chronic pain in individuals. Chronic pain is too frequently ignored, somatosized and even criticized within the medical model. These outcomes will assist practitioners to recognize that chronic pain is a serious health concern facing the world today. Chronic pain needs to be addressed, acknowledged, and validated in order to assist individuals at the level of self, group and society, which too frequently is ignored, somatosized and even criticized within the medical model.

Theoretical Framework

The theoretical framework used in this project stems from several theories and paradigms. Strength based perspective has the concepts of resilience, with the belief that the individual has the ability to overcome adversities and adapt successfully to varying situations. The focus will be on the person’s strengths, interest and capabilities, not their deficits, symptoms diagnoses and weaknesses. Shriver (2004) uses a comparison of Pathology vs. Strengths to show how the Strengths perspective can use the client’s abilities as an asset to grow, change and experience well-being, even if the person has pain from time to time.

For instance, instead of defining the person as a “case,” the strengths based perspective identifies the person as unique with talents and resources, not solely as a diagnosis, and regardless of it. In pathology, therapy is looked at as “problem focused”
instead of “possibility focused” in the Strengths perspective. The practitioners in pathology are skeptical of a person’s stories and rationalizations, because they are the expert in the client’s lives. In the strength perspective, the practitioner wants to know the person from the inside out and extends active listening and probing for more narratives, as they develop trust with the client to understand their mental and emotional state as it relates to the physical. The practitioner also looks to the client, their families and community as the experts about who they are and how they feel. This comparison is ideal for the subject matter being researched in this paper. Instead of only trying to reduce the symptoms of trauma, the focus is centered on how to do that by looking at the bigger picture of where the trauma symptoms are stemming from so that healing can began.

The strength based perspective falls in the same variant of theoretical thoughts of humanism and existentialism. Humanism and existentialism relate to health and well being. Existentialism emphasizes that each person has a unique take on the world from their experiences. That is how we interpret the past, and act towards the future, giving us meaning to our lives. Humanism and existentialism perspectives have an influence on social work and have influenced particular practice theories. These two viewpoints have much in common, and emphasize the concepts of freedom, choice, values, personal responsibility, respect for the clients subjective experience, autonomy, purpose, and meaning. Payne (2005) states that “humanism believes in the capacity of conscious human beings to reason, make choices and act freely” (p. 182), or control their own behaviors and the environments in which they live. Some of the other influences humanists have brought to social work are aspects of therapy. Humanist brings to the
therapeutic relationship a genuine interaction with real attitudes. Humanist has a positive regard for clients, and they empathize with the clients views of the world.

Person-centered therapy ties right into these theories as an intervention. This approach is based on concepts from humanistic psychology and shares many concepts and values of the existential perspective. The goals of the person-centered therapy are independence and integration of the individual, and to focus on the person, not the person’s presenting problems. Rogers (1977) believed that the therapeutic process should be “to assist clients in their growth process, so that they can better cope with problems they are now facing and with future problems” (p. 168). Lyddon (1989) speaks to dominant theories and the psychological perspectives of counseling and social work, by taking the counseling piece of the contextual theory and the position that humans are active, self constructing and changing, which would require a multidimensional strategy and observation. This emphasizes that relationship building and interaction would be the best approach with the belief that the professional doesn’t always know best.

Under the framework of the strengths perspective, Saleeby (2006) believes there is the relationship between health, adversity and resilience. The human condition of suffering can also make us strong. Some may even be grateful, consider their suffering as a benefit, or have an epiphinal moment related to their pain condition. McMillan (1999) notes “three factors have been documented after a review of studies, on how people may have benefited from adversity” (p. 296). One factor observed was that once a traumatic event is faced, a greater confidence may follow, leading a person to believe they can handle adversity. This creates the perception that future events may be less
stressful. A second factor of resilience studied was that one’s values, beliefs, priorities and commitments may be challenged, resulting in enhancement of a person’s health and lifestyle. Thirdly, when a discovery is made and person experiences vulnerability because a trouble surface, then help is requested. A more positive and balanced view follows, with a need for others support, as well as a shift in their own human authentic existential shaping and moral stance with the respect to the rest of the world.

Saleeby (2006) adds that “not only children and adults learn about themselves and develop strengths as they confront challenges and adversity, that if they are lucky they find and make connection and compatriots in the making of a better life, and they find themselves in a community where natural resources are available, no matter how sparse they may seem” (p. 296). The interaction of factors, at all levels, including the biological, interpersonal and environmental is what resilience is dependent upon.

Saleeby (2006) also states that resilience has been found to be a common facet of the human condition according to many resilience researchers. Masten (2001) states that “resilience does not come from rare and special qualities, but from the everyday magic of ordinary, normative human resources in the minds, brains, and bodies of children, in their family’s relationships, and in their communities” (p. 9).

Definition of Terms

The following is a list of terms used in this research project. The definitions were taken from *The Social Work Dictionary* (5th ed.), unless otherwise notated.

Chronic pain: Pain that continues or recurs over a prolonged period of six months or more persistently caused by various diseases or abnormal conditions. Some factors
that can complicate the treatment of persons with chronic pain are scarring, continuing psychological stress, and medication.

Depression: An emotional reaction frequently characterized by sadness, discouragement, despair, pessimism about the future, reduced activity and productivity, sleep disturbance or excessive fatigue, and feeling of inadequacy, self-effacement, and hopelessness.

Grief: Intense and acute sorrow resulting from loss.

Guilt: An emotional reaction to the perception of having done something wrong, having failed to do something, or violation to an important social norm.

Macro orientation: An emphasis on the socio political, historical, economic, and environmental forces that influence the overall human condition, cause problems for individuals, or provide opportunities for their fulfillment and equality.

Micro practice: To identify professional activities that are designed to help solve the problems faced primarily by individuals, families, and small groups.

Resiliency: The human capacity (individual, group and/or other community) to deal with crisis, stressors, and normal experiences in an emotional and physically healthy way; an effective coping style.

Trauma: A serious injury or shock to the body, from violence or an accident. Trauma could also be an emotional wound or shock that creates substantial, lasting damage to the psychological development of a person.
Assumptions

This study is guided by three general assumptions: 1.) Chronic pain affects adults that have endured child abuse or events that are considered traumatic; 2.) There is little public awareness surrounding education and resources on pain management; 3.) There is a lack of attention from the medical community, and often chronic pain is viewed as hypochondriacs.

Justification

The incidents of Chronic Pain in the United States are increasing with affects of an estimated $5.8 million Americans (Mayo Clinic). Chronic pain is also costing more than $70 billion in health care costs and lost productivity each year. Research is beginning to identify the frequent co-occurrence between chronic pain and personal history of trauma (Turk, 1999).

Summary

With more research proving that these conditions are real, persistent with more people suffering. It is imperative that the medical community be more open to these opposing thoughts of suffering and treatment. Persistent pain, like any chronic disease, extends over time and affects all domains of a person’s life. This pain can present and compromises a person’s physical, emotional, mental, vocational, familial, marital or social aspect of life. Turk (1999) stated that “living with chronic pain requires considerable emotional resilience and tends to deplete an individual’s emotional reserve” (p. 45). This research project will help identify how health care practitioners are
currently addressing this problem, what challenges they face, and what similarities occur to affect a positive diagnosis.
Chapter 2

REVIEW OF THE LITERATURE

The literature review for this project is divided into three major themes: 1) Unresolved Historical Trauma; 2) Cumulative Emotional Stress, and 3) Acceptance. These themes will present as a framework while exploring what influence trauma has on individuals that experience chronic pain. The nature of chronic pain can be complex; however, with a review of the literature which provides statistical analysis and a discussion of hypothesis, suggested treatment plans are recommended. In addition, active interaction with participants in research studies, and a review of articles suggest treatment plans due to the outcome of research studies.

Unresolved Historical Trauma

In the article, *A Comparison of Chronic Pain and Controls on Traumatic Events in Childhood*, studies conducted at the Harvard Medical School in Massachusetts General Hospital examined the statistical association between traumatic events in childhood and adolescence and chronic pain. Goldstein (2000) suggests more recent studies indicate a relationship between traumatic events and fibromyalgia, gastrointestinal disorders and migraines. This study used a chronic pain group, 92 patients recruited, and control group of 98 hospital employees without chronic pain. Since there is a high incidence and prevalence of child abuse in the general American population, it is important to determine whether the incidence of traumatic events in childhood is significantly greater in the chronic pain group who seek treatment for pain, than the control group.
Goldberg and Goldstein (2000) explained that the purpose of the study was to compare the incidence of child traumatic events in a chronic pain group with the incidence of child traumatic events in the control group. Each participant was asked to complete two self-reports measures with a childhood history of abuse consisting of nine questions. The second part was about traumatic events with six items relating to the other major upheavals that shaped a person’s life significantly, such as death, frequent moves or violence. The results were that age was a significant predictor of being in a pain group, with 45 years of age being the maximum and then it starts to decrease thereafter. As reported by Goldberg and Goldstein (2000), the Chronic pain patients reported significantly greater abuse history at physical abuse being 37% of pain patients compared to 11.2% of control group. Sexual abuse was reported by 27.2% of pain patients compared to 8.2% of controls. Other or any abuse reported was 54.4% by pain groups compared to 21.4% of control groups. The incidence of child abuse in patients with chronic pain varies between 36% and 62%. American females have been sexually abused before age 17 at approximately 18% and that expands to 25% when other variables are added, such as exhibitionist acts.

Another co-occurrence that is shown in this study is that Child protective agencies have increased from 1.4 million in 1986 to 2.9 million in 1994. There is a greater chance of being abused in children who were raised in families where alcoholism and drug addiction. Another fact found in this study is that of the 91 patients with chronic pain reported that patients who were female, with an alcoholic or drug addicted parent, were more likely to be members of the myofascial and fibromyalgia groups. In the results,
there were statistical differences between the two groups on history of childhood abuse
the chronic pain group reporting more abuse.

A study on two cases, done by Barbara Shapiro, M.D., who is an Associate
Clinical Professor of Pediatrics and Psychiatry at the University Of Pennsylvania School
Of Medicine, is conducted while doing treatment for both families after they had been
strongly recommended by a medical specialist they had consulted. Both of these cases
experienced trauma and had conflicted relationships with their mother, who in turn had
suffered trauma in their lifetime. Shapiro (2006) believes that girls and women are
disproportionately affected by chronic pain, unrelated to medically defined disease in the
article *Bound Together by Chronic Pain and Trauma: A Study of Two Mother Daughter
Relationships*.

The first patient’s mother (the patient was a 15 yr. old girl), had described her
daughter as being sick all the time, allergic to everything and an irritable baby. She
missed school frequently because of her illnesses. As the girl grew, she started
developing muscle and joint pain which slowly increased in severity to the point that she
spent most of her day in bed, ate little and was unable to leave the house for any
activities. The mother did not seem to have one positive thing to say about her daughter,
the father was at the sessions, but rarely said anything. The girl described her
relationship with her mother as unpleasant. They had daily fights and continuous
conflicts. They sought medical advice during the prior years, but the girl’s distress
continued to escalate. Shapiro (1996) stated that “all the members of the family were
united in their anger at the health care professionals who either had not believed the
severity of the pain or who offered no possible solution” (p. 96). After fifteen months of psychotherapy, the daughter was finally able to share with Dr. Shapiro about the repeat of severe physical, sexual and emotional abuse by an older male relative, starting at age 4 or 5 yrs. After this discovery, they then increased the therapy sessions to three times a week to continue discussions on past traumatic events which were troubling her.

The second case was for an adult woman whom shared that her father was an alcoholic and physically abusive to her mother. The woman’s mother, described in various sessions, was self-involved, depressed and had attempted suicide on numerous occasions. The clients mother had also given away the older, but at the time, 3 yr. old sister and she was cast off to an orphanage at one point to live there after her father left to serve the military. After she returned to the home, no explanation was given as to why she had been sent away, and the violence and cold silences in her home became worse. Her father would tell her she was to blame for her mother’s suicide attempts and ultimate happiness. She described being used as an object of her mother’s rage.

In psychotherapy, the aim was to explore, shed insight and understanding that accompanied working on tolerance, self awareness of mind, and boundaries with self and others. With one of these patients, they were still living in an unsupportive environment Shapiro (2006) describes this type of behavior as selfish love, including hostel aggression, rage and guilt. With the second patient, as an adult she was dealing with selfish rivalry and pain served differently for each individual. Both mothers were depressed affecting the daughters development at all stages causing continual stress and discomfort both emotionally, mentally and physically (Shapiro, 2006). For both, the
findings were that the body was a primary arena of suffering and expression and the mind 
body was a major defense projecting hatred and aggression into the illness they endured. 

In the article, *The Link Between Child Abuse and the Chronicity of Painful Conditions: A Social Psychological, Systemic Analysis* presents a prevalence of child trauma in the developmental histories of chronic pain patients, suggesting there is 
evidence of a link between chronic pain syndromes and child abuse including physical, 
emotional abuse and neglect. To date, much work has been done to figure out if such a 
link exists. Other theoretical attempts used to explain a link include psychodynamic 
theory, attachment theory and beliefs about control and depression. The article looks at 
the systems analysis to examine the link of context in which injury has occurred. The 
belief is that the analysis will show the complexity of an environment to the development 
of painful conditions that can be analyzed through social psychological explanations for 
the individual.

Rubin (2005) states that pain is subjective and influenced greatly by prior 
experiences and that pain is real in the article *Psychosomatic Pain: New Insights and Management Strategies*. The relationship between a history of abuse and chronic pain 
disorders has been widely reported but this has become a controversial topic. Key points 
in this article are that a history of abuse may be identified in more than 40% of woman 
and at least 20% of men with chronic pain disorders. These patients should routinely be 
asked about a history of abuse. Patients with more severe or frequent abuse, usually 
during childhood, often develop specific syndromes or combinations of syndromes such 
as posttraumatic stress disorder, fibromyalgia or other conditions that are because of
repression and somatization. Observation and documentation of dysfunctional behaviors may provide important evidence of psychogenic disease. Improved treatment outcomes may be achieved by accepting the patient’s symptoms as real and by providing empathy, validation and multidisciplinary therapies.

Rubin (2005) comments that unfortunately, childhood abuse proves to be a widespread problem in all socioeconomic classes surveyed in this country. A national survey of 5,877 showed reports of childhood sexual abuse in 13.5% of women and 2.5% of men. In addition, women who were physically or sexually abused during childhood have medical and psychological problems similar to women who are currently experiencing abuse. Physical symptoms include chronic fatigue, bladder dysfunction, headaches, asthma, diabetes, heart disease, depression, substance abuse and seizures.

When used properly, multidisciplinary treatment options for chronic pain have been shown to have validity and efficacy in treated various disorders. Stress management has been seen as effective in exercise, mediation, psychotherapy including counseling and biofeedback. Holistic treatments offer physical therapy, massage therapy, supplements and acupuncture. Medications are also an option when appropriate such as antidepressants and muscle relaxants. Psychotherapy is commonly offered to patients with chronic pain. Improving coping skills and decreasing emotional success can be underlying problems that can be unresolved or repressed trauma. Mind-body relationships suggest severe emotional or physical trauma may alter brain physiology and produce specific syndromes.
Cumulative Emotional Stress

This study on Psychological Functioning in Woman with Fibromyalgia: A Ground Theory Study was to evaluate woman with Fibromyalgia by analyzing childhood conditions and adult psychological functioning. The prevalence of fibromyalgia is estimated to appear in 2% of the population with dominance in women. The criteria include a history of widespread pain lasting for 3 months or more and pain specific tender points. Fibromyalgia is a long lasting condition and most patients do not recover after 5-10 yrs. This condition influences daily life greatly. Okifuji and Turk (1999) suggested that fibromyalgia is a disorder linked to a dysergulated stress-response system.

The aim was to give women with fibromyalgia interviews and invite them to express their own views and experiences. The qualities found in these interviews are categorized to explain as much as possible for the study. The participants were approached by the primary doctor with a letter about the study from primary care, a private rheumatologist’s outpatient clinic and hospital special units. Twenty-one women ages 26-72 years were selected strategically to obtain as much variation in the data as possible. Qualitative methods found to be an important complement to traditional quantitative methods for improving our understanding of psychology in medicine.

Goldberg, Pchas, and Keith (1999) state the relationship between sexual and physical abuse in childhood and chronic pain has been reported in several studies. The purpose of the article Relationship between Traumatic Events in Childhood and Chronic Pain, was to examine the relationships between traumatic events in childhood. These included sexual and physical abuse, alcoholism, and drug addiction and three types of
chronic pain: facial pain, myofascial pain and fibromyalgia. Facial pain is pain that originates in the face, that may be caused by an injury, an infection in a structure of the face, a nerve disorder, or it may occur for no known reason. Myofascial pain refers to pain and inflammation in the body's soft tissues. This is usually a chronic condition that affects the fascia, the connective tissue that covers the muscles and connects the muscles to the bones (WebMD, 2009). Fibromyalgia is characterized by chronic widespread pain and tenderness for at least three months. People with fibromyalgia feel pain and/or tenderness even when there is no injury or inflammation. Having trouble sleeping, headaches, morning stiffness, trouble concentrating, and irritable bowel syndrome and depression are some of the symptoms related to fibromyalgia. As with many conditions that cause chronic pain, it is common for people with fibromyalgia to have anxiety and depression as well. Fibromyalgia is a long-lasting (chronic) condition with no cure. Symptoms tend to come and go. You may have times when you hurt more, followed by times when symptoms happen less often, hurt less, or are absent. Some people find that their symptoms are worse in cold and damp weather, during times of stress, or when they try to do too much (Fibromyalgia, 2009).

This study was conducted from 91 outpatient clinics of a rehabilitation hospital and a general hospital. Each patient was given a series of questionnaires and rating scales. The report results from Goldberg, Pachas, and Keith (1999) stated that all three groups had a history of physical abuse in childhood exceeding 32%. The rank order was 47% for fibromyalgia, 40% for facial, 33% for myofasical and 32 % for other types of pain conditions. All three groups also had a history of sexual abuse exceeding 22%. The
percentages of sexual abuse in rank order were fibromyalgia at 47%, myofascial at 23%, facial at 22%. All four-pain groups also had a history of verbal abuse exceeding 38%. The percentages were in rank order of 53% with fibromyalgia, 45% for facial, 42% for myofascial and other pain at 39%.

Other scales of trauma were taken such as a death of a friend or family member before age 17, the range was between 52 and 59%. Major family upheaval such as separation or divorce was most prevalent in fibromyalgia and myofascial pain with percentages ranging from 36 to 65%. Childhood illnesses were most prevalent in fibromyalgia that ranged from 18 to 76%. All three groups had a family history of alcohol dependence exceeding 38%. There was no statistical difference in the three groups of medications taken. Pain intensity seemed to be a higher average with patients with a family history of alcoholism. Goldberg & Goldstein (2000) suggest an interaction among all of these traumas contributes to a sense of uncertainty, unpredictability, and vulnerability of the child. This article is summarized that the child with a trauma in their history does not develop adequate coping mechanisms to confront new illnesses or accidents in life, which can add to the individual’s sense of victimhood.

Farmer & Mayou (2002) really speak to the psychological aspects of trauma being important, even when injury seems trivial in this article Trauma. Minor trauma can be a part of everyday life, and for most people these injuries are of only brief importance. However, some can have psychiatric and social complications. Most people experience major trauma at some time in their lives. Some specific trauma and prevalence found in this article are assault at 38%, serious car or motor vehicle crash at 28%, other serious
accident or injury at 14%, Fire, flood, earthquake, or other natural disaster at 17%, shocking experience at 43%, diagnosis with a life threatening illness at 5%, learning about traumas to others 62% and sudden, unexpected death of close friend or relative at 60%, and any other trauma at 90%. Farmer & Mayou (2002) warned that “psychological and interpersonal factors also contribute to the cause of trauma, and clinicians should be alert to these and their implications for treatment. Tactful questioning, careful examination, and detailed record keeping are essential” for recovery (p. 4).

Some of the immediate effects of frightening trauma under the category of severe distress is usually temporary but can indicate a risk of long term post-traumatic symptoms. The severity of the emotional symptoms can be closely related to how frightening the trauma was than to the severity of the injury; even if the person is uninjured, they may suffer considerable distress.

Another finding is that a small number of those who have suffered trauma, continue to complain of physical symptoms and disabilities that are difficult to explain. The examinations can be unclear or vague, and the relationship between doctors and patients may become strained. The outcome is usually that the doctors feel their patient is disabled for psychological reasons, whereas patients may feel that doctors do not believe that their symptoms are real and that they are unsympathetic and are not offering appropriate treatment.

Recommendations are whether symptoms are physical or psychological, it is essential for the practitioners to agree a coordinated behavioral and rehabilitative approach with patient and family that aims to achieve the maximum improvement.
Unfortunately, there is a shortage of appropriate multidisciplinary specialist services for such people. This leaves primary care teams in the key role in monitoring progress and implementing a biopsychosocial approach to rehabilitation” (Farmer & Mayou, 2002, p. 17).

The psychologically determined consequences of trauma can appear as pain and a disproportionate disability, unexplained physical symptoms, an anxiety disorder, a major depressive disorder. The effects these symptoms may present are an impact on the family such as more arguing or depression by the family members and, an avoidance or phobic anxiety disorder.

To promote optimal recovery, Farmer & Mayou (2002) suggest sympathetic care, which takes into account the patients needs. In addition, specialist advice might be needed and should be sought for persistent problems within the first few months of an injury to counteract long term affects of trauma. “Long delays in providing adequate assessment and treatment lead to unnecessary suffering and disability and may make such problems much more difficult to treat” (p. 37).

Acceptance

Information related to psychosomatic causes for pain is researched in the article *Psychosomatic Reasons for Chronic Pains*. The study found that college students with chronic pain with a history of physical and/or sexual abuse were 43.5% of the 275 females and 23.8% of the 151 males. The study suggests that many victims of sexual abuse repress their memory so the actual numbers of abuse can in fact be higher.
The holistic approach and idea is that the connection between abuse and chronic pain is that strong negative emotions are repressed by the person and such feelings can be hidden in the tissues and the organs of the body. Therapy would focus on integrating body, feelings and mind. Confronting the pain in the body is therapeutic because local and understandable pain is more manageable for a patient to diffuse pain.

A multidisciplinary treatment is often best integrated with the holistic plan, leaving the possibility that the root of the problem is not always visible. Clinicians should routinely ask chronic pain patients about history of past or present abuse as a mutual level of trust and confidence is gained. Ventegodt & Merrick (2005) believe that processing the patient’s complicated and repressed feelings of guilt, fear, and shame is often very helpful in alleviating chronic pain in the clinic.

The role of the emotion in the relationship between traumatic experiences and physical pain is explored in *The Relationship between Traumatization and Pain: What is the Role of Emotion*. Samples of participants were recruited from two clinics at a Midwestern University Hospital. Out of the 138 outpatients, the age ranged from 18 to 78 years with a mean of 39.72 years old. 84% were women and approximately 95% identified themselves as white/Caucasian. The rates of chronic pain patients, who have been abused, have been identified. These authors Heckman & Westefeld (2006) do not believe that the specific proportions of abuse survivors who experience chronic pain have been well documented. Many factors have not been tested that could relate to symptoms. The groups that have been tested are severity or type of abuse, the length and frequency of abuse and level of violence.
The participants were recruited from two clinics. One was a back care clinic and the other an adult outpatient psychiatry clinic. The descriptive, demographic measures used in the study were age, gender, ethnicity, education levels, employment vs. disability, students vs. homemakers and status of relationships and number of children. These packets of surveys were given on the participants at the time of their appointment after they had been going to the clinics for over 5 months of time.

The results were that 74% stated that they had been traumatized as children or adults but they did not differ significantly for the non-traumatized patients in terms of demographic variables except that they were more likely candidates from the psychiatric clinic. Certain types of traumatic experiences, such as childhood sexual abuse were less frequently associated with symptomalogy than other. Neglect could be more pervasive and therefore have long lasting effects. The test was not found to be significantly different from the traumatized group to those of the non-traumatized group. The results discussed could have occurred for several reasons: too many variables used and the non-traumatized group may have been too small. Heckman & Westefeld (2006) also conclude that the study confirms the widespread occurrence of traumatization in children and adults and contributes to the notion that abuse prevention could contribute to the reduction in psychiatric and somatic symptomatology in the population.

A article was written on *Biofeedback and Emotional Disclosure* based on the 37th Annual Meeting of the AAPB was held at the Hilton in Portland Oregon on April 6-9, 2006. The theme of the meeting was “Synthesis and Coherence: Integrating the Whole”. The meeting was a diverse program offering presentations, keynote speakers and special
addresses and workshops or short courses. Abstracts and poster presentations were given the “Citation Award Paper.”

One paper written by Dmitry Burshrteyn, Ph.D., who was attending Siena College at the time, purposed a study and shared in the follow up and findings in his abstract. Over the course of writing, individuals can construct a life story or narrative and in doing so they create psychological distance between events and themselves. Expressive writing and biofeedback direct attention to sources of stress and give an emotional release.

To examine the cognitive emotional aspects of the expressive writing they measured the frontal cortical activation for involvement with twenty college students randomly assigned. One group did expressive writing only and the other group did expressive writing as well as biofeedback. He wanted to find out what the effects of biofeedback and expressive writing as it can generate new understanding of the past events. Pennebacker (1989), states that this new understanding had been associated with improvements in physical and psychological health.

*The Assessment and Management of Acute Pain in Infants, Children and Adolescents* states that acute pain in children is often inadequately assessed and treated. Often insufficient knowledge among caregivers, myths that children do not experience pain the way adults do or fear of adverse effects of medications contribute to the lack of effective management. The Academy of Pediatrics (2007) states that pain is an inherently subjective multi-factorial experience and should be assessed and treated as such.
Self-report, behavioral observation or physiological measures are used to access pain. The child’s age depends on the communication capabilities specific to measure validity and usefulness of location, quality, intensity, and tolerability. In conclusion, only ample knowledge about pediatric pain exits to treat children effectively and what is know about pediatric pain conditions and the treatment is not universally applied. Pediatricians are encouraged to facilitate the use of services through child life programs that work on improving psychological and physical comfort. There is a need for more research for pain management. Treatment of children will improve as pain management education expands as the issue of pediatric pain is brought into greater public awareness.

Summary

When studying the literature and various studies about chronic pain, common characteristics stand out. The relationship of chronic pain and the history of childhood abuse, including physical, sexual, neglect verbal, emotional abuse and unsupportive environments were shown to be prevalent. An association of childhood traumatic events leading to fibromyalgia, gastrointestinal disorders and migraines was predominantly found. Chronic pain patients reported a significantly greater percentage of abuse history than any other control groups.

Other notable discoveries were that children had a greater chance of being abused in families with alcoholism and drug addiction. Addiction can lead to major upheavals in the family. This can be separation or divorce, death, frequent moves, and/or violence. Interactions of several types of trauma can contribute to a sense of uncertainty,
unpredictability and vulnerability of the child. This consequently stunts the development of the child gaining good coping mechanisms to confront new stresses in life.

Although abuse is universally not well documented, therefore insufficient knowledge is obtained; widespread views were that women that suffered with chronic pain had a higher percentage over men reporting similar histories of physical and sexual abuse. Feelings that could be repressed of guilt, fear, and shame, depression, and anxiety are significant in the chronic pain experience. Multidisciplinary treatments have shown efficiency in relief of chronic pain endurance.
Chapter 3

METHODS

Research Design

This qualitative exploratory study will examine the influences that traumatic events have on individuals experiencing chronic pain, by reviewing the research of medical professionals who work with these individuals. Exploratory research can add new insights into an issue or situation. This technique is usually used when there has been little research done on a subject or that if it’s a new research area. Given its fundamental nature, exploratory research often relies on secondary data research. This can be accomplished by reviewing available literature and/or data, and by using qualitative approaches like informal discussions or formal approaches through in-depth interviews (Rubin & Babbie, 2008).

Grounded theory was used to guide this study, as it did not use statistical data. According to Kreuger & Neuman (2006), grounded theory allows the researcher to be open to changes in their research question. In other words, researchers who use grounded theory let the data they collect guide the project instead of planning the project completely in advance (Kreuger & Neuman, 2006). The design is a qualitative approach, to give the researcher the opportunity to directly interview participants, allowing a forum for in-depth open ended questions, so that participants can offer descriptions of their experiences. The goal of this research project was to evaluate what influences does trauma have on individuals suffering with chronic pain, and to explore the need for a
medical social worker as part of the treatment team for the inclusion of emotional support, mental health counseling, and access to community resources.

Subjects

The subjects are professionals who have worked with people with chronic pain in the greater Sacramento California area. All participants spoke English. Participants completed an informal consent (see appendix B). Participants were not offered inducements for participation, nor penalized for non-participation in this project. Participants were recruited by this researcher through email contact and calling the participants personally to ask for their contribution to this research. The methods used were through internet searches and word of mouth referrals. Other participants were identified through a snowball sample. Participants were asked to identify other care providers specializing in work with the chronic pain population, to invite their colleagues that may be interested, and provide the contact information. This researcher contacted these additional referrals by email and/or by phone.

There were a total of six respondents who participated in this project. Due to the lack of response of medical doctors, this researcher invited alternative medicine professionals to participate. However, all participants in this project provide care for chronic pain clients. The criteria for the chosen subjects included: proximity, job description, contacts with patients, and knowledge of the issue. This includes medication or referrals, physical treatment such as massage therapy, acupuncture, chiropractic, yoga and exercise, or psychological and spiritual treatment such as counseling and meditation.
Instrumentation

The instrument used in this study was a series of interview questions asked of the participants. The researcher of this study formulated the questions after reviewing literature about chronic pain and trauma. The use of interviews served as a scope for qualitative questions, exploring the descriptions of the participant’s experiences on working with clients who have chronic pain (see Appendix B). Demographic questions that were close-ended were also asked of the respondents, which included only their age and gender.

Data Gathering and Analysis Procedure

This study focused on the experience and expertise of participants in an interview format. The use of an audio tape recorder was used to record the participant’s answers in order to be reviewed later for analysis. The length of the interviews ranged from 60 to 75 minutes. The answers were then transcribed from the audio tapes and the data analyzed for emerging themes. The procedure of open coding was used to analyze the data collected in this study. Open coding is a method of organizing data by choosing themes or codes (Kreuger & Neuman, 2006). For the analysis process in this study, the researcher compared the answers to the open-ended interview questions. Through this analysis six themes or codes were found in order to guide the focus of the study.

Human Subject Protection

This research project is considered “minimal risk” as questions may stir up feelings about their own chronic pain if they experience any, their loved one’s chronic pain, and/or what trauma might have been the culprit of the pain. There is a minimal risk
of the participants own fear about the development of chronic pain could surface. Subjects will merely answer questions voluntarily about their expertise, interest and care to people with chronic pain, with an explanation that the interview will stop at any time if the participant chooses to do so. Names will be left out of the research and information will be gathered privately in the subjects chosen public location.

This researcher has obtained approval of thesis research from the Human Subjects Review Board of California State University, Sacramento due to the fact that human subjects will be chosen and utilized for data collection. An informed consent (see Appendix A) was signed by the participants before interviews were administered, stating their agreement, understanding their rights to voluntary be in the research conducted. This original informed consent, along with other data collected, are stored in a lock box at the researchers home to protect the participants confidentiality. Additionally, the audio tapes were labeled by using a number as the identifier. Another measure put in place to ensure confidentiality during the recorded interview, was that the researcher audibly assigned fictitious names to the participants that corresponded with the number identifier. All this data will be destroyed 30 days after approval of this thesis project.
Chapter 4

THE PROJECT

In the overall findings of this project, themes emerged from the interviewed participants. Themes that identified what influences traumatic events have on individuals that experience chronic pain are: 1) Powerlessness; 2) Unresolved Historical Trauma; 3) Cumulative Emotional stress; 4) Acceptance; 5) Legacy of poor coping skills, and 6) Integrative approach.

Table 1

Themes

<table>
<thead>
<tr>
<th>Respondents</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powerlessness</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Unresolved Historical Trauma</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>5</td>
</tr>
<tr>
<td>Cumulative Emotional Stress</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>6</td>
</tr>
<tr>
<td>Legacy of Poor Coping Skills</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Acceptance</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Integrative approach</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>
Demographics/ Profiles of the Participants

The samples in this study were from a variety of professional specialties, who all work with individuals who suffer from chronic pain. All the participants found they had different approaches and modalities of treatment for their patients or clients. All accept for one had experience with their own chronic pain.

Participant number one is a fifty-eight year old male. He is a Senior Consultant, Trainer and Coach for addiction-free pain management. His professional education is in managing pain and co-existing addiction. He has been in this profession for twenty-six years. This participant’s educational background is Bachelors in Behavioral Science, a Masters in Counseling Psychology and a Doctorate in Addictive Disorders. He began his career in 1980 in the addiction field working as a youth educator with Narcotics Anonymous, counseling on alcoholism. Participant number one also taught Alcohol awareness classes to youth, starting from four years of age in Kindergarten, all the way through College youth. In the mid 1980’s he became the chief therapist for an Addiction Pain Program. He worked with chronic pain as the co-existing disorders, but focused his treatment on issues such as domestic violence, eating disorders and medication management. Participant number one was a Licensed Family Therapist in the early 1990’s. In 1996 he started teaching and training others in his addiction management systems. This participant has written numerous articles and books on managing pain and co-existing disorders. This participant uses more of a coaching and counseling approach currently, and very little psychotherapy anymore in his treatment.
Practitioners need to make patients the most important part of the team. I am a coaching guide not an authority guide. I use a timeline competency to look at their past if they feel it ended badly. I have them look at how they think it could have been done better. I arm them with the tools, like a tool box. Knowledge is power for our clients. The more they know, the more likely they can move to a solution. It’s a practical application. The more we practice, the more we educate. Pain is inevitable, but suffering is optional when living with a chronic pain condition.

Participant number two is a sixty-one year old male. He is a Psychologist practicing Neurophysiology/Psychopharmacology. He has been in this profession for twenty-seven years. Participant number two’s educational background is a Ph.D. in Psychology and a Post Doctorate in Clinical Psychopharmacology. He started in this field in 1982. In 1992 he became licensed and started his independent practice. This participant’s private practice began working as a psychologist for the county jail with the conditional release program. Participant number two also worked at Kaiser and he created a work stress program. He then was a Professor of Family Medicine for seven years. For two years he worked at a Regional Aids Clinic practicing Psycho-Pharmacology.

Cognitive therapy perspective is always used. It’s important in my treatment to deal with hopelessness. Pain can be isolated or in full context of the person. I also use a pare-hypnotic technique that re-programs the brain triggering the locus of control center.

Participant number three is a fifty-three year old male. He is a Physician and Medical Director for Integrative Medicine including Herbal Medicine and Nutrition. He
has been a Medical Doctor for twenty-one years and in his current practice for fourteen years. Participant number three’s professional education is a Bachelor in Bio-Chemistry, a Masters in Nutrition Science and a Medical Doctor. His first professional job was in 1991 at a Clinic as a Family Physician. This participant then moved on to doing a dual practice in Family Medicine and Integrative medicine in 1995.

A common misconception is when the parishioners see pain instead of the person. And although chronic pain is not curable, there is treatable healing. I focus less psychotherapy, although I still incorporate a bit, and use more multidisciplinary treatment plan depending on the individual needs of the client.

Participant number four is a sixty-one year old male. His professional education is a doctorate in Law. He has been practicing law for thirty five years and is currently a practicing health care Lawyer in administrative law helping health care professionals. Participant number four has been guiding instructor for thirty-five years with a Meditative Mindfulness practice for people with illness, to the medical community, private industry and government that offers training programs, workshops and retreats. He has done post graduate classes on mindful base cognitive therapy in depression relapse and a multi-year training for community meditative training and leader. He has also written many articles in Journals around the country describing meditation techniques for the lawyers in the work environment.

We have the resources, now we have to figure out how we mobilize them. We offer a range of practices in forms of meditation, body movement and daily life practice.
Usually this combo opens a person up naturally, and this curiosity can change a person’s life.

Participant number five is a forty-six year old female. Her professional education is Bachelors in Human Development and advanced training in body oriented psychotherapy and massage therapy. She co-founded a Holistic Health Center and has specialized training and she instructs mindful based stress reduction classes. Participant number five has been in this profession for six years.

Massage therapy has been seen as an extra, however changing world view and our society’s life changes are creating a need for this stress reduction and pain management technique. The massage therapy technique works on the psychological well being of the person through stress reduction, and physiologically through the body systems.

Participant six is a thirty-eight year old male. His professional education is in Chiropractic. Participant six has been a doctor for nine years. If a client is able to afford other modalities along with chiropractic, results tend to last longer and improve pain levels significantly. As shown in Figure 1, six themes emerged that identified

*Powerlessness*

A common theme found among participants is that often, people with chronic pain fall into a victim position. For four respondents, they found that their clients would become hypervidulent about their chronic pain and the chronic pain would become their identity. Participant number one mentions that personality has some influence over the client’s perception of pain.
Pain occupies their consciousness and their time is spent trying to not hurt, organizing things around themselves to have as little pain as possible, often missing out on much of what their life contained previously. I will see patients who have chronic pain become victims of the pain and view themselves in the victim position, as if the pain is doing something to them, as if it is out to get them. Chronic pain sufferers are not the only candidates who assume this position; however, it is common to hear that type of dialog. They get so focused on the pain, it consumes them and they become hypervidulent. Participant number two has witnessed his patient’s psychological belief that the pain is persistent regardless to all appropriate therapy.

Often people want to hold onto the past, and it’s almost as if pain has defined the person. Certain people, no matter what you do to treat the pain, it’s always going to be there for them.

It is needed to help these people understand that we may never have the cure for the pain. But I still accept them as a person, patient and human being, and remind them that there is always healing that can be done whether or not there is a cure.

Living with chronic pain can be very depressing situation, and if there is any emotional condition that leads to depression or anxiety, the condition can certainly worsen.

Participant number three states that pain is a subjective experience. Responding in the victim role may also be a contingency of social reinforcement. Often you’ll find that pain has defined them because the pain is persistent. Instead of believing they can manage the pain and lessen the pain, they believe there is no cure, no pill to remedy their
situation and give them a quick fix as our fast paced society would prescribe, so they identify as a victim. Their family, employers and the medical field may be modulators of why they identify with this role. Participant number six has witnessed hyper-sensitiveness and mistrust in the medical field, adding to the feeling of helplessness.

Some of my patients have been active and get an injury that becomes chronic. They then will have less activity and become depressed, sometimes very depressed. Some are more hyper-sensitive to chronic pain. My job is to help give them some alternatives and re-build their trust issues they have lost with doctors, who they feel should of “fixed” them and could not, and might not of given them any alternative therapy idea’s or hope of recovery, acceptance or balance of how to continue living with chronic pain.

*Unresolved Historical Trauma*

Another theme found among participants is their client’s unresolved historical trauma. Five of the participants have found that pain is a personal experience, influenced by many psychological factors, including their emotional state. Although these factors do not cause the pain, they can trigger and exacerbate a pain episode. Participant number four has witnessed patterns that have developed in the clients he works with that are decades old. Our family of origin has much more influence than we think. Belief system instilled as a youngster and from one generation to another can often transfer. The victim role can be modeled from a mother or father, and then someone starts to feel pain and this pattern of “I can’t do anything about this, my life is ruined and I can’t function” is what they have seen in their family. So they come for help with this belief system of I am
helpless to this pain, and often these folks are the hardest to train because the victim role has consumed them and they identify with this as who they are.

The problem really isn’t the physical pain, it is however relating to it. What is our experience to physical pain in the body? What we are working with is emotional and psychological pain to begin with. Participant one finds that his work with clients with persistent pain that extends over time can affect all domains of the client’s life.

All patients I work with share a commonality of 100% unresolved historical trauma. Usually their resiliency depends on what life stage they were in when they had the trauma affect them. The younger they are the more susceptible, such as early to later adolescence. Some have true addiction because of true pain, and those are both outcomes of unresolved trauma. Chronic pain can impact relationships with parents, spouses, work environments, friendships and in general, their quality of life. Participant three feels clinicians should be alert to historical trauma and the implications for treatment by asking tactful questions, careful examination and keeping detailed records (descriptions) about previous trauma. I find that many people that suffer from chronic pain that have a difficult time recovering, have suffered past emotional trauma also. Healing past emotional trauma is important because significant child events are sometimes minimized, but have a great influence on the adult person. A high percentage of chronic pain clients have suffered from child abuse. That is why I always go back to the question: How was your childhood, what was it like for you? I don’t think many primary health practitioner’s ask that question.
Participant number six also believes that practitioners often fall short in engaging the client fully to treat them successfully. Our failure as treatment providers is to not identify co-existing factors. Look at current life stresses, help them to cope with these involves the family environment, work environment, social and spiritual connections that they may or may not have. Participant number two also feels that previous trauma affected his clients. Historical trauma is not something I’m tracking on, but it does come up and certainly more with people with chronic pain and headaches.

*Cumulative Emotional Stress*

One prominent theme that emerged from the participants was the overlapping stress that appears to be a common factor with many of their clients. All six participants find that many people that they work with that suffer from chronic pain, tend to display amplified emotional stress in many facets of their lives. Participant one found that stress and emotional stress, as well as interactions with significant others, all can amplify psychological emotional pain. Cognition gets impacted by emotional pain. The affect part is influenced because of the emotional part, and that becomes a problematic way of thinking, especially if they get into suffering mode. Fear, anxiety, anger are the most common feeling that accumulate in chronic pain people. Shame, guilt and depression definitely come up on the emotional end as well. Then behaviorally they start having urges and impulses to do self-destructive and self-defeating activities. This is because they are in the limbic system of fight, flight or freeze. Reactions from their environment can then happen. So when they are in the problem mode, their survival mode, other people get afraid and angry, and when those other people get concerned, their reactions
further reinforces the persons suffering. Cognition affects urges behaviorally, so social relationships or reactions are affected. Participant number two gives an example of how emotional stress can overlap physical pain, and how often it appears these factors correlate with one another. First there is a trauma that occurs, then pain that follows. Usually depression and then anxiety overlap. Emotional pain and depression can sometimes create chronic pain as well. Often you’ll find that chronic pain always has this overlap of various issues accumulating because of an ongoing physical pain or the creating of ongoing physical pain. Participant number three comments on focusing on the big picture of feeling over-whelmed, the impacts that added stress and how to address the emotions. We have to look at current life stresses, with some people they feel they pile up. Helping them to cope with these involves looking at the family environment, work environment, social and spiritual connections that they may or may not have. Participant number four explains that emotions and stress surrounding the emotion fear can intensify pain. Fear, worry, anxiety heightens perception of current pain. Mentally, these certain thoughts activate your sympathetic nervous system to fight some threat, that chemically and hormonally triggers pain. Participant number five comments on how fear seems to evolve from an accumulation of stress. A common trait I see time and time again in my chronic pain clients, is fear and being afraid. This anxiety impacts their social relationships, their family and work associations. Participant number six shared a personal experience of emotional stress that caused him chronic pain. My back went out when I was 21 years old. I was young and healthy and that’s what brought me to be interested in the work I do now. I didn’t realize it at the time, but I was living in an
uncomfortable environment with my parents. My mentor told me I needed to move out of my parent’s house. But I really didn’t believe that my suffering had anything to do with the stress of my living environment. I did eventually move out, my back healed and I haven’t had any back pain or problems since.

Legacy of Poor Coping Skills

Of all the stressors associated with chronic pain, the participants believe that our family of origin has much more influence than we think. Our belief systems instilled as a youngster and from one generation to another can often transfer. Four out of six of the participants reflect on examples of this occurrence presented in chronic pain patients. Participant number four states that his works does help his clients break the cycle of unhealthy coping mechanisms. Most of the work I do with my clients is to help them see the pattern that has developed of unhealthy habits and break down decades of developmentally not being able to cope, sometimes from one generation to another the way coping skills were modeled could of been very unhealthy. For the most part, if people are seeking out my services, they are ready to try alternative methods and are probably more open than most to heal and be out of pain or at least try to manage the pain that has been in their lives chronically for some time more than likely. Participant number three talks about the pattern that can take place from one generation to another. The victim role can be modeled from a mother or father, and then someone starts to feel pain and this pattern of “I can’t do anything about this, my life is ruined and I can’t function.” This is what they have seen in their family. Often these folks are the hardest to train because the victim role has consumed them and they identify with this as who they are.
Participant number two points out physiologically how poor coping skills can contribute to chronic pain. Poor pre-morbid functions are a common characteristic I see in individuals with chronic pain. Before they got chronic pain, they didn’t have good coping skills or good social skills. Attachments fall into this category, as attachment in relationships with people starts and stops time and time again, and if one doesn’t know how to deal with their emotional needs, and their brain does not make a distinguishable difference in what physical pain and emotional pain is, chronic pain can occur.

Participant one believes that developmentally the life stage that the trauma took place and the family of origin plays a role in successfully in clients coping with their chronic pain. Their resiliency has a lot to do with their developmental stage that the trauma took place and their personality on how they will deal with the after effects. Their upbringing also comes into play. The more stable the family of origin is their behavior usually demonstrates how resilient they are. Although sometimes dysfunctional family systems lead to a highly resilient person and some people use this as an asset to overcome and become very successful.

Acceptance

Chronic pain can be a life long struggle. Chronic pain might not be curable, but it can be manageable. Acceptance is one of the keys to success for a person suffering with chronic pain. With acceptance, they have the potential to have the quality of life they desire. Participant number one found that with acceptance, his clients became active in their recovery through various modes of therapy. Once a person is trying to use activities to lessen chronic pain such as yoga and stretching to take care of their bodies, their
prognosis tends to be more positive as they are being preventative. These folks are usually more adaptable to change and have a good social and spiritual connection, with it very important to move forward and recognize their challenges and limitations as well as how to live a whole life. Participant number three believes that with a pain reliever such as massage therapy, a feeling of comfort helps the individual to have hope that they have the power to alleviate their pain through management. Massage therapy is seen as an extra in most people’s realm of treatment. When I see their world view change, and they turn pessimism into optimism, and mindfulness is integrated into their everyday life, I know they are on the road to recovery and self approval.

Participant number two describes that a patient that is receptive to alternative methods reinforces best results. The patient has to be willing to hope and believe they are out of the victim and suffering role. The best outcomes are when they are willing to try new treatments and solutions with an open mind.

Participant number three notices that a person with spirituality appears to accept their condition. The amount of social and spiritual connectivity will help people cope with chronic pain. This can mean many things, not just church, but the idea that there is a higher power, whatever that means to them. Secondly, a person who has the ability to adapt to change in life appears to have better coping skills in general. Participant number four summarizes what he has witnessed in his profession working with chronic pain clients. It has to do with how we embrace our experience, what kind of values they hold and what quality of mind they posses. People that I’ve worked with, who theoretically
have had the same exact intensity of pain, and one person will be suffering terribly and the other person is actually doing quite well. I find fascinating.

*Integrative Approach*

The emergent theme of using a collaborative and an integrative approach was discussed by four out of the six the participants when working with their clients on a treatment plan. These practitioners believe an integrative practice would help each individual be successful, first by building rapport with the client, and then working on connecting their mind and body and spiritual ideologies. Participant number three believes that a way of living or life style and management system needs to be in place for chronic pain suffers. Some treatment plans are holistic in nature and incorporate classes on stress reduction, massage therapy, herbs, acupuncture and yoga as an activity. If medication is needed, I will prescribe it, but usually I lead with a more psycho-therapy or holistic approach because medicines can only mask the pain for so long.

Participant number six will suggest other treatments to compliment his therapy. I find that if they are able to afford other modalities along with chiropractic, such as acupuncture, massage therapy, physical therapy, sometimes pain medication if needed, these all incorporated into a plan tend to give the best over all results for chronic pain suffers. It also helps if they are able to identify if the results are helping or not and give that feedback to the practitioners they are working with. Participant number one prefers working with people using the bio-psycho-social-spiritual approach. He also uses a respect centered approach incorporating understanding, compassion and empathy.
Not many people on a national level talk about the spiritual component. Especially within health care professionals, it has been semi-taboo subject. However, its part of being human, we all are spiritual. First in my treatment plan would be the assessment and collecting data. Secondly would be a medication management system plan to make sure all is accounted for. Next, a cognitive plan to deal with a cascade of their thoughts, feelings, urges and reactions are an important component. We also talk about an intervention without using any pharmacology. Lastly an activity tracking solution to help encourage more movement that is essential to chronic pain suffers.

With trauma, specific interventions such as relaxation response, diazotization, containment of addiction if present with a collaboration of professionals and meeting a person where they are at with understanding, compassion and empathy empowers the to learn how to identify their needs. Participant number five understands that pain is hard to work with and learn to manage. Chronic pain is not always constant so people need to pay attention. Being mindful and paying attention and being aware in the moment is really helpful. Stress reduction is the key. Meditation and yoga is suggested for basics to begin this practice of being mindful while reducing stress.

**Summary**

Traumatic events can create long lasting physiological problems, and as the mind is connected to the body, if the mind has suffered emotionally, then the body will suffer as well. A feeling of powerlessness as the physical pain in the body can be dehibiliting and can occupy much of the person’s existence. Unresolved historical trauma that hasn’t been treated can trigger and exacerbate a pain episode. Cumulative emotional stress is
often found in chronic pain sufferers as well as life’s stresses can overlap and build upon each other. Acceptance is a state that is optimal for chronic pain sufferers as it appears that once there is acceptance, a management program can be incorporated with treatment to enhance more quality into a way of life. Legacy of poor coping skills often creates a barrier for chronic pain suffers as they usually have never been taught, or had role models that demonstrated how to manage chronic pain. This lack of coping strategies can exasperate the problem which results in a non-belief system of “I am helpless to this pain”. An integrative approach as a multidisciplinary option for treatment of chronic pain has been shown to have validity and efficacy. Exercise, mediation, psychotherapy including counseling and biofeedback, physical therapy, massage therapy, chiropractic treatment, supplements and acupuncture can be used for stress management. Medications are also an option when appropriate, such as antidepressants and muscle relaxants.
Chapter 5

CONCLUSION

Summary

The outcomes of this study were affected by a few factors. The professionals willing to participate in this study were from an array of disciplines under the umbrella of the healing occupations. This provided a diverse perspective and expertise on this subject matter. Different levels and conditions of pain, with variants of treatment were established.

The limitations were that the majority of the participants were male. At the beginning of this study, many more participants were willing to contribute and appointments were scheduled. However, many of those appointments had to be rescheduled or cancelled as they couldn’t afford to take the time to be interviewed, due to the doctors and alternative medicine professionals busy work schedules. A small sample of six participants completed the study. All participants were of Caucasian decent, so there was also a lack of cultural diversity among the participants.

Another slight drawback was that the articles for the literature review on the research topic were not easily attainable. However, the articles which were examined did pertain to the research, and had common themes of unresolved history of trauma, cumulative emotional stress, and acceptance were found in concurrence with the themes from data gathered from participants in this study. Even though these main themes captured in a similar pattern, and the studies found in the articles supported the examination, greater public awareness was a repeatedly reported. The information
collected by the professionals treating chronic pain, reinforced the need for extended research to continue to expand their knowledge base, more awareness, and better diagnostic measures to be utilized.

Preventative measures pertaining to child abuse also emerged in the pre-treatment of chronic pain. Family violence is growing in frequency and intensity in our society. Family violence cannot be dependent merely on better services, punitive judicial actions and other protective approaches. “Family violence must be seen in the context of root causes of violence in our society, including poverty, racism, sexism and insufficient support for child and elder care” (Social Work Speaks, 2006). The National Center for Child Abuse and Neglect estimates that more than one million children annually are physically, sexually and emotionally abused, and that more than one million are seriously injured. The shame and guilt experienced by victims of child abuse, as well as the societal denial regarding this problem, are among the reasons for it being under reported (Child Welfare Information Gateway, 2008)

*Implications for Social Work Practice*

As our fast-paced society continues to race along, more stress is burdening our families, individuals, and society as a whole. With the high rate of abuse in American society today, this author believes that as the stress continues to increase, so will the continual cycle of abuse, neglect, and trauma. As a result, more individuals will develop chronic pain. There will be a great need for addressing and treating chronic pain, if individuals are in pain emotionally and physically, which can affect their ability to take care themselves or their families. The outcomes of this project displays that intervention
is needed from our society, not only from a micro level but from mezzo and macro levels as well.

On the macro level, development of new belief systems surrounding the issues of chronic pain needs to be given attention, to contextualize the seriousness and reality of how this illness burdens individuals and families. Beginning at the mezzo level, the medical community is on the forefront of treating these individuals because of their pain. Hospitals need to enforce and support treatment surrounding the issues of chronic pain so that more acknowledgements will be generated, and solutions discovered to help alleviate this issue. Therefore, that people suffering with chronic pain can obtain assistance with the reduction of their pain in alternative ways instead of only traditional prescribed medicines and/or surgeries. The more the medical community recognizes chronic illness as a detriment, the more acceptance on a macro level will be achieved.

At a micro level, social workers will be needed in direct practice, on a multidisciplinary team to help with counseling and case management to support treatment. Social workers have an ethical commitment to stay current with the literature and studies to support best practices, making this a natural fit on a medical team. Another important skill a social worker can bring to the arena is empowerment; building on one’s strengths and looking at past trauma to understand the present. Another would be recognition of the mind and body connection, and helping clients to discover the pride at having survived and overcome their difficulties thus far. There also needs to be an understanding that there is a bio-psycho-social-spiritual aspect to humans, and these aspects may represent some barriers for success, or could be the way to begin the healing
process. Social workers would develop new values and coping mechanisms to get the best quality of life that is reasonable, manageable and attainable for them individually, so they can feel successful in treatment.

Implications for Social Work Research

Future research should center on alternative, holistic and/or multidisciplinary remedies. These include psychotherapy or physical therapy with modes such as massage therapy. Chiropractic and/or acupuncture treatment are other solutions used to relieve and manage chronic pain. Trauma does effect a person’s complete being, physically, emotionally and mentally. With more research proving that these conditions are real, persistent and increasing in the numbers of more people beginning to suffer, the medical community will be more open to new ideas surrounding treatment.

The change in philosophy and understanding will help the treatment, and the practitioners are more successful, as they will be receptive to the idea of alternative measures that can help alleviate some of the condition, and the fact that this pain chronic and real to the patient, and will continue without support and treatment. Specialist and research are important to impact in bridging the gap between public awareness and the art and science of treating the patient. Prescribing medication that only masks the problems that cannot go away with medicines alone is not the only approach. A multi-disciplinary treatment team would be advantages to address the biological, psychological, social and spiritual nature of the individual. Social workers skill set and education of treating the patient in whole, with a psychosocial analysis is critical for all facets of the pain, not just
the ailing body. The need for a social workers presence in pain clinics and as a part of the team that treats people with chronic pain is becoming increasingly evident.

**Conclusion**

This project was guided by three assumptions: 1) Chronic pain affects adults that have endured child abuse or events that are considered traumatic, 2) There is a little public awareness surrounding education and information about pain management and; 3) There is lack of attention from the medical community and often chronic pain is viewed as hypochondriacs. The outcome of this project proved the first two assumptions to be in alignment with the literature and the research. Participants in this study provided insight and a direction of services that are available now, with the idea that this pain condition is serious, so the third assumption proved to be challenged. Although, much work needs to be done to resolve this issue, it is crucial for the social worker to utilize their skill sets, and be creative in problem solving as we view strengths and problems as a larger systems context. Social workers, who by virtue of their values and education, will take on a leadership role in this effort, and consult and collaborate with other professionals to build upon policy and practice when advocating to make a difference for individuals suffering mentally, emotionally or physically.

Continued research on this significant issue is proving to key in finding a solution to the vast populations that are suffering from this condition. The effects of chronic pain extend from the individual, to society, and can impact economic and social costs for all. As social workers intend to advance the social conditions of a community, and especially of the disadvantaged, providing psychological counseling, guidance, and assistance,
increased attention to this chronic pain condition will began to explore alternative measures and resources of treatment. Continual work towards an advancement of bridging the medical professionals to the profession of social work, to collaboratively make favorable decisions regarding the welfare of the patients, would be a favorable outcome.
APPENDIX A

CONSENT FORM

You are being asked to participate in research that will be conducted by Heather Daniels, a Masters of Social Work student at California State University, Sacramento. The study will be a qualitative exploratory study looking at the influences that traumatic events have on individuals experiencing chronic pain. You will be asked to complete a one-time voluntary interview about your expertise, interest and care you provide to people with chronic pain.

The questionnaire may require 60 to 75 minutes of your time. Some of the items in the interview questions may seem personal, but you don’t have to answer any question if you don’t want to. You may gain additional insight into factors that influence chronic pain, or you may not personally benefit from participating in this research. It is anticipated that the study will be beneficial for social workers to gain knowledge on what may influence chronic pain and what psychosocial factors and treatments might be most beneficial for the clients suffering from chronic pain.

The interview data collected and conducted by the researcher will be captured on an audio recorder. The Informed Consent form and the information received from the participants will be kept in a locked file box, at the researchers home, and only accessible to the researcher. All tapes collected in this study will be destroyed upon approval of the thesis, by the Graduate Office or no later than one year after interviews were conducted. Until that time, they will be stored in a secure location.
This study appears to present minimal risks. A minimal risk regarding issues about your own chronic pain if you experience any, your loved one’s chronic pain, or fear about the development of chronic pain and/or what trauma might have been the culprit of the pain could surface. Names will be left out of the research and information will be gathered privately in the participant’s professional’s office.

You will not receive any compensation for participating in this study. Your decision whether or not to participate will not prejudice your future relation with Sacramento State. If you decide to participate, you are free to discontinue participation at any time without prejudice.

You will be offered a copy of this form to keep.

_______________________________________________________________________
Your participation in this research is entirely voluntary. Your signature below indicates that you have read this page and agree to participate in the research.

____________________________________                  ___________________________
Signature                                                                           Date
APPENDIX B

INTERVIEW QUESTIONS

1. What is your age and gender?
2. What is your professional education?
3. What is your current occupation and position?
4. How many years have you been in this profession?
5. Can you briefly describe your professional history?
6. Have you been a member of a different profession before your current profession?
7. Do you remember what brought you to work with people with Chronic Pain?
8. What is your personal experience with Chronic Pain?
9. How many years have you had this condition?
10. Do you have individuals in your personal life that suffer with Chronic Pain?
11. What is your relationship with this person? (caretaker, dependent, family member, spouse, friend?)
12. Can you tell me the different ways Chronic Pain presents in your patients/clients?
13. Do you see any commonalities in your patients/clients that suffer with Chronic Pain?
14. Do you feel chronic pain in adults often co-exists with a historical traumatic life event?
15. Can you tell me about the different types of historical trauma you see?
16. In the case of traumatic historical events, at what life stage did the trauma most often occur?
17. Can you tell me a little bit about what a treatment plan for a chronic pain patient would look like?
18. Do your treatment plans for individuals who have experienced trauma differ from those who have not experienced trauma? (if so, how)

19. In your work with chronic pain patients are there psychosocial characteristics which lead to a better prognosis?

20. In your work with chronic pain patients are there treatments which lead to a better prognosis?

21. Could you speak to some common characteristic you have seen in individuals who have a poor prognosis?

22. What else would you like to share with me about your work with Chronic Pain patients/clients?
REFERENCES


Herman, J. (1992) Trauma and recovery: the aftermath of violence, from domestic abuse to political terror. Flenviend, Ill.: Harpercollins.


