

Brief Psychoeducational Group for Stroke Survivors and Family Caregivers

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This article describes the implementation of a brief psychoeducational group for stroke survivors and family caregivers. The rationale for group intervention and specific techniques utilized to provide psychoeducation on coping strategies for common symptoms of distress are discussed. In addition, session formats, themes, and implications for group leaders are identified.

Keywords: brief intervention, groups, stroke survivor, family caregivers

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As group leaders aim to benefit the well-being of individuals, it is important to examine each individual from a systemic and holistic point of view. This becomes integral when individuals experience acute distress due to medical concerns, such as stroke. The integrated care team surrounding a stroke survivor includes physical health professionals, mental health professionals, and family caregivers. Family caregivers often provide unpaid caregiving services to a loved one who experienced medical issues. Having a stroke can be particularly distressing and has unique implications for family caregiving (Rigby et al., 2009). Stroke survivors and their family caregivers are at risk for experiencing symptoms of depression and anxiety (Balhara et al., 2012), and if left untreated, symptoms could worsen. In working to support the emotional needs of stroke survivors and their family caregivers, the authors designed this brief group curriculum to provide psychoeducation on common psychological symptoms of distress this population may experience and tools for them to cope with those stressors.

Stroke Survivor Stressors

A stroke is an attack on the brain where blood flow to the brain is cut off, which deprives brain cells of oxygen, causing cell death (American Stroke Association, 2024a). A stroke survivor is a person who experienced a stroke and has lived. There are an estimated 6.5 million stroke survivors living in the United States of America (USA) today (Family Caregiver Alliance, 2022). Common impairments stroke survivors can experience as a result of a stroke are memory loss, vision problems, speech/language problems, paralysis on the left or right side of the body, and cautious or inquisitive behavioral styles (American Heart Association, 2024). Moreover, stroke survivors commonly experience depression and anxiety (Lincoln et al., 2013). Family caregivers

often provide support to stroke survivors in recovery and beyond (Cameron et al., 2013), and are themselves prone to distress after their loved ones experience a stroke, potentially for many years (Haley et al., 2015).

Caregiver Stressors

There are approximately 53 million caregivers in the USA who provide unpaid care to adults or children (National Alliance for Caregiving & AARP 2020), many of which are informal (i.e., unpaid or family) caregivers (Joo et al., 2014). Many elderly stroke survivors receive help from family members with daily living activities (e.g., bathing or getting out of bed) and instrumental activities (e.g., managing money or taking medication). Hekmatpou et al. (2019) reported that level of health status, care hours, quality of family relationships, and economic status influenced caregiver burden in family caregivers. Caregivers often put aside their own self-care needs to care for another individual, putting them at risk for emotional, mental, and physical health problems (Balhara et al., 2012). Woodford et al. (2018) conducted 19 semi-structured interviews with informal caregivers of stroke survivors and some reported experiences of adapting to changes and losses associated with the caregiving role, dealing with social isolation, and poor long-term health and social care support. Many caregivers experience clinically significant symptoms of depression (Family Caregiver Alliance, 2022) and have higher levels of stress when compared to non-caregivers (Butow et al., 2014). They often report having high financial burdens and feelings of frustration, anger, drain, guilt, or helplessness (Joo et al., 2014; Gallup-Healthways, 2011). Given that caregivers experience negative consequences due to their roles, interventions and programs to decrease caregiver burden and highlight the strength-based aspects of caregiving are

needed (Abdollahpour et al., 2018; Haley et al., 2015). In targeting family caregivers of stroke survivors, a tailored group design can be an essential component of comprehensive care (Lutz & Young, 2010; Sian et al., 2017).

Group Design

One of the recent developments in stroke survivor psychosocial treatment is to offer interventions for stroke survivors and their caregivers. This article offers a group framework and an outline of brief psychoeducational group sessions for stroke survivors and family caregivers. Minshall and colleagues (2019) conducted a systematic review of 31 articles that offered psychosocial interventions for stroke survivors, carers and stroke-carer dyads. They found interventions reduced depressive symptoms in stroke survivors and their carer, but that more interventions are needed that target both depression and anxiety and should include both social components and psychological components (Minshall et al., 2019). Bakas and colleagues (2017) conducted a meta-analysis between 2012-2016 on the state of the evidence for stroke family caregivers and dyad interventions. All of the dyad intervention studies ($n = 5$) reported at least one significant caregiver outcome and positive survivor outcomes (Bakas et al., 2017). Nine studies tailored the interventions based on a needs assessment, and Bakas and colleagues (2017) suggested that future studies should do the same and incorporate both skills-based and psychoeducational components. In a review of 10 quantitative studies from 2000-2014 of family-centered interventions for persons with chronic illnesses, Deek and colleagues (2016) found that when the family is involved in the self-care intervention, patients with chronic diseases showed positive improvements. Based on findings from previous authors, a needs assessment, group leader reflections, and participant feedback, this

article offers a brief group curriculum with five targeted sessions for stroke survivors and their caregivers with a focus on the topics of depression, anxiety, relationship communication, meditation, and COVID-19 stressors. The structure of this group is rooted in its facilitation style, based on integrated co-facilitation.

Integrated Co-Facilitation

Given the combination of behavioral and physical health concerns, a stroke can trigger, care for stroke survivors is necessarily integrated, often involving a variety of medical professionals ranging from nurses, doctors, counselors, speech therapists, psychiatrists, and other related professionals (Aziz et al., 2017). To lead this group successfully, it is encouraged that both a nurse and a licensed professional counselor (LPC) lead these groups. The nurse trained to help stroke survivors can answer physical nuances related to post recovery and the LPC can focus on mental health. Processing and reflecting after the group may help the two group leaders to better understand the integrated nature of this work and how to best accommodate the needs of the group in subsequent sessions. Continued processing and reflection post-groups will also help the co-leaders to ensure that their health orientations do not clash, but rather complement each other and maintain professional identity (Gersh, 2008). However, collaboration with nurses may help to provide a bridge between medical-model focused physical health clinicians and wellness-oriented LPCs (Doyle et al., 2018), thus making a reasonable choice for co-facilitation in this group curriculum.

For example, this type of group has been used in the past by the authors with LPCs and a registered nurse with expertise in stroke care as co-leaders. The LPCs have previously worked in hospital settings and provided counseling to individuals with

medical conditions and their caregivers. The nurse was trained in stroke and post stroke recovery. By having not only behavioral and physical health experts' group, but also experts in different models of understanding health (e.g., wellness and medical models), group members can learn to understand the stroke and post-stroke care experiences from different points of view. With both professionals in the group, it may reduce the necessity to schedule different appointments or telehealth visits to ask questions related to mental and physical health issues. If participants were required to have an unintegrated group format, their utilization of services may decline (Lavingia et al., 2020). Further, having a physical health clinician in the group may make potential participants more likely to attend the group given the finding that most individuals with behavioral health concerns address them with physical health clinicians as opposed to LPCs (Kroenke & Unutzer, 2017). Based on the importance of integration within healthcare and co-facilitation with nurses, it stands to reason that this group curriculum would fit within integrated-care focused programs or at the very least, co-located programs (Hall et al., 2014). However, given limitations of the implementation of some integrated care programs (Kroenke & Unutzer, 2017), the group format does not necessarily have to be held in integrated care settings if the collaboration between behavioral and physical health is retained. With group leadership established, the group format will yield a novel approach toward counseling stroke survivors and their caregivers.

Group Format

In discussing the construction of the group, we will integrate information based on best practices for group counseling, along with recommendations received from an initial pilot trial of the group conducted in a community center setting. The proposed

group format is informed by the literature, the experiences of the group leaders running stroke groups, verbal participant feedback, and a brief needs assessment. The needs assessment given by the nurse asked the participants one question of “What group topics would you want covered?” The answers included communication tools, education on depression, anxiety, and how to meditate. These topics are consistent with Hafsteinsdóttir and colleagues’ (2011) findings on the educational needs of patients with a stroke and their caregivers. In addition to the stated influences on the group, best practices for running this type of group need to be considered.

The group is recommended to meet monthly or bi-weekly in 60–90-minute formats. Due to caregiving responsibilities and medical appointments of the stroke survivors or family caregivers there may be time constraints on meeting every week (Wood et al., 2015). One factor to consider when deciding if a group is open or closed is to consider the population and setting (Corey, 2016). Family caregivers who provide care for a loved one whose conditions worsen overtime (e.g., further strokes or deteriorating states of wellbeing) may have high dropout rates of interventions due to deteriorating health conditions (Messecar, 2016), and as such, we recommend an open group format. An open group format would allow participants to come and go in the group, depending on their current health or caregiving responsibilities. Moreover, an open group allows for new members to join at all times, and this can provide new stimulation for other members (Corey, 2016). As an open group is recommended, it is the group leaders’ role to pay close attention to how the other members are reacting to new members (Corey, 2016). To integrate new members into a group and build cohesion, group participants are encouraged to share in 2-3 minutes their experience as a caregiver or stroke survivor

using the making the rounds technique (Gladding, 2016). It is also the group leaders' responsibility to take into consideration how participants' intersecting identities and worldview interact with new or returning members (Ramazanu et al., 2020; Sanuade et al., 2021). Group leaders are encouraged to consult with the Association for Specialists in Group Work: Multicultural and Social Justice Competence Principles for Group Workers (Singh et al., 2012) before running this group or others for multicultural group counseling considerations to take when running groups. In addition to group format and attention to multicultural and social justice competencies, the theoretical framework for this curriculum is based on relational and mindfulness principles to help shape the group.

Theoretical Framework

Based on the literature and the needs identified by group members, the interventions for the group were informed by Relationship Conflict and Restoration Model (RCRM; Sells et al., 2009) and Mindfulness Based Cognitive Therapy (MBCT; Segal et al., 2013). The relationship tools presented during session one were based on the RCRM. Sells and colleagues (2009) developed RCRM by incorporating attachment theory, contextual family therapy, and narrative approaches as well as aspects of emotion-focused marital therapy, various systemic approaches, and existential theory (Beckenbach et al., 2010; Sells et al., 2009). The creators of RCRM describe a conflict cycle they observed among married couples during which couples engaged in a cycle of conflict, pain, defense, and injury which has been supported empirically (Beckenbach et al., 2010; Bokar et al., 2011; Sells et al., 2009). The creators of RCRM propose responding to the conflict cycle by facilitating a reconciliation cycle that promotes justice, empathy, trust, forgiveness, and grace (Beckenbach et al., 2010; Sells et al.,

2009); a response that increased intimacy among married couples (Beckenbach et al., 2010). Due to the needs and time constraints of this group curriculum, the leaders chose to focus on grace within the reconciliation cycle. Within the RCRM, grace is defined as “the quality which enables one person to extend kindness, mercy, or goodness to the other without the expectation of reciprocal compensation” (Beckenbach, et al., 2014, p. 176; Sells et al., 2009) and is utilized to disrupt conflict cycles and facilitate reconciliation cycles within couples’ interactions. Grace within relationships has an important role in forgiveness, the reduction of potentially harmful aspects of relationships, and can contribute to the creation of empathy (Patrick et al., 2013). Grace was applied to married couples as well as non-married and non-romantic dyad relationships for the purposes of this group, as caregivers can have various types of relationships with the person they are caring for.

The other four group sessions were informed by MBCT. MBCT is a therapeutic intervention that integrated classic cognitive behavioral therapies and mindfulness approaches to treat recurrent depression (Segal et al., 2013). MBCT was adapted from Mindfulness Based Stress Reduction, developed by Jon Kabat-Zinn in 1979 (The Center for Mindfulness, 2017). MBCT focuses on helping individuals obtain new levels of awareness and disconnection with automatic thought patterns, thus altering the ways in which they think (Segal et al., 2013). MBCT groups generally meet for two hours a session for eight weeks and group members are encouraged to practice mindful exercises in between sessions (Segal et al., 2013). Wood et al. (2015) adapted MBCT to use with caregivers of cancer survivors to decrease caregiver burden. Specifically, MBCT has also been shown to be effective in reducing levels of depression and anxiety (Merriman et al.,

2015). Due to the time constraints of this group curriculum, sessions were reduced to 90 minutes and meditation sessions were also shortened in session two, three, and four. The sessions were informed by the main points of MBCT (i.e., exploring how best to prevent the establishment and consolidation of negative thinking patterns and needing kindness to play an essential role in practice, and empowerment; Segal et al., 2013) which were used and adapted to meet the needs of group participants. More justification to reduce traditional meditation time comes from feedback from researchers (e.g., Jani et al., 2018; Merriman et al., 2015) that stroke survivors and their caregivers have requested to shorten meditation times because it is hard to concentrate for an extended period. The three techniques from MBCT used were mindful eating using the raisin exercise, breathing meditation, and countering thoughts exercise.

Session Format

The group consists of five 90-minute sessions. Approximately the first five minutes of each group meeting should consist of group leaders addressing informed consent and confidentiality, as well as providing space for the introduction of group leaders, group members, and a conversation about expectations for group engagement. This initial discussion should be consistent throughout groups to facilitate a sense of safety and rapport among group members participating in group dialogue in an open group format (Gladding, 2016). In previous iterations of this group, leaders found that the group members engaged in rapport building without the leaders present, given their shared experiences. This observation, combined with common group practice demonstrates the importance of continued introductions in an open group to build social

support, has been found to be helpful to stroke survivors and their caregivers (Morris & Morris, 2012).

The following 30 minutes of the group is reserved to facilitate participants' sharing of their caregiving experiences or stroke survivor experiences during the first group for members, or since the previous group met for members attending multiple groups. Sharing personal experiences has been shown to be helpful in building cohesion among members (Gonzalez-Voller et al., 2019). The largest part of the group is focused on providing psychoeducation on the week's topic, offering an intervention, and having participants practice it. The last 15 minutes of the group are used to wrap up the day's topic and emphasize the practice of things learned in the group between sessions. Participants can also be given contact information of the group leaders if they have any questions in between sessions. With the general guidelines of the sessions established, the next integral piece to understand will be the psychoeducation topic of the week and the purpose of that session.

Topic 1: Relationship Tools. The first psychoeducation topic is relationship tools when engaging in social and romantic relationships. In the initial needs assessment completed in the construction of this curriculum, group members requested relationships tools, which is a need supported by researchers finding improved health outcomes for people living with chronic illness (Deek et al., 2016). The developers of this curriculum found that using an adaptation of the Couples Enhancement Workshop (CEW; Beckenbach et al., 2014) was helpful in establishing relationship tools with stroke survivors and their caregivers. The CEW is based on the RCRM (Sells et al., 2009), an empirically supported model of couples-based group work (Beckenbach et al., 2010;

Cook, 2013; Patrick et al., 2013). The adaptation of the CEW (Beckenbach et al., 2014) is required to fit the time limits of the group and appropriately address the needs of stroke survivors and their caregivers. The relationship tools for this group, based on the CEW, focus on a discussion of grace within romantic and non-romantic dyad relationships. Leaders provide an overview of the concept of grace and the application of grace within relationships. Leaders invite participants to discuss their initial thoughts and reactions to the concept of grace. Participants also discuss initial reactions and applications of grace in their relationships. Next, leaders should provide paper handouts to participants that include a definition of relational grace and prompts for discussion. Group leaders can prompt members to divide into breakout groups of two or three dyads and use the discussion prompts on the handout to discuss the role of grace in their relationships. The prompts on the handout are constructed to facilitate the group members' identification of relational grace, identification of times they have engaged in relational grace, and strategies for engaging in relational grace following the group meeting. While participants engage in discussion, leaders can visit each dyad or triad and prompt reflections. Group members are then prompted to conclude their discussions and return to the full group. Group leaders then facilitated a discussion about the themes that emerged during their conversations and applications of the themes in their relationships. In previous iterations of this group curriculum, participants discussed their thoughts that grace is helpful for their relationships and identified grace as helpful for communication. Many participants identified times in their past interactions within relationships during which they did and did not utilize grace. Once the discussion about grace concludes, leaders are encouraged to discuss strategies for utilizing grace to improve interactions and

communication within their culture. Leaders can then close out the group by having each participant identify how they will apply grace in their relationships.

Topic 2: Meditation. The next session focuses on the topic of mindfulness. Mindfulness was also found in the initial needs assessment of the group and reflects extant research that supports mindfulness training as effective in reducing stress of stroke survivors and their caregivers (Jani et al., 2018). To begin the session, group leaders invite participants to discuss their own perceptions or experiences of mindfulness techniques. Common with many new mindfulness and meditation practitioners, participants in early groups identified using mindful breathing, yet finding it difficult to sit for hours on end. Leaders normalized this experience by stating that other stroke survivors and caregivers have also reported wanting shorter durations of mindfulness sessions for similar reasons and normalizing their trepidations of mindfulness practice (Jani et al., 2018). To help promote knowledge about mindfulness and its usefulness, leaders should provide participants with psychoeducation on what mindfulness is. The purpose of this handout is to provide a basic definition of what mindfulness is and its benefits (e.g., improving mood, improving stress, and coping with pain). Utilizing some of the lessons from MBCT (Segal et al., 2013), stroke survivors and their caregivers learn about two basic techniques in MBCT, mindful eating using the raisin exercise and belly breathing (Segal et al., 2013). To practice mindful eating, group leaders can bring in appropriate foods, in consultation with nurse co-leaders. If food is not appropriate for everyone based on dietary needs, water and mindful drinking can be a substitute. Group leaders use the raisin exercise (Segal et al., 2013) as a guide to introduce participants to mindfulness by way of mindful eating: examining all aspects of eating a raisin,

examining mindfully its shape, texture, external characteristics, and internal processes of eating. Open-ended questions can be asked (e.g., What do you notice about the smell of the chocolate, how does the chocolate feel to you?). The last 10 minutes of the session are spent with leading a 10-minute diaphragmatic breathing exercise. Participants in early versions of this group indicated that they felt more in the present moment after doing the raisin exercise and participants discussed a desire to continue mindfulness activities in their daily life. In addition, they reported the breathing exercise was helpful in coming back to the present moment, reducing stress levels, and that 10 minutes was long enough. Thus, future group leaders should keep mindfulness practices to shorter durations.

Topic 3: Depression. Like previous sessions, the third session focuses on a topic identified in the initial needs assessment for the group, which was depression. As researchers have stated, it is common for both stroke survivors and their caregivers to experience symptoms of depression (American Stroke Association, 2024a; Family Caregiver Alliance, 2022) and these symptoms can negatively impact their quality of life if left untreated (Wan-Fei et al., 2017). In this session, stroke survivors and family caregivers learn about the relationship between symptoms of depression they both may experience after a stroke. In addition, participants are invited to discuss their thoughts and feelings about the topic of depression. The group leaders can give out and review a fact sheet handout that identifies common symptoms and treatments for depression. The purpose of this handout is to normalize feelings of depression as they can be common among survivors and caregivers. Moreover, group leaders can educate participants on Pseudobulbar affect (PBA), a condition that can be a result of a stroke wherein a disconnection is made between the frontal lobe, cerebellum, and brain stem (Lapchak,

2015). Although some symptoms can include bouts of laughter without a trigger, they can also mimic depression (American Stroke Association, 2024b). PBA occurs after a neurologic episode or brain injury and common symptoms include uncontrollable crying and intense feelings of sadness (American Stroke Association, 2024b). After this discussion, the co-leaders lead participants through a countering thoughts exercise. Countering thoughts is a technique used in Cognitive Behavioral Therapy (CBT) that aims at reframing unhelpful thoughts into more helpful thoughts that is often used with clients who are experiencing symptoms of depression (Corey, 2016). The group leaders first share their own examples of unhelpful thoughts they have reframed and emphasize that this technique does not need to only be used when someone is depressed but dealing with any negative thoughts. Group leaders use the tenets of MBCT to emphasize nonjudgmental acceptance of thoughts, which furthers the practice of mindfulness in the second session (Wood et al., 2015). Then, participants are encouraged to write down at least one unhelpful thought they notice and then reframe it with evidence from their lives that would say that actual thought is not true. Reframing negative thoughts might help in short-term gains as mindfulness concepts are practiced continually and a mindful acceptance of negative thoughts becomes less impactful. Participants are encouraged to continue discussing this topic after the group process. If they are experiencing severe symptoms of depression, leaders can discuss the possibility of a more comprehensive physical or mental health referrals (e.g., support groups, individual counseling, and following up with doctors about PBA). In the early iterations of this group, the general theme of feedback from participants was that many had not heard about PBA prior to the group and that learning about it made sense since some of them had experienced

symptoms. In addition, group leaders observed that practicing the countering technique in the group helped participants see how their mood can change when countering thoughts.

Topic 4: Anxiety. The initial needs assessment conducted in the development of this group curriculum pointed to anxiety being a key concern for participants. In this session, stroke survivors and their caregivers learn about the relationship between symptoms of anxiety they may be experiencing after a stroke. As researchers suggest, both stroke survivors and their caregivers can experience symptoms of anxiety (Balhara et al., 2012; Wan-Fei et al., 2017). In a continued effort to provide resources during this short group curriculum, the group leaders can provide participants with a handout discussing the common symptoms and treatment for anxiety. The purpose of this handout, like the session focusing on depression, is to normalize those symptoms of anxiety that can be common post-stroke for survivors and caregivers. To reinforce the mindfulness lessons of previous sessions, participants are asked how mindfulness can be used to address issues surrounding anxiety (Jazaieri et al., 2013). Moreover, to reinforce the countering and meditation techniques that were taught in previous sessions for participants who attended all four sessions, group leaders can revisit the diaphragmatic breathing technique and countering. Group leaders use the countering thoughts technique from session three on depression, tailored towards anxiety, as CBT techniques may also help reduce symptoms of anxiety (Kneebone & Jeffries, 2013). Similar to the last session, leaders share their own example of an unhelpful anxious thought and then participants are encouraged to write down at least one anxious thought they have noticed and reframe it with evidence from their lives that would say that their actual thought may not be accurate to their situation. Again, group leaders used the tenets of MBCT to emphasize

nonjudgmental acceptance of thoughts (Wood et al., 2015). Early feedback from the group curriculum development from participants was that the diaphragmatic breathing exercise was helpful in calming down feelings of worry and that the countering exercise was starting to become easier to counter their thoughts for those who had attended all four sessions. Group leaders also noticed that participants were able to counter thoughts quicker in this session than in session three, possibly due to the practice emphasized for participants to do in between sessions. Group leaders observed multiple participants engage in countering during session four.

Topic 5: Reflections on COVID-19. Based on the needs assessment given for the development of this curriculum, another topic identified was related to COVID-19. The group members identified wanting an opportunity to reflect on the last year of COVID-19 and learn ways to accept change. Moreover, stroke survivors and caregivers both experienced increased emotional distress during the COVID-19 pandemic (Kong, 2021; Sutter-Leve et al., 2021). The purpose of this group topic is to provide psychoeducation on common stressors individuals have experienced during the COVID-19 pandemic and facilitate reflections from participants on their current fears and hopes. As COVID-19 continues to appear and different variants of the disease develop and individuals continue to struggle with these effects, it is necessary for group leaders to be flexible in how this portion of the group is conducted over time. During the group's development, an activity the authors designed, called Worry and Hopes in Bags, was created. The materials needed are two different colored papers or post-it notes; one for participants to write one worry and one to write one hope. Group leaders prompt participants to anonymously write down at least one worry and one hope they have had over the last year during the pandemic on

the colored papers. Leaders walk around and collect the papers in the bag; then they read one hope or worry aloud. Group leaders then encourage participants to talk with the person next to them about if they relate to that fear or worry and what advice they would give that person. The leaders can then ask the pairs of participants to share what they produced and identify themes in the group. Next, to normalize the worries and hopes, leaders can move the conversation along to common mental health symptoms others have experienced during the pandemic and offer coping strategies. Example process questions are “What are some symptoms you have experienced during the COVID-19 pandemic?” and “What coping techniques did you relate to and how will you use it?” The last half of the group is used to teach participants the three-minute breathing space exercise (Segal et al., 2013) to potentially reduce their current or future worry and continue mindfulness exercises. First, the leaders had participants think about and rate the worry they wrote down on a scale of 1-10 (e.g., 10 being the most worried they have been). Then, they lead participants through the three-minute breathing space exercise. Finally, participants rated that worry again on a scale of 1-10. In the group curriculum's development, feedback for this session included participants noting that they felt an increased sense of support after meeting in person and talking about their experiences with one another. In addition, the group leaders observed participants' rated numbers of their worrying decreased after doing the breathing space exercise.

Research and Clinical Implications

To determine the effectiveness of this open group, future researchers are encouraged to conduct pre-test and post-test survey assessments. Measuring participants' levels of depression, anxiety, communication distress, and mindfulness awareness before

and after sessions will provide further insight into the effectiveness of the group offered. In addition, formal interviews with participants are encouraged to ask what worked and what did not work. Upon further refinement of the group, research examining the effectiveness of the group in survivor health outcomes and caregiver health outcomes would be a logical next step to show the potential use of this group curriculum to improve pertinent health outcomes. Examining the connection between behavioral and physical health for stroke survivors and their caregivers can further inform the development of the group curriculum. Further, dyadic examination of relationships within stroke survivor and caregiver dyads can yield useful understandings of how a group curriculum may influence the overall quality of life of dyads, or potentially how a social relationships model can measure the health of a group (Christensen & Feeney, 2016; Wood et al., 2021). In its current state, this brief group offers a curriculum for group leaders to follow and adapt as needed to fit the particular groups they work with from viewpoints of individual needs and cultural backgrounds specific to the group leaders' communities (Singh et al., 2012).

Clinical Implications

The brief group curriculum presented in this paper is a resource for group leaders to use as a template to lead groups for people who have experienced a stroke and their family caregivers. Given that this group was offered in an open format, future group leaders can use each session to lead a group independently or can adapt the group into a closed format to lead for four weeks consecutively. Group leaders can adapt, “apply and modify knowledge, skills, and techniques appropriate to group type and stage, and to the unique needs of various cultural and ethnic groups” (Thomas & Pender, 2008, p. 115).

The group leaders encourage future group leaders to consider cultural considerations including considering participants' cultural backgrounds when discussing concepts of depression, anxiety, meditation, and relationship norms and conducting the sessions in the participants preferred language. Group leaders are encouraged to use the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2015) and the Association for Specialists in Group Work: Multicultural and Social Justice Competence Principles for Group Workers (Singh et al., 2012) as frameworks to lead this brief intervention in a culturally responsive way, as the authors did. For group leaders working with this population, an awareness of common stroke survivor and caregiver literature is needed to provide informed and culturally responsive treatment. For group leaders to recruit participants for future groups, we recommend building relationships with existing stroke survivor and family caregiver support groups. Specifically, building relationships with nurses, as nurses are an integral part of the coordinated team effort in stroke rehabilitation and recovery (Powers et al., 2018). Further considerations of treatment for this population include assessing the mobility issues participants may have, as persons who have experienced stroke can experience paralysis on the right and/or left side of the body (American Heart Association, 2024) and need mobility assistance. Moreover, group leaders should have referral sources for nurses and or medical professionals they can recommend to participants if presenting needs are beyond the purpose of the group (e.g., existing PBA symptoms). Lastly, group leaders are encouraged to have their own basic mindfulness practice to increase the authenticity of teaching the techniques in the sessions. For examples of handouts group leaders can use, they can e-mail the lead the author.

Conclusion

As the counseling field expands, so does its purpose and mission. With a larger focus on integrated care in almost the past twenty years, it is incumbent upon the field to better understand physical health and how it affects the experiences of not only those with a particular affliction but those around them as well. In this case, the authors looked at the needs of stroke survivors and their caregivers to provide a group curriculum that is relatively brief to avoid any hindrance to their experiences, but to provide some respite, social support, and alleviation of some of the psychosocial issues they can experience post-stroke. Given the continued intersections of physical and behavioral health exacerbated by the COVID-19 pandemic, there is an ever-growing need for counselors to not only understand physical health but adapt interventions consistently and methodically for groups with different experiences of health. Therefore, utilizing concepts from established relationship-enhancing therapies, mindfulness, and CBT, this group curriculum is presented to counselors as one way to better serve the needs of stroke survivors and their caregivers.

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