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**THE VALUE OF FOCUSING, A PSYCHOLOGICAL SELF-
HELP STRATEGY, WHEN LIVING WITH CHRONIC
LOW BACK PAIN: A MIXED METHODS STUDY.**

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Abstract

Chronic low back pain (CLBP) is a widespread and disabling condition affecting many thousands of people in the UK, causing distress in many areas of their lives. Most people with CLBP do not have access to specialist advice and resort to managing it themselves. The government drive to encourage people to manage their own long-term conditions has led to some work on the use of self-help techniques with CLBP. However little research has been done with CLBP populations who are not seeking specialist advice. This study actively sought people from this population group. Focusing – a self-help technique based on the client-centred psychological approach – was introduced to two people who had long-term CLBP. In addition two people who had been using Focusing in their lives for some time and have long-term CLBP (but have not applied Focusing to that problem) were also recruited. Focusing was taught either face-to-face or by telephone for six weekly hour-long sessions; the experienced Focusers spent an hour each week for six weeks Focusing with their pain.

Using a mixed methods approach the four participants were interviewed a number of times, namely before, immediately after and three to six months following the Focusing sessions. They also completed the WHOQOL-PainUK questionnaire, the short-form McGill Pain Questionnaire and a global QOL measure at these three times. During the Focusing sessions they completed the SF-MPQ and the global QOL weekly. Within the concurrent nested design the qualitative aspect formed the theoretical driver for the study; the quantitative element providing a smaller amount of data. This enabled the findings to be framed in a way which makes them accessible to the wide range of healthcare professionals involved in the management of CLBP; an approach described as one of ‘utility’. The management of potential incongruencies in using a mixed method approach was a continuous theme throughout the study and a model – the context of stability model – was devised to enable a harmonisation of these in the study design.

During the study three of the four participants reported a change in the meaning of their pain, and improvement in the perception of their pain and its impact. After using Focusing with their CLBP participants reported that the pain no longer controlled what they did, they were able to feel more ‘themselves’ and value themselves and Focusing had given them a supported place to talk about their pain. Focusing appears to have an impact for these people in enabling the acceptance of CLBP and an improvement in overall quality of life was found. The physical, psychological and independence quality of life domains in particular showed sustained improvement. No negative side effects were noted by any of the participants. Further study is needed to demonstrate whether the use of Focusing with CLBP confers longer term benefits and is suitable for a wider range of people.

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Introduction to the study

What prompted this study?

This research study grew from a studentship offered by Bournemouth University in 2006. A combination of staff members with an interest in Focusing (Prof. Les Todres), pain (Dr. Eloise Carr) and the psychological impact of long-term conditions on people (Prof. Roger Baker) led to discussions around the possibility of researching this area. I was awarded the fulltime studentship and brought with me 15 years specialist clinical experience of working with people in pain, both in the chronic and acute fields. The impact that chronic pain in particular has on people's lives and the large number of people affected by back pain drew my attention, and whetted my appetite.

Back pain and Focusing

In the UK Focusing is a little known therapeutic approach. To enable others who are not aware of Focusing to taste a little of the experience there is an imagined diary entry immediately following this introduction. This piece of writing is an amalgam of my experiences of learning Focusing (something undertaken and built upon during the research study) and aspects learned from other people, who use Focusing, during the study. Barbara McGavin first drew my attention to the idea of back pain as an anchor, and I learned more from her than I can say.

Working with many people who have back pain I was aware that most of them do not go to specialist pain clinics. Many self-manage their pain, feeling that the support from their GPs and other healthcare professionals is minimal. The size and impact of the 'problem' of chronic back pain is reviewed in Chapter 1 and leads to the identification of questions posed by the possibility that Focusing might make an impact on how people live with, and manage, their chronic low back pain.

Breaking new ground

As the review in Chapter 1 shows, there is little written about Focusing and pain, and, as far as I am aware, this is the first time that the use of Focusing with chronic low back pain has been subjected to the rigours of a research study. So, although small in numbers, this PhD study is breaking new ground.

This study also breaks new ground in the area of mixed methods research – the approach decided upon to address the questions posed. Chapter 2 contains a small, but exciting, contribution to how a mixed methods research study may situate itself and manage the potential contestations from the qualitative and quantitative worlds of research. These different research paradigms are sometimes viewed as a threat to mixed methods research. Using a ‘context of stability’ model from the world of music and harmonic theory a model is suggested which doesn’t view the differences as pulling away from each other, but as having the potential to provide stabilizing forces within the research design.

Outline of the study

The presentation of the study in this thesis follows a fairly conventional route. It begins with a review of the literature around chronic low back pain and Focusing, identifying how the two might interact. This provides two of the research questions which ask both qualitative and quantitative questions. This approach reflects my position as a clinician, someone whose daily work revolves around both those areas. However, this position is a little more complex in research so Chapter 2 considers how a mixed methods approach, and its methodological structure, might inform this study and answer the questions posed. In turn this provides a third research question around the use of mixed methods in research. In Chapter 3 the design of the study is considered, outlining the problems encountered during this process and their resolution, and the ethical considerations the study posed. Chapter 4 takes the reader into the findings of the study. These are presented with the qualitative and quantitative findings integrated in an attempt to ensure the nested methodology is consistent throughout the study. Keeping this mixed methods approach in the forefront, Chapter 5 discusses the findings, providing some links with the philosophy that underpins Focusing; Chapter 5a discusses the methodological findings. Contributions to knowledge and the limitations of the study are also in these two chapters. My conclusions and possibilities for future directions form the basis of the final chapter.

Within the appendices is included the analysis of the interviews given by the participants and also a transcription of the Focusing sessions for all the participants. These are lengthy documents, and therefore provided on the CD in the back cover of the thesis. They provide the basis for the findings and discussion and are frequently referred to in the main body of the thesis.

Before Chapter 1 there is a Prologue, an imagined diary entry of a person using Focusing while living with chronic low back pain. It is based on personal experiences whilst learning about Focusing and attempts to give a flavour of the experience of Focusing. However it is entirely a work of my imagination, not a specific session. The anchor theme was, as mentioned above, first suggested to me early in the planning of the study during a conversation with Barbara McGavin. The thesis is completed with an Epilogue, a reflection how using Focusing has brought an extra dimension to my approach to the study.

Prologue – a Focusing diary

I'm just trying to get myself comfortable in this chair, moving the cushions until it feels as though my back is supported. That's better, but I can still feel that niggle there ... trying to pull my attention away from that and into my feet. Feeling them warm in my socks and enjoying a wriggle, I bring my concentration up my legs, aware of the pressure of the chair on my thighs, and continue up my back. Need another shift now as the cushion isn't quite right and I burrow my buttocks further into the chair. This is the most difficult part, getting comfy enough to concentrate on bringing my awareness into my body. Now feeling the knobbly parts of my upper back against the back of the chair and shifting my shoulders - just to be more aware of the changing sensation of the pressure between my upper back and the chair. But that makes me realise how tense my shoulders are and I bring my awareness to them, rotating them and hearing the clicking deep in my ears as they roll back and forward. How tense they are and how much I hadn't realised until I turned my attention to them. I continue, paying attention to my arms and hands, again aware of how doing this allows me to relax my hands in my lap and I move my fingers around in a small dance of freedom. Thinking this makes me smile and I move my attention to my face, aware that as I smile there is a part inside me which also smiles and I feel a moment of happiness in the middle of my chest. I take my attention into my upper body, following the happy feeling and just pause there, inviting any other feelings to make themselves known to me. I sit patiently, listening and waiting...

And my attention is drawn to my back, to the place that so often feels painful. And as I move my attention towards it I am aware of a growing sensation of pressure, as though something is being held in and there is something trying to contain it. I repeat the words back to myself, "there is something that feels under pressure, and something else which feels as though it is trying to contain it". And as I say those words I am aware that the pain in my back is getting worse, it feels as though it wants to explode and I rub my knuckles into my back, along my spine, to try to ease it. And I try to return to the part which is trying to contain and constrain. I bring my awareness alongside that feeling, trying not to ask 'why' but to ask 'how'. How does it feel? How does it feel to try and constrain that pain which is bursting to get out? And it's not easy to be there, the pain keeps coming and I keep rubbing my knuckles in my back. And an image comes to my mind - one of a ship at anchor pulling on the chain, the anchor chain taking the strain and holding the ship steady. The waves move around trying to rock the ship and move it away, but the anchor chain holds firm. The big metal links that form the chain take the strain easily and confidently. I say to myself, "the anchor chain is taking the strain, effortlessly, it is what it is designed to do". But the ship is still moving, being rocked sometimes quite violently by the waves and the chain is still constraining. And I stay with that part of me that is the anchor chain and see it is constantly coping with strong, sometimes opposing forces. Then I am aware of a strange feeling, a feeling of vulnerability, as though the chain is speaking to me. I listen and it tells me that it is afraid sometimes, afraid that it will not be able to hold the painship firmly enough, afraid that a great wave will rip the anchor

away, that the metal will break and the ship will just be knocked around by the rough seas. And there is a part of me, a part deep within my heart which is moved by this, that wants to reach out and comfort the vulnerable chain. And it says to the chain, "I can hear you, I can hear the worries you have, I can stay with you." And on the deck of the boat I see sailors moving towards the anchor chain, busy with the running of the boat, and I say to the chain, "Can you see the sailors?" And they are letting the chain out a little more, releasing the tension, easing the pulling and I suddenly become aware that I am no longer rubbing my back, that the pain I was aware of as a growing wave is receding a little and there is a moment of release deep within me.

I want to stay with that feeling of release but the demands of the day are impinging. I take a moment to acknowledge all that I have felt, and bring myself back to the present. And the chair is still uncomfortable and I'm still aware of the pain in my back and I carry the ship and chain with me into the day.

Chapter 1 – Exploring chronic low back pain and Focusing

Introduction

This thesis contains many hundreds of stories; much of it revolves around the story of four people, their lives with chronic back pain and their interaction with Focusing. But along the way there are insights into other lives. There are those who have informed the research which provides the focus for this study; both the perspective of the people performing the research and those participating in it. Many thousands will have contributed to the research looking at the prevalence and management of low back pain. There are stories of people who study pain and develop theories and models of pain which inform our understanding and management of this condition. There are stories of discovery – that of Focusing being a central one. There is the discovery of ways of undertaking research and stories of how challenges in research are met and resolved. There is the story of discovery that follows the researcher, opening up in front of her a pathway previously unconsidered. And there is the story that will weave into the thesis as it is read.

The first chapter outlines the story of chronic low back pain (CLBP), defining it, briefly outlining its pathophysiology, considering its prevalence, current management and the meaning people ascribe to it. Embedded in the chapter, and providing a different perspective on pain, is a section looking at some of the current theories and models of pain. Although complex, these provide an insight into the fraughtness of chronic low back pain, its effects and management and help bring into place the position adopted for this study.

The chapter then describes Focusing, a psychological self-help skill, discovered and identified from the world of client-centred psychotherapy. Here narrative takes priority and much is found in personal anecdotes and reports. The chapter concludes with a consideration of the challenges Focusing may bring to CLBP, and the challenges CLBP may bring to Focusing; ending with the identification of two research questions which then provide the focus for the rest of the thesis.

Chronic low back pain

Definitions of chronic low back pain are manifold and dependant on the context in which they are placed. In reviewing the epidemiological literature Andersson (1999) identifies definitions which are as varied as low back pain which lasts longer than 7 -12 weeks; or extends beyond the expected time for healing; or is frequently recurrent; or, in relation to work-based studies, pain which has led to a loss of work days. The World Health Organisation is clear that the term ‘chronic low back pain’ is not a disease or diagnostic entity (Ehrlich, 2003) and it has also been defined as clinically significant pain likely to be present one or more years in the future (Von Korff & Miglioretti, 2006). This has led to the novel prospective definition which is reviewed later in this chapter. For this study CLBP was defined as a participant report of low back pain for 12 months or more.

From a pathophysiological perspective chronic low back pain is a complex biopsychosocial combination of anatomical, biomechanical, neurophysiological , immunological, psychological and social factors (Cepeda, Cousins & Carr, 2007). This complexity goes some way in explaining the vast amount of available literature on and about chronic low back pain.

Searching the CLBP literature

The literature on CLBP is vast; a quick search on Medline alone provides over 4500 papers with the search term ‘chronic low back pain’. This poses difficulties for experienced researchers in teams, let alone a single-handed PhD student. For example, in their meta-analysis of RCTs of psychological interventions in CLBP, Hoffmann et al (2007) ensured broad inclusion criteria with both organic and non-specific CLBP and a wide definition of a psychological intervention. This led to the identification of nearly 1000 papers which were then sifted to just over 200. The further challenge of a mixed methods approach also increased the amount of available literature as both qualitative and quantitative literature was searched. Facing these challenges I adopted an approach to the literature search of ‘berrypicking’ (Bates, 1989). This model is based on the idea that typical search queries are not static but evolve as researchers gather their information. The information is gathered bit by bit, over time, using a wide range of searches

and sources. This seemed preferable to vigorously limiting my search criteria with the inherent possibility of missing interesting and appropriate material. As I worked through the study different leads were taken – for instance in the exploration of mindfulness meditation and CLBP – and enabled changes in thinking and direction at times which a more regimented approach may have disallowed. A variety of search techniques were used. For example, starting with a key systematic review paper trails of interest were followed which included grey literature such as patient-focused websites and blogs, as well as the more traditional publications and conference papers.

Chronic low back pain is a widespread and disabling condition. One of the most common musculoskeletal complaints in the UK, low back pain has a reported prevalence of 6% - 49% (Croft, Macfarlane, Papageorgiou, Thomas, & Silman, 1998; Palmer, Walsh, Bendall, Cooper, & Coggon, 2000). In many papers reporting chronic pain prevalence back pain is a major contributor (Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006; Elliott, Smith, Penny, Smith, & Chambers, 1999). A comparison of two UK back pain prevalence surveys (1987 and 1997) demonstrated an increase in prevalence of 12.5% (Palmer et al., 2000). They commented that social changes in that decade may have made back pain more acceptable for sickness absence. In 1994-5 one in seven incapacity benefit awards was for back pain (Henderson, Glozier, & Holland Elliott, 2005). This figure dropped by 42% over the following 10 years, with mental health problems (particularly stress) now accounting for more benefit payments than musculoskeletal problems. There has been some suggestion that this is merely re-labelling the problem (Croft & Dunn, 2006) and it seems, from this recent assessment, that the pendulum of social acceptability has swung again. Recently the profile of chronic pain – including CLBP – was raised when it was included in the UK Chief Medical Officer's 2008 annual report. Here it was reported that each year 1.6 million adults develop back pain which lasts longer than three months, commenting that 'chronic pain reduces quality of life more than almost any other condition' (Donaldson, 2009, p. 35).

It has been suggested that 90% of episodes of back pain in primary care resolve in a month – but Croft et al (1998) point out that recovery was defined as not

returning to the GP. Their study indicates that, although symptoms may improve, most patients will have some pain or disability a year later. This leads them to say that ‘[l]ow back pain should be viewed as a chronic problem with an untidy pattern of grumbling symptoms and periods of relative freedom from pain and disability interspersed with acute episodes, exacerbations and recurrences’ (p. 1359). This comment adds to those above in attempting to define CLBP.

CLBP affects many thousands of people in the UK, causing much suffering to those with the pain, their families and friends. It is frequently accompanied by symptoms such as depression, social isolation and physical dysfunction (Demyttenare, et al., 2007) and, both individually and economically, has an effect on employment, social services and the use of healthcare facilities. The CMO report (2009) quotes that the cost to the UK of back pain in 1998 was £12.3 billion, equivalent to 22% of the health expenditure that year. Much of this was from days off work. This economic impact has led to calls to prioritise pain in UK health policy, although currently the governmental response has been disappointing. (Phillips et al., 2008). The recent report by the chief medical officer may have some impact in this area, highlighting as it does the inadequacy of chronic pain services in the UK (2009).

Correlation between symptoms, signs, test results and pathology is notoriously difficult to pinpoint in CLBP and, when they see their GP or specialist, many people are given the non-specific diagnosis of ‘mechanical’ low back pain (Stannard & Booth, 1998). Patients find this lack of diagnosis or identification of an underlying mechanism problematic (Verbeek, Sengers, Riemens, & Haafkens, 2004) feeling that it implies that their pain is not real. This aspect can make relationships between the healthcare professional and patient difficult.

So CLBP is not a straightforward diagnosis either for the patient, the healthcare professional or wider society. In following the story of this type of pain an understanding of pain, its definition and the theories that surround it is needed. This chapter will consider three definitions of pain followed by a discussion of a number of theories of pain. At times these theories touch each other and then move away, all taking a slightly different perspective. And it is these different

perspectives that lead to the creation of the different models of pain that are then discussed.

What is pain?

Pain is a very commonplace and relatively simple phenomenon, yet we have difficulty in describing it completely, much less treating it successfully.

(Hardcastle, (1999) p 207)

For such a small word pain has proved to be a difficult concept to pin down – belying Hardcastle’s assertion that it is a simple phenomenon. Her forceful opening statement of simplicity is immediately followed by a caveat. This movement is something found frequently when pain is discussed, showing the paradox that something simple can be complex. This may be because of the many ways we use the word. At times it conveys very little – ‘I have a pain in my leg’ indicates nothing other than the location. It tells us nothing of the sensation, the feelings it engenders or the impact it might have on daily life. What about the pain expressed at the death of a close friend – is that the same? What are the similarities that cause the same word to be used to mean something that would seem to be very different from the pain of a broken leg?

Hardcastle (1999) states that pain is commonplace and people speak of the ‘universality of pain’, meaning that it is something everyone experiences. But a quick look at different cultures will show how differently we experience or express pain. The classic study by Zborowski (1969) considered attitudes towards pain in 2nd World War American veterans. Dividing them into four ethnic groups he suggested that the Jews and Italians tended to be more expressive in their response to pain than the Irish and Old-Americans. There were some behaviours that went across the ethnic boundaries and he concluded that ‘people responded to their pain not only as individuals, but also as Italians, Jews, Negroes, or Nordics’ (p. 20). In some regions of India, as part of religious rites, people are hung by large hooks put through the skin on their backs. When watching a video of this students cringe in empathy with the pain they assume those people are feeling, although no visual signs of pain are given. There is no reason to suspect damage to the Indians’ nociceptive systems, so pain messages are sent along the pain processing pathways, but the experience of pain is such

that expected pain behaviours are not seen. As well as cross-cultural differences there are inter-cultural differences over time. In the UK the painful condition gout, although now medically accepted as a form of arthritis, still holds a fragment of its 18th and 19th century condemnatory moral meaning of a life of luxury and red wine (Morris, 1999). It becomes clear that in using the word 'pain' we may be meaning a number of different things. But there is still an underlying folk mythology which says that everyone knows what pain is, and people use the word assuming their listeners will understand it. This idea of a folk psychology of pain will be returned to later.

Representations of pain are manifold, and depend on the viewpoint of the person making the representation. A cognitive scientist attempts to explain what is going on in the brain when we believe we are in pain. A neuroscientist tells of the neural activity that takes the impulses to the brain. A philosopher will have a different understanding of the meaning of pain. A psychologist may speak of the impact of pain on our behaviour. And language will be used to describe all these different aspects. In their discussions a neuroscientist and a philosopher (Changeux & Ricoeur, 2000) face this difficulty. Ricoeur (the philosopher) says he knows what a representation is because he has the 'notion of intentionality, the notion of purpose, the notions of subject and object; but [he] does not see how [he] will find representations in the brain' (p31). Changeux says he 'is not interested in language games involving the word *representation*' (p160) stating the aim of the scientist to be that of exploring 'worlds that are yet unfathomed and that may even seem to be unfathomable' (p177). It seems that pain is certainly a world which is unfathomed and, later in the chapter, some of the ways in which pain is being explored will be discussed but there are still some parts which seem unfathomable. This struggle, when using words in which the meaning is assumed, is inherent in many aspects of life - pain is just one of them. As this chapter goes on to consider the theories and models of pain there will be a constant rebalancing, finding that the representation or understanding of pain depends upon the person speaking. To complicate things further, it is not just a difference between the person with pain and others; clinicians who work with people with pain may well hold different views amongst themselves.

The chapter now considers definitions of pain (in referring to chronic pain it is specifically non-malignant chronic pain) found in the medical and nursing literature, followed by a discussion of some of the theories and models of pain.

Definitions of pain

IASP

The International Association for the Study of Pain (IASP) defines pain as ‘An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage’ (Merskey & Bogduk, 1994, p. 210). It is worth noting that this definition is designed to cover all pain. Earlier in the text there is a discussion specifically on the definition of chronic pain where they suggest that chronic pain is ‘that pain which persists beyond the normal time of healing ... three months is the most convenient point of division between acute and chronic pain, but for research purposes six months will often be preferred’ (pxi). It is clear that there may be times when healing is not expected to occur – for instance when pain is due to arthritis – and the pain may be recurrent rather than constant. This clarification of the definition demonstrates the complexity of attempting to define chronic pain; in fact it seems most statements about chronic pain have an explicit or implicit codicil. Although widely accepted and quoted the broad IASP definition is not without its detractors. As shown later, Hardcastle (1999) promotes a robust counter argument.

McCaffery

In 1968 McCaffery wrote ‘Pain is whatever the experiencing person says it is, existing whenever he says it does’ (McCaffery & Pasero, 1999, p. 17). Perhaps less of a definition than a statement it has been influential in the pain and nursing world for over 40 years and still brings people up short with its emphasis on the reliability of the patient’s report of pain. More recently pain has been identified as the 5th vital sign (the others are pulse, temperature, respirations and blood pressure) (American Pain Foundation, 2004). This shows its importance clinically and also demonstrates its subjectivity against the relative objectivity of the other vital signs. It is the subjective nature of McCaffery’s definition which provides the basis for its detractors. These include those who want hard, objective data relating to clinical expressions of pain as well as those who note

that not everybody is able to say what their pain is, for instance babies or people with cognitive impairment.

Prospective

A rather different, prospective approach to defining pain has recently been considered in the field of chronic back pain (Von Korff & Miglioretti, 2006). They suggest a definition of ‘clinically significant pain likely to be present one or more years in the future. Specifically *possible chronic back pain* is defined by a 50% or greater probability of future clinically significant back pain. *Probable chronic back pain* is defined by an 80% or greater probability of future clinically significant back pain’ (p. 762). This is a very different way of defining pain; taking it away from definitions dependant on pain history and the patient’s current pain status. It also subtly changes the emphasis from CLBP being a position which seems unchanging and never-ending to one that focuses attention on what might be done to improve outcomes (Von Korff & Miglioretti, 2005). The US study exploring this prospective possibility was replicated in the UK (Dunn, Croft, Main, & Von Korff, 2008) using the prognostic measures of depression, diffuse pain and pain duration and showed it to be broadly generalisable to the UK back pain population. However Dunn et al (2008) suggest that using this prognostic approach may be more beneficial clinically at a follow-up appointment rather than initial consultation with the GP. What it offers is the possibility of a discussion early on in the CLBP pathway to consider the question ‘how long will my pain continue?’ It is perhaps more accurate to say that, although the authors present this as a definition of pain, it is more of a clinical tool to assist in communicating the potential impact of the pain rather than a definition of pain itself.

Theories of pain

The definitions of pain above, have a clear biomedical focus. Theories of pain most often have a biomedical basis but there are different philosophical positions which can be taken. In the following paragraphs a chronological perspective on the mainstream biomedical theories will be taken. To offer a contrasting approach Hardcastle’s interpretation of the same biomedical data, but from a stance of philosophical psychopathology will be explored as an example of how pain may be part of a different theoretical perspective but stays broadly within a

medical framework. Other theories of pain are in circulation but will not be discussed because they focus primarily outside this framework and therefore have less relevance to this study.¹

Like concepts of pain, which, as noted previously, are culturally dependant and have changed over time (Rey, 1998), theories of pain have also changed. There has been rapid change in the 20th century; prior to that the dominant theory was the specificity theory proposed by Descartes in the 17th century. This held that injury activated specific pain receptors and fibres which projected impulses to a pain centre in the brain. There was no room in this model for psychological contributions to the pain experience, the pain expressed was expected to be in proportion to the injury. This reflects the dualistic perspective of the body and mind inherent in Descartes' philosophy. However it did mean that pain which could not be explained physiologically, or was greater than anticipated, was frequently said to be 'all in the mind' and treated by psychiatrists. In the following paragraphs the dramatic changes in the development of pain theories during the last 45 years will be outlined, starting with the gate control theory. The development of this was based on scientific observation and laboratory techniques. Building on this theory one of its publishers took the behavioural and emotional aspects of pain and, with a grounding in psychological theory, has suggested the neuromatrix theory of pain. Only this year (2009) another theory, this time specifically a theory of chronic pain, was published from a laboratory bringing together observations on brain activity, changes in chemistry and the size and shape of the brain.

Gate Control theory

The publication of the gate control theory (GCT) of pain in 1965 (Melzack & Wall) changed the way that pain was considered, by emphasising the modulating effect of the spinal cord and the dynamic way in which the brain was involved in the perception of pain. The production of this theory was the result of a longterm

¹ Examples of this include Scarry (1985) whose theory of pain leads to seeing its political power in torture and war and Mills (2005) who, in taking a modern queer theory towards the representation of pain in the middle ages, sees pain as a key political and religious force in medieval culture. Bendelow and Williams (1995) develop a theory of pain based on a socio-cultural context, and Morris (1991) considers pain as a biocultural phenomema.

collaboration between Melzack (a clinical psychologist) and Wall (a basic scientist and physiologist). The GCT proposed that peripheral inputs were modulated in the dorsal horn by other peripheral inputs and by descending mechanisms from the central nervous system. Although parts of the theory are quite mechanistic the inclusion of the central systems meant that the brain was seen as an active system which filters, selects and modulates pain inputs. Suggesting modulation both at the dorsal horn (in the spine) and centrally (in the brain itself) allowed for the inclusion of psychological factors (Melzack, 1999) and was one of the biggest advances in thinking about pain, providing the basis for much current laboratory work. However this theory required some physiological stimulus, or activation of peripheral nociceptors, to start the cascade. So, although the gate control theory purports to challenge the Cartesian dualism of body and mind, it could be argued that, even if somewhat hidden, the dualism is still present. A body-based action has to take place before the psychological modulators (mind-based) can be activated. This limits the usability of the GCT in describing pain such as that of CLBP where a physical cause may not have been identified. Melzack continued to worry away at this discrepancy, eventually suggesting an extension of the gate control theory.

Neuromatrix theory

In developing the neuromatrix theory of pain (Melzack, 2005) suggested a different way of understanding brain function. Based on his work on phantom limb pain he came to four conclusions which in turn led to the theoretical concept of the pain neuromatrix:

1. because the sensation of the phantom limb feels so real he concludes that the body we normally feel is subserved by the same neural processes in the brain; although normally activated by inputs from the body they can be activated even in the absence of inputs
2. then he suggests that all the qualities we normally feel (including pain) can also be felt in the absence of inputs; concluding that the origins of the patterns that underlie our qualities of experience are in the neural networks of the brain
3. the body is perceived as a unity, there is a “self” which is separate from others and the surrounding world. He concludes that this sense of unity has to be

produced in the central nervous system (the brain) rather than the spinal cord or periphery

4. the brain processes involved with the body-self are genetically specified although modified by experience.

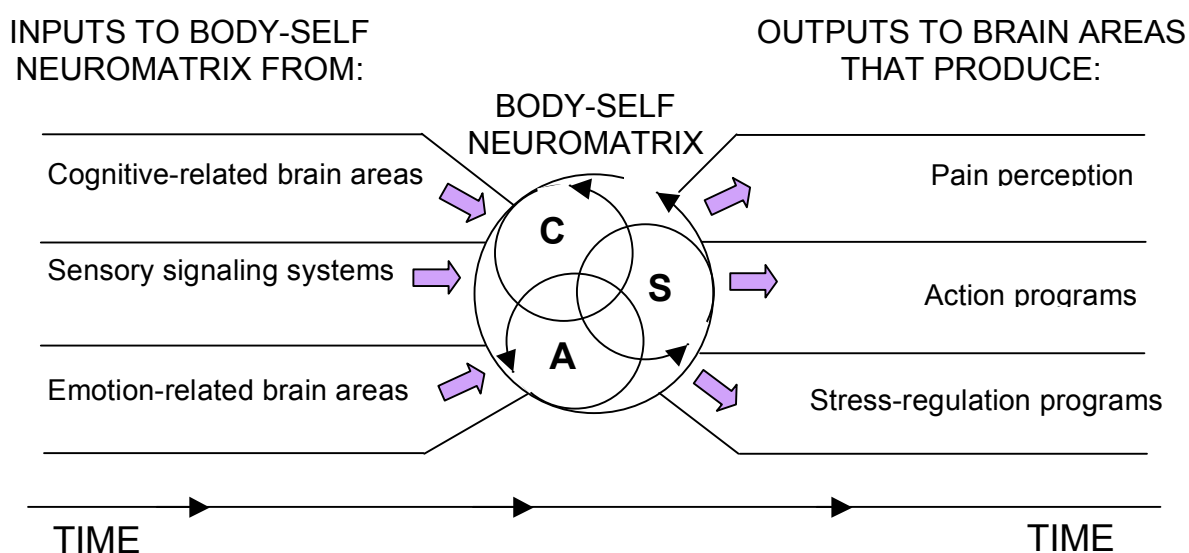


Figure 1.1 Factors that contribute to the patterns of activity generated by the body-self neuromatrix. (C=cognitive, A=affective, S=sensory) Adapted from Melzack (2005) p. 91

Based on the concept of neural networks his theory suggests a body-self matrix in which cyclical processing and synthesis produces a neurosignature. This sentient neural hub changes the neurosignatures into a changing stream of awareness and finally an action neuromatrix, producing complex actions (see Figure 1.1). The neuromatrix is not found in any one part of the brain, but 'comprises a widespread network of neurons which generates patterns, processes information that flows through it, and ultimately produces the pattern that is felt as a whole body' (p87). Inputs to the body-self matrix come from cognitive-related brain areas (memories, meaning, anxiety), sensory signalling systems (musculoskeletal, cutaneous) and emotion-related brain areas (limbic system). The cyclical processing of these sensory, affective and cognitive inputs feeds into brain areas that produce pain perception, action programmes and stress-regulation programmes (including cortisol, endorphin levels etc). The cyclical

processing in the body-self is central to this, and it can be seen that, using this theory, pain perception could be initiated by input other than the sensory. This concept of the neuromatrix can be seen as the theoretical basis in both neuroimaging and cognitive studies (Bushnell, 2005; Chapman & Okifuji, 2004)

Melzack's insistence that the body is felt as a unity, that we do not 'learn' to feel qualities of pain experience (throbbing, lancinating etc) but that our brains are built to produce them, begins to challenge the Cartesian dualism.

The future – a theory that accounts for clinical differences in chronic pain?

The advances in neuroscience and the challenges of understanding chronic pain have led to advances in laboratory based-work on transmission and also to brain imaging studies. These offer new insights and also raise new questions. For instance, why should it be that CLBP is also accompanied by reduced gray matter volume, making it equivalent to a brain 10 or 20 years older? (Apkarian et al., 2004). In the discussion of this phenomenon the authors remain within their field of expertise and do not consider the qualitative data in which people with CLBP say that it makes them feel older (Osborn & Smith, 1998). Perhaps people with CLBP have been aware of these changes through their bodies, and science is only just catching up. More seriously, this neglect of qualitative studies in the discussion of the quantitative studies fails to allow for a more human understanding of the data. (With the growth of mixed methods studies it may be that these gaps in discussion between the types of research will be narrowed.) These investigations in the neurosciences are leading to new definitions of chronic pain (Apkarian, Baliki, & Geha, 2009) which, building on the brain's ability to reorganize itself, are formulated within contexts of learning and memory. This theory is illustrated using the example of CLBP. Drawing on evidence from studies into brain chemistry, cognition, brain morphometry, spontaneous fluctuation of pain and brain activity they contend that 'brain-derived biomarkers relate far better to the clinical characteristics of chronic back pain than do physical factors or psychosocial approaches used in the past' (p. 86). By linking these markers with the brain's ability in learning and memory they suggest that the IASP definition of chronic pain could be recast to read that 'chronic pain is a persistence of the memory of pain and/or the inability to

extinguish the memory of pain evoked by an initial inciting injury' (p. 93). They go on to contend that treatment of this persistent memory could be explored using novel pharmacotherapeutic approaches, currently in animal trials. They do not consider the possibility of psychological treatment in memory and learning although there is a quantity of published work in this area.

I suggest that we will continue to see new definitions and theories as the complexity of chronic pain is explored in the coming years. However there seems to be a need for work which draws together the qualitative and quantitative approaches. Connections need to be made more explicit between the 3rd person and 1st person science – this is returned to later in this chapter after the consideration of Focusing.

Materialistic theory

Hardcastle (1999) uses physiological and neurological pain imaging data but takes her philosophical stance from materialism, claiming that all mental causes are physical. This biological stance suggests that pain is correlated with some event or events in the body and very firmly states that pain should not be identified with the experience of pain. This does not detract from research findings that suggest that psychosocial factors are involved, but she is clear these are involved in the pain experience, not in pain itself. The logical consequence of this is that psychogenic pain, or pain of psychological origin, cannot exist because there is always a physical, bodily reason (even if we are yet unable to determine what it is). She states that the IASP definition is inherently flawed, claiming as it does that 'pain is the same as the experience of pain' (p162) and therefore that pain may not be connected to any physical cause or event. She notes that 'there is no other sensory process about which the scientific community makes that charge' (p162).

This theory of pain is challenging to some groups of clinicians, particularly those who see non-specific CLBP as a diagnosis of convenience disguising socioeconomic, work-related or psychological reasons (Andersson, 1999). Here the suggestion is that the patient is somatising; that CLBP is 'a problem of mind rather than of biomechanical dysfunction' (May, Rose, & Johnstone, 2000, p.

223). Patients robustly deny the fact that psychological factors are involved in their pain, citing the inability of medical staff to provide a firm diagnosis, a medical reason, for their pain. (Verbeek et al., 2004). The problems in the consultation room with a clinician and patient coming from completely different perspectives (psychosocial distress or physical reality) are easy to imagine. Further support for the patient's perspective of an organic or physical cause for the pain is provided by a study that showed that 40% of patients referred to a multidisciplinary pain centre had incomplete or inadequate diagnoses. On further investigation in 98% of these patients an organic cause for their pain was identified (Hendler, Bergson, & Morrison, 1996). This is food for thought and, perhaps, support for a materialistic theory of pain. And the continuing laboratory work, as exemplified by Apkarian and others, does seem to move away from a psychogenic explanation towards a focus on the role of the brain in the perception of pain.

Hardcastle (1999) takes her argument further by suggesting that the everyday (or folk) concept of pain is imprecise and confused, not capturing the scientific complexity of chronic pain. Her stance on this is eliminativist, that those concepts should be replaced by 'correct', scientific ones. It seems sad that she wants to discount folk theories – especially as the evidence from papers such as those cited above suggest that folk theory also holds to an organic basis for pain, rather than a psychogenic one. Although sympathetic to her argument that psychogenic pain is a myth (because, from a pragmatic viewpoint rather than materialist, there seems insufficient evidence to say that an organic cause cannot be isolated) it does not necessarily follow that everyday concepts should be eliminated. This approach reduces and dehumanizes the person with the pain, suggesting that their understanding of their subjective experience counts for nothing in the scientific discourse. Hardcastle's (1999) renunciation of everyday concepts disallows people to make meaning of their pain in any other than a scientific framework and sets a monumental (and probably impossible task) of changing beliefs. Chapman et al (2000) suggest that there are limited studies on the folk concept of pain, citing just one paper (Aldrich & Eccleston, 2000); it could be argued that a number of qualitative studies which consider the meaning

of pain for individuals (some of which are discussed below) are also based on the folk concept of pain.

Theories of pain can helpfully engage people in thinking about their own perspective on pain. Exciting though the laboratory work by Apkarian and other is, it seems to lack a humanity, bringing everyone to the level of their brain cells and activity. This position does not sit comfortably with the phenomenological philosophy (more about that in the next chapter) which underpins this research. This study is drawn to Melzack's theory with its potential for both 1st and 3rd person science to co-exist.

Models of pain

As with theories of pain, there have been a variety of models of pain suggested over the years from different traditions. Models base themselves on particular theories and seek to develop an approach which takes the theory forward into a treatment approach. For instance, a purely biomedical model would treat chronic pain with medication, exercise or invasive interventions but would not consider the psychological aspects of treatment. Within chronic pain the biopsychosocial model is the most commonly seen. It has a number of sub-models such as the fear-avoidance model, the diathesis-stress model and the social communication model on which slightly different treatment protocols may be based.

Biopsychosocial model

The biopsychosocial model describes how the experience of pain is dependant on the interaction of biological, psychological and social factors, and has been explained in the following way:

Predispositional factors and current biological factors may initiate, maintain, and modulate physical perturbations; predispositional and current psychological factors influence the appraisal and perception of internal physiological signs; and social factors shape the behavioral responses of patients to the perceptions of their physical perturbations. (Turk & Flor, 1999, p. 20)

It is interesting to note that the development of these models would not have been possible without the general acceptance of the gate control theory of pain which enabled a place for psychological factors in pain. The focus of the

biopsychosocial model is not on the disease itself but on the illness behaviour and the changing or dynamic processes inherent in that behaviour. This model of illness behaviour was applied to CLBP (Waddell, 1987) and led to the development of fear-avoidance models such as the one below (Figure 1.2), which relates to chronic musculoskeletal pain.

Figure 1.2 shows how CLBP can become a self-perpetuating cycle. It presupposes an initial injury and the response of the person to the experience of the pain determines whether or not they become enmeshed in the pain cycle. Catastrophizing, or seeing the pain as threatening, leads to avoidance of activity, to further pain from disuse, and back around the cycle again. Using this model leads to modes of management which seek to break the cycle, in particular using input from cognitive-behavioural therapy (CBT) to challenge the catastrophizing. It relies heavily on the psychological factors in describing what may be happening, little attention is paid to the physical factors (only in the initiation of



Figure 1.2: Fear-avoidance model (Vlaeyen & Linton, 2000, p. 329)

the pain) or social factors. Working with this model may limit choices that healthcare professionals make in considering management options and a recent randomised controlled trial using this model produced some interesting results (Woods & Asmundson, 2008). Although participants in the trial had improvements on many measures related to fear, they failed to improve in the primary outcome measure – that of reducing their disability.

Although the biopsychosocial model is the one that dominates chronic pain currently there is some challenge to it from the cultural and neurophenomenology perspectives. Grace (2003) argues that the biopsychosocial model has been used to fill ‘the vacuum created by concerns about the role of the dualism of mind and body’ (p. 43). She sees it being used as an explanation of purported causal relationships between the different domains and argues that, usually, these relationships are not supported by consideration of the processes involved. In this study use is made of the biopsychosocial model, but the discussion (Chapter 5) does consider how the processes of Focusing enable an embodiment rather than a dualism of mind/body. This is possible because Focusing is based on an experiential approach to meaning (and pain) whereas cognitive psychology is the approach used in the biopsychosocial model.

Diathesis-stress model

In an attempt to integrate earlier models and place a more even weighting on the factors the diathesis-stress model has been suggested (Asmundson & Wright, 2004). An initial physical pathology is needed to set the cycle in progress. As above, they suggest that in order for the cycle to continue the pain has to be appraised as threatening. However, they go on to suggest that this is likely to happen if the person has a predispositional vulnerability factor (perhaps an anxiety), that is, the person has a future-orientated preparedness and, when the negative event occurs (pain), they develop cognitive and behavioural actions which maintain this input. This identification of a predispositional factor is reminiscent of the early work by Engel when he suggested that there might be a pain-prone personality. The language used now is rather more tentative and these factors are seen as a part of the whole picture rather than a defining tool. Asmundson and Wright also include social factors, with social modelling and learning influencing the manner in which a person interprets and responds to pain.

Social communication model

There is a recent argument made that a model is needed that explicitly focuses on social factors (interpersonal processes), rather than on the biophysical or psychological factors (intrapersonal factors) so that human needs within pain can be addressed (Craig, 2009). The social communication model uniquely includes

not only the person with pain but others too, whether they are family members, healthcare providers, or others with whom the person with pain may come into contact. It explores the intrapersonal factors (what the individual brings to the painful experience) from both perspectives; for example how the person with pain might express their experience and how another person might assess that experience. So issues such as empathy are involved in the intrapersonal factors. Interpersonal influences on pain consider the experience and expression of it within the constraint of social and environmental settings. For instance it may be that it is felt to be socially unacceptable to show signs of pain; people with CLBP have reported that they feel no-one wants to spend time with someone who is in pain (Walker, Sofaer & Holloway, 2006). This model could be applied in a larger frame – perhaps informing public policy and governmental response.

This model humanises an approach to pain. It ‘blames’ less and makes a more equal relationship between the person with pain and others.

Challenges from sociology

Social science has both challenged and informed some of the above models and theories, exploring pain and suffering through narrative, art or literature to find ways of understanding the complexities of the emotional response to pain (Charon & Montello, 2002; Frank, 1995; Morris, 2001). It has frequently done this by focusing on the person rather than the pain in an attempt to de-medicalize the concept of pain. The methods employed are often those of illness narratives or phenomenological accounts which allow a personal response to pain and suffering. This brings an emphasis on the meaning of the pain to the individual rather than the management of it (Bendelow & Williams, 1995). There is a suggestion that this approach enables a transcension of the body/mind dualism in which pain is often found and a reclaiming of pain ‘from the exclusive jurisdiction of medicine’ (Bendelow, 2006, p. 69).

These varied (but frequently overlapping) theories and models encapsulate a variety of opinion and data from a variety of experiments and theoretical positions which are called into use clinically with a variety of consistency to support a plethora of management options for CLBP. Before being swung in

different directions by whichever is the prevailing idea of the moment it is salient to consider the following comment by Oliver Sacks:

These new insights of neuroscience are exciting beyond measure, but there is always a certain danger that the simple art of observation may be lost, that clinical description may become perfunctory, and the richness of the human context ignored.

(Sacks, 2008, p. xiv)

Perhaps that is why I am constantly drawn back to McCaffery's definition and theories and models of pain which accommodate the concept of being human; they place the person with pain at the centre and offer the possibility of humanising the experience of pain.

Current management of CLBP

In light of the personal and economic impact of CLBP there has been much interest in identifying which of the manifold treatments currently available are useful in managing the cluster of symptoms with which people present. These strategies include manual treatments, medications, psychological treatments, complementary therapy, traction and supports, exercise, invasive treatments, education, TENS, self-management and surgery.

National guidelines

A clinical guideline from the National Institute for Health and Clinical Excellence was published in May 2009 (NICE, 2009). It should be noted that this guidance covers low back pain from 6 weeks to 12 months and not specifically CLBP. It suggests that manual therapies, exercise, acupuncture courses and combined physical/psychological courses should be offered along with drug therapy, appropriate surgery and aligned educational materials. Traction, injections, TENS and stand alone educational programmes are not recommended. A similar report, undertaken by SBU – the Swedish Council on Technology Assessment in Health Care (SBU, 2006) graded the available evidence for many current therapies for CLBP (See Figure 1.3).

The plethora of available therapies is indicative that many of them are not effective for many people, and generally a combination of approaches is

Chronic low back pain	NSAIDs	2
	Specific exercise	1
	Exercise, including components that affect behavior	1
	Multimodal rehabilitation, including psychological methods	1
	Tricyclic antidepressants	3
	Weak opioids	1
	Spinal cord stimulation (SCS)	2
	Behavioral therapy	2
	Acupuncture	1
	Harpago (herb)	3

Figure 1.3: Evidence for treatments for CLBP. Evidence grade: 1=strong scientific evidence, 2= moderately strong scientific evidence, 3=limited scientific evidence. From SBU, 2006

undertaken. This is hardly surprising considering the complexity of pain (as described above) and the anatomical complexity of the lower spine. In assessing effectiveness outcomes such as reported pain reduction and improved function are generally considered. As CLBP is such a complex problem, it may be that these are not the outcomes which are of most import to the patients themselves.

These pharmacological, invasive and rehabilitation interventions will not be discussed further, as this study is considering the impact of using Focusing, a psychological self-help skill (see later section). The remaining discussion is constrained to the use of psychological therapies in relation to CLBP, looking closely at the recent use of mindfulness meditation in particular.

Psychological approaches to CLBP

Psychological interventions in the management of CLBP are now seen as almost routine adjuncts to the medical and exercise treatment strategies. The development of the gate control and neuromatrix theories provides the theoretical underpinning for these approaches, and the biopsychosocial model provides the framework in which they are placed. Behavioural approaches to managing chronic pain have been widely used since the publication of Fordyce's (1976) seminal book *Behavioral Methods for Chronic Pain and Illness* (McCracken,

2005). These methods aim to change pain behaviours – such as avoiding physical activities – by using techniques such as goal-setting and pacing. It has been observed for many years that CLBP is associated with behaviours and misconceived beliefs about pain which may feed into concomitant difficulties such as depression. The behavioural approach was therefore modified when some of the insights from cognitive therapy were added (Turk, Meichenbaum, & Genest, 1983); leading the way to the rapid growth of cognitive-behaviour therapy (CBT) in chronic pain management. See Figure 1.4 for a diagrammatic outline of CBT as taught in many pain management programmes.

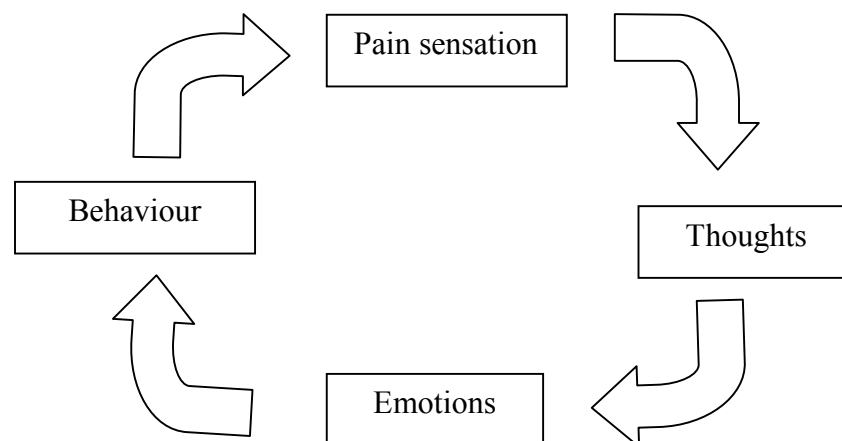


Figure 1.4: CBT – modelled on pain

Cognitive models assume that a person's distress in relation to an event (eg an increase of pain) is a consequence of their perception of that event rather than a direct reaction to it (Adams, Poole, & Richardson, 2006). They identify features such as negative thoughts and aim to change the way people think about their pain. CBT combines cognitive and behavioural approaches. It is also worth noting that a CBT approach aims not only to alter behaviour but, if thoughts are changed, there is a possibility of altering emotions as well. There have been a number of systematic reviews of psychological interventions for CLBP in recent years (Guzman et al., 2001; Neilson & Weir, 2001; Van Tulder et al., 2001) which have some evidence for the efficacy of this approach. A meta-analysis of psychological interventions for CLBP found they offered positive effects for pain intensity, pain related interference, health-related quality of life and depression

(Hoffman, Chatkoff, Papas, & Kerns, 2007). In particular CBT and self-regulatory (eg hypnosis) treatments were particularly useful. In an interesting development to explore the efficacy suggested by the above meta-analysis (Morley et al., 2008) a methodology of clinically significant change was used to answer the question – does the treatment provide measurable benefit in the clinical situation? They concluded that between 1 in 3 and 1 in 7 patients (depending on the outcome measure) made clinically significant gains using a CBT based pain management programme. This could be considered as a ‘number needed to treat’ and, although the ideal would be that every patient improved with treatment given, realistically somewhere between 3 and 7 is reasonable. (In acute pain the NNT for morphine injection to treat pain is 2.9 – that is for every 2.9 patients given the injection 1 will have a reduction of pain by 50% (Bandolier, 2007)). The evidence is that psychological approaches offer effective techniques for managing CLBP. However many approaches are used, although CBT dominates, but all seem to have some effect.

Contextual CBT (CCBT)

CBT approaches to chronic pain are purported to work around challenging erroneous beliefs, an attempt to change thoughts and meanings. These function within a dualism which holds that our minds (thoughts) control our body (behaviour). This logic has been challenged recently with some evidence that improvements to symptoms during CBT-based programmes occur prior to learning specific cognitive interventions (Longmore & Worrell, 2007). This does not mean that CBT is ineffective but some pain management centres have started to shift focus from the content of the thoughts to the context of them. This growth in the concept of contextual CBT (Hayes, 2004; Hayes & Batten, 1999; McCracken, 2005), in which psychological events are seen as ongoing and inseparable from the historical and social context, places an emphasis on the verbal processes involved in shaping one’s reactions and responses to events. CCBT is an acceptance-based approach, heavily dependent on relational frame theory, as espoused in Acceptance and Commitment Therapy (ACT) (Hayes & Batten, 1999; MAMI Group, 2006; Segal, Teasdale, & Williams, 2004).

ACT is based on six core processes or positive psychological skills and mindfulness is a key component, particularly associated with acceptance and cognitive defusion (separating thoughts which are blended together) – see Figure 1.5.

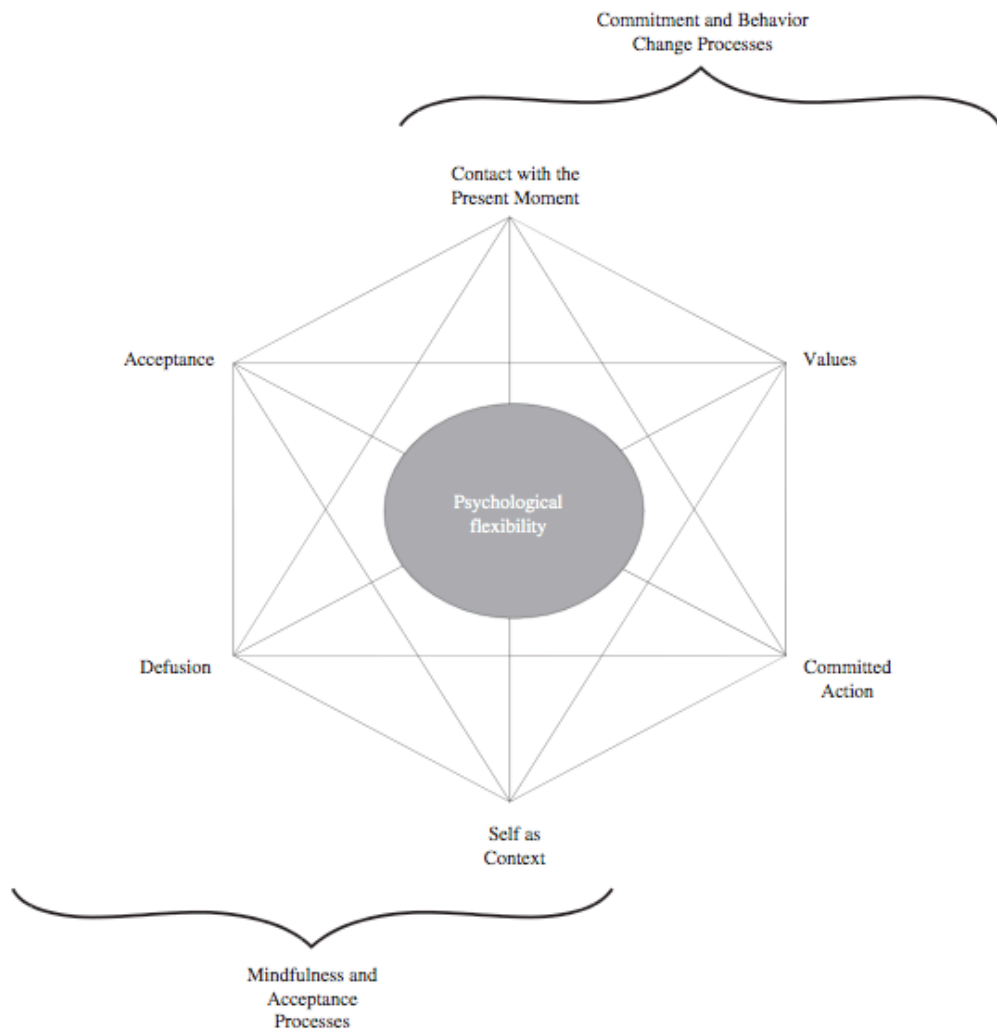


Figure 1.5: A model of the psychological processes in ACT (Hayes, Luoma, Bond, Masuda, & Lillis, 2006, p. 8)

There are a limited number of studies which provide evidence for the effectiveness of ACT in pain. A paper which gives an overview of ACT (Hayes & Batten, 1999) identified only two – an unpublished dissertation (Geiser, 1992) and laboratory-based comparison using the cold-pressor test (Hayes et al., 1999). The latter looked at the impact of control-based and acceptance-based rationales on the participants' pain tolerance, indicating that the acceptance rational may

encourage individuals to distance themselves from their private events and enable them to experience the consequences of their action. It would appear that the whole ACT package was not used in this study. This selective use seems to be prevalent in other pain and ACT-related studies. For instance, McCracken (2005) has taken some of the aspects (in particular values, acceptance and mindfulness meditation) and incorporated them within a residential chronic pain management programme. On the other hand, it may be that this aspect of ACT is more easily identified and isolated in research. In the UK most of the available work on acceptance and values in chronic pain comes from the Royal National Hospital for Rheumatic Diseases, Bath (see, for example, McCracken & Vowles, 2008).

Mindfulness meditation (MM)

The seminal paper on mindfulness mediation and chronic pain (Kabat-Zinn, 1982) presented results which suggested a ‘pronounced decrease in severity and frequency of pain over a 10-week period’ (p 44). Although Kabat-Zinn published some follow up studies, there seems to have been little interest in MM and chronic pain until recent years when an interest in acceptance and chronic pain seems to have sparked further studies. MM has been defined in a number of ways, generally in terms that describe it as “simply attending, without judgement, to sensations, thoughts, emotions or other perceptions as they arise in the moment” (J. W. Carson et al., 2005). A recent consensus suggests it has two components (i) ‘a self-regulation of attention so that it is maintained on immediate experience’ and (ii) a manner which is characterised by ‘curiosity, openness and acceptance’ (Bishop et al., 2004, p. 232). There is one report of a pilot randomised controlled trial where MM was used with experimental pain; the control group using guided visual imagery (Kingston, Chadwick, Meron, & Skinner, 2007). In this study of healthy students it was found that pain tolerance increased in the mindfulness group, but that this was not related to an improvement in mindfulness skills – a comment which resonates with the findings noted earlier by Longmore and Worrell (2007) in relation to CBT.

In relation to mindfulness meditation and CLBP there is a mixed methods study which reports both data types in separate articles using MM with older people.

From the quantitative results they demonstrate a significant change in pain acceptance (Morone, Greco, & Weiner, 2008) and the participants reported less pain and improved sleep, attention, well-being and quality of life in their diaries (Morone, Lynch, Greco, Tindle, & Weiner, 2008). Looking more broadly at the processes of MM and chronic pain there is some suggestion that it can lead to behaviour patterns which are less caught up in distressing thought and emotions (McCracken, Gauntlett-Gilbert, & Vowles, 2007) and there is some support that teaching it remotely, via videoconferencing, may be effective (Gardner-Nix, Backman, Barbati, & Grummitt, 2008).

Although the published work on the use of mindfulness meditation and chronic pain is growing there is little that considers the patient experience in a qualitative manner, using that information to explore the underlying processes of the intervention. There has been some attempt to identify the processes in a quantitative manner (McCracken & Thompson, 2009), placing a number of cognitive-behavioural components into four categories: acting with awareness, present focus, responsiveness and social awareness. The first two were shown to have significant correlations with patient function in chronic pain in areas including depression, use of pain related medications, psychosocial disability and pain related distress. Identifying these component parts is part of a project to discriminate the mechanisms of mindfulness from its roots in Buddhism, thus making it more acceptable within the Western medical model (McCracken et al., 2007). There is also some preliminary evidence that mindfulness meditation may reduce cortisol levels, (Galantino, Baime, Maguire, Szapary, & Farrar, 2005; Robert-McComb, Tacon, Randolph, & Caldera, 2004) a substance the body produces in response to stress cascades (including those of CLBP). Melzack (2005) suggests that the continuing presence of substances such as cortisol could activate the pain neuromatrix and generate pain experiences. Further studies into these physiological effects may also promote acceptance of interventions such as mindfulness mediation. Finally, with more ready access to neuroimaging, it is not surprising to find studies on MM. There are some preliminary results showing that MM may be associated with structural changes to parts of the brain important for sensory, cognitive and emotional processing (Lazar et al., 2005), and that it may also reduce negative affect through the labelling of negative

affective stimuli (Creswell, Way, Eisenberger, & Lieberman, 2007). It must be noted that these are general studies and not related to pain processes.

Client-centred psychotherapy

As Focusing is related to client-centred psychotherapy it is of interest to note one paper which reported a pilot study comparing client-centred group therapy with exercise for CLBP (Machado et al., 2007). A randomised controlled trial of 33 patients (follow up was 21) it showed that immediately following the interventions the exercise group improved significantly, but at six months there were no statistically significant differences between the two groups in all outcome measures – pain, disability and depression. Some of the concepts in client-centred therapy have been brought into clinical consultations and a ‘patient-centred’ communication approach. There is some evidence that this type of approach is useful for patients with musculoskeletal chronic pain in significantly reducing psychological distress and trends towards improving pain and mobility (Alamo, Moral, & de Torres, 2002). However the literature in this area is very limited.

Self-management

With the financial impact of CLBP on the health and social services budget (mentioned above), it is perhaps surprising that there have not been greater initiatives by the government in relation to chronic low back pain. The Department of Health’s white paper *Self care - a real choice* (DH, 2005) is seen as a key component in supporting people with long-term conditions. Self-care skills training could include interventions such as Focusing, and the concept of self management in chronic illness (including chronic pain) is receiving increasing attention. The Expert Patient Programme is one such initiative which has been specifically developed for people living with long-term conditions and aims to support people in increasing their confidence, improving their quality of life and to better manage their condition (Donaldson, 2007). Although self-management is perceived by health professionals to be mainly educational, patients perceive it as something which enables them to have order in their lives (Kralik et al., 2004). An Australian community-based self-management study (Blyth et al., 2005) showed that using active strategies (exercising or relaxation) reduced the likelihood of having high levels of pain related disability. They

suggest attention should be given to improving the uptake of active self-management strategies for chronic pain in the community (Their study is also of interest because it is one of few which recruit from the community without reference to health care providers.) So the story of pain widens to include government and financial aspects.

This chapter started by suggesting that stories were important. Having considered the definitions, theories and models of pain it then reviewed broadly the current management of CLBP, with a narrowing of focus to the psychological interventions. But if stories are important then the voice of the person with CLBP must be heard, not just that of the clinician defining and treating the CLBP. The following part of this chapter considers the meaning that CLBP has for the people who live with it, and those with whom they interact.

The meaning of CLBP to the individual

“The neglected encounter between pain and meaning”

(Morris, 1991, p3)

David Morris, a leading thinker and writer who considers the cross-roads of biology and culture, (1991, 1999) argues, from a biocultural perspective, that meaning is fundamental to the experience of pain. He states that, made by our minds and cultures, meaning is ‘intrinsic to human pain’ (1999, p. 118), and that pain cannot exist without meaning. This leads to a suggestion that an embodied approach is needed; that the physiological and nociceptive models are inadequate. The perception of pain from a biocultural perspective, includes nociception but is inextricably tied up with meanings associated with emotional, psychological and cultural experience. From this perspective the meaning of pain is its intrinsic feature and can only be found when the person with pain is given a voice. This voice can be found in qualitative studies which report the participants’ voice (a 1st person approach) and also in those quantitative studies which use tools such as those that measure quality of life (a more 3rd person approach) to report the meaning that pain has for the individual. A brief review of these studies in relation to CLBP follows. But meaning also has a more philosophical aspect and so there is a short discussion on what meaning is and how it fits in this study prior to the review.

Meaning

Meaning, or seeking changes in meaning, is a central tenet of this study. On a day-to-day basis people think they know what is meant by the word ‘meaning’. For instance, someone might say that their CLBP means that they can’t do what they want to do. The meaning in this comment is made from many other, unspoken meanings (I can’t bend to weed, I can’t reach into a cupboard. I can’t sit still to see a film ...). So the meaning that is articulated is derived from multiple meanings behind that.

Meaning, and making meaning, has long been a philosophical enterprise. Frequently colour, or the meaning of a different colour, has been considered. Within the terms of linguistic theory one might say that, for instance, the word ‘blue’ means or signifies (in Saussurian terms) a particular colour. Derrida might suggest that the meaning is ascribed not because of the essence of blue, but because it is not red or brown; the meaning is about difference. These approaches seem to some extent to take words away from a context and to isolate them; blue is isolated from red because it is different. This type of approach to meaning feels uncomfortable in this study because meanings are personal to the individual but contain some connectedness to others as well.

Rarely are words using singly and if someone says ‘the sky is blue’ it may mean that it is a nice day, they are feeling happy about it, it’s not raining etc. The meaning of what is said carries far more than just defining a colour. On the other hand, they could say ‘I’m blue’. Others in our culture would understand that to mean that they were down in the dumps, sad, not their usual cheerful self and may wonder why that is. The listener would not expect the speaker to be the colour blue. The meaning of blue in these cases has very different feel; it is not that blue is not red. There is an emotional sense to blue here, one that may produce a feeling in someone.

Johnson’s book, *The meaning of the body* (2007) draws on the work of Dewey and Damasio. He suggests there are three important elements in defining meaning. Firstly, meaning is relational or interconnected. It relates to different qualities (frightening/joyful), events and experiences for example. It is also

relational in time, to the past, present or future. Secondly, meaning is social; it exists in shared communication (which may be with yourself or others). Lastly, meaning is grounded in the body and in bodily interactions. Applying his criteria to the statement 'I'm blue' one can see that to get the meaning one has to know (or have learned) that there is a quality of sadness, that it is about now and this implies that there have been times in the past (and may be in the future) when the speaker is not feeling blue. There is a social element – it may be said to oneself, but even that holds a possibility of engaging with the meaning and may lead to explorations of why one feels blue. If the thought is shared with another person they may ask why. However, this social element of meaning also means that there is some selective choice in what is spoken or not spoken (even to oneself). Lastly there is a bodily response to the statement. Someone might experience a slight heaviness in my chest when they say these words, and there is evidence from the realms of neuroimaging that there will be neuronal connectivity in various parts of the brain linked to the emotions (Damasio, 2000).

Johnson's overarching theme is that the body and mind are one entity, rather than the more commonly held Cartesian dualism, and that meaning is therefore found in the body. Our mind, he argues, is not a separate entity, but embodied. Or, as Damasio (1996) does, one can invert Descartes and say 'I am, therefore I think'. Gendlin (1962/1997) would probably not quite agree with Damasio, his work suggesting that felt-experience is pivotal in creating meaning for people. For Gendlin meaning-making is situated firmly in the body, and he might be paraphrased with 'I am, therefore I feel'. This approach to meaning, one which is situated in the body, acknowledges the social needs of sharing meaning and encourages interconnected and relational aspects is one that will enhance the meaning that may be found in this study. A comment on the centrality of meaning to qualitative research methods is encouraging: 'human beings...act out of an awareness of the meaning of the situation...so meanings...are basic units of research' (Ashworth, 2000, p. 139).

Meaning and quality of life

The literature shows that CLBP has a major impact on the individual. Often, in studies considering the meaning pain has for people, researchers will use the participant's quality of life scores as a gauge. There is a large body of pain literature which considers the impact of pain on the individual's quality of life (QOL). Much of it shows that QOL measures are sensitive to the treatment of pain, although sometimes a reduction in pain is not always reflected with an improvement in QOL (Niv & Kreitler, 2001). They conclude that it is necessary to consider a person's QOL to treat pain successfully. Rather than discuss the issue of QOL and CLBP here in detail that discussion is placed within the context of finding a QOL measure that would be appropriate to this study; this can be found in Chapter 3. A smaller number of particularly relevant studies are considered here which focus more explicitly on the meaning of the pain to the person with it.

In short, it can be considered that QOL is related to a person's beliefs and the meanings placed on parts of life. One study indicated that QOL was associated more strongly with a person's beliefs than with the intensity of pain suffered (Lamé, Peters, Vlaeyen, Kleef, & Patijn, 2005). This is one of the few quantitative studies considering beliefs and meaning in chronic pain. In reviewing the available literature the frame of reference was widened to include pain other than CLBP – some salient papers looking more widely at chronic pain are therefore included. Most studies describe meaning at a certain point in time for the person and only one study could be found in which the outcome was specifically to identify if meaning changed (Lewandowski, Good, & Draucker, 2005). Some changes were identified in the study which used guided imagery as the intervention.

In briefly describing the findings from the other studies reviewed I will consider the meanings ascribed to chronic pain in physical, psychological and social domains. This follows the dominant biopsychosocial model.

Physical meanings

Specific to CLBP there is evidence that the pain disrupts the mundane activities of daily life, such things as sitting and standing (Osborn & Smith, 2006). These change from being done without thought and effortlessly to activities which require forethought. Interestingly a quantitative study showed that people with chronic pain spent more time lying down and less time sitting than people without pain (van den Berg-Emons, Schasfoort, de Vos, Bussmann, & Stam, 2007). People with CLBP find their pain interferes with household tasks, raising their children and how they engage in leisure activities (Strunin & Boden, 2004).

There are reports that chronic pain generally means living with a reluctant body; one which feels fatigued and in pain with a loss of energy; one that feels that the pain is never-ending and restrictive. (Lewandowski et al., 2005; Paulson, Danielson, & Söderberg, 2002; Söderberg, Berit, & Norberg, 1999). Sleep is disrupted and the pain symptoms may be unpredictable (Johansson, Hamberg, Westman, & Lindgren, 1999; Ong, Dunn, & Croft, 2006).

There is also a strong meaning that the pain is real, leading to a search for the bodily ‘proof’ of pain (Richardson, 2005; Walker, Holloway, & Sofaer, 1999). This is explored further below in relation to relationships with healthcare professionals. Pain is seen as proof that something is wrong and needs to be investigated, that a diagnosis is required (Aldrich & Eccleston, 2000).

Psychological meanings

There has been interest from a sociological perspective on the meaning of self and one’s body in chronic pain. The painful part of the body may be seen as separate from the ‘real’ body or person (Osborn & Smith, 2006). Pain can challenge or threaten the ‘real’ self, causing an identity crisis (Aldrich & Eccleston, 2000). The meaning of pain becomes something which divides the body, providing contradictory selves. Even though there is a dichotomy, the painful self is embodied in the perceived ‘real’ self. In their exploration of this Williams & Bendelow (1998) suggest that the re-organisation of themselves leads ‘people in pain to find a meaning for their suffering, even if it is ‘dysfunctional’ from an orthodox (scientific) viewpoint’ (p139). This

embodiment of an unwanted self can be seen as one of a number of meanings attached to the effects of pain.

Other meanings include the loss of identity, hope, direction and credibility (Holloway, Sofaer, & Walker, 2000; Walker et al., 2006). People may feel empty and shy, be easily angered and carry a feeling of grief or bereavement (Paulson et al., 2002).

The invisibility of the pain can lead to self-doubt about it and self blame (Richardson, 2005; Seers & Friedli, 1996).

Social meanings

In the qualitative literature a recurring theme in the meaning of living with pain is that no-one understands. Amongst others Seers and Friedli (1996) show how important it is for people with chronic pain to have their pain believed by others. Osborn and Smith (1998) reiterate this in the CLBP population with an observation that diagnosis is particularly required by these patients. The disbelief of the medical fraternity when organic pathology is not present leads people to locate culpability for it “among clinicians who were confused or uncertain about diagnosis and treatment” (May et al., 2000, p. 223). Not even the doctor understands, and patients have to work hard to be seen as credible and their pain as legitimate (Clarke & Iphofen, 2008; Ong, Helen, Dunn, & Croft, 2004). There are also feelings that the doctor is not interested if the problem can’t be identified (Walker et al., 1999) and the importance of diagnostic tests in helping people make meaning of their pain is highlighted (Rhodes, McPhillips-Tangum, Markham, & Klenk, 1999).

The loss of employment and the related financial losses can lead to the social embarrassment of benefit claims (Patel, Greasley, & Watson, 2007; Söderberg et al., 1999; Walker et al., 2006). There is also loss of social roles and responsibilities within the household and in the community, leading to a restructuring (Strunin & Boden, 2004).

Social isolation can occur, with people withdrawing from others (Osborn & Smith, 1998; Seers & Friedli, 1996). This is seen as part of the stigma carried by people with CLBP (Slade, Molloy, & Keating, 2009). There is a feeling that they are not understood.

Other studies

There are very few studies which bring positive aspects to the meaning of pain. Pain has been seen as spiritual growth and self-growth by a small number of participants in studies (Aldrich & Eccleston, 2000) and Carson and Mitchell (1998) present their findings in a way that shows a forbearance and personal challenge to pain. This restitutive reading of narratives can be found in the work of Frank (1995) and others. However Richardson et al (2006) are keen to challenge this, finding ‘no sense of personal renewal or revival in the pain stories’ of their participants (p. 1583). There appears to be no discussion in the literature about this difference in findings or what the gain is, either for the person with pain or the health care professional, if a position of a restitutive reading of CLBP is taken.

It can be seen from the short review above that chronic pain (including CLBP) holds a number of meanings for people. However there is little literature identifying changes in meaning during interventions for pain. If beliefs are key to managing pain – and the CBT approaches to pain are based upon this premise – then an investigation into changed meaning seems appropriate. Focusing is an intervention which claims to enable meaning-making and the chapter now considers what it is and asks if it has a place in the management of CLBP.

Focusing

Trying to describe Focusing has been rather like trying to explain a complex and tantalizing poem to someone – it is possible to grasp parts, but difficult to make a whole. And like a poem, it is always more than: more than the words, more than the parts, more than the whole. In the information sheet for this study, it was described it in these terms:

Focusing gently enables people to develop a sense in their body about situations, problems or issues. When people make contact with these subtle and sometimes vague inner feelings, they can become aware of the meaning associated with them. Focusing

can help you change, enabling you to become more friendly towards what is happening in your body.

...

A typical Focusing session lasts between 30 – 60 minutes. It is a quiet process and you will take a little time at the beginning of each session to relax and gently start to become aware of the sensations in your body. The Focusing practitioner will help you to describe and explore these subtle feelings in a reflective way.

The next part of this chapter reviews the available literature on Focusing and pain, exploring Focusing in a way which will clarify why, as a process and skill, it seems to offer opportunities for people who have CLBP.

A definition of Focusing

Focusing is a special way of paying attention to yourself, so that you sense the whole way you are feeling about situations or issues in your life. This is different from just having emotions or just getting in touch with feelings. Focusing involves having a different kind of relationship with emotions and feelings. It's as if you are becoming your own good listener. The result is greater calm, wiser choices, and a deeper sense of connection to your own life and being.

(<http://www.focusingresources.com/faqs.html#wif> downloaded 5.5.09)

Reviewing the literature

Searching for literature on Focusing and pain has been difficult. The term 'focusing' is a general word and brings many completely irrelevant references. Adding 'Gendlin' improves the accuracy, but many of the recent publications rely heavily on the review by Hendricks (2001) which is available most easily on the Focusing Institute website. There are a few books on Focusing, some written for psychotherapists (e.g. Purton, 2004) and others more directed at the self-help market (e.g. Cornell, 1996). Some edited books on psychotherapy or experiential therapy have chapters on Focusing (e.g. Iberg, 2002). The Focusing-related websites have some further literature and there is some information on pain and Focusing on blog sites. The literature on chronic pain and Focusing is extremely limited.

Gendlin (1996) is quite clear that Focusing is not a therapy, it is a naturally occurring process which was identified during research on outcomes during client-centred psychotherapy. However the available research on using Focusing is situated in the therapeutic environment rather than that of self-help. A thorough review by Hendricks (2001) considered over 80 studies which showed that during therapy clients' outcomes were related to their experiencing level when they were using Focusing. In her exploration of Focusing Wagner (2006) leans heavily on Hendricks to report studies that demonstrate Focusing as effective in managing problems as diverse as depression and addiction in client groups as diverse as prison inmates, the elderly, psychotic patients and children. On further inspection many of the studies are case reports (single and series) or published in non-peer reviewed journals such as the Focusing Institute's own journal *The Folio*. A certain amount of it is in the form of doctoral theses and much is, not surprisingly, in psychotherapy journals; not frequently encountered by pain clinicians. While this in itself does not negate the worthiness of the writing, it does mean that much has not been subjected to wider review in the scientific community. This presents Focusing with some credibility issues and is an area which those involved in Focusing will need to address if it is to relate outside the psychotherapy and 'complementary or alternative' worlds in the UK. No qualitative research studies using Focusing could be located, something which might be considered surprising.

Focusing and healthcare

In the context of using Focusing in healthcare Katonah (1999, p. viii) defines it by saying what it does, rather than what it is: 'Focusing accesses forward movements and healing of the whole person through newly emerging meaning-making as it is being created through the body'. This definition emphasises the importance of seeing Focusing as a process, not an end in itself; a process which leads to a carrying forward, a kind of solving, the formation of something new and different (Gendlin, 1997), a way of making meaning. This aspect of Focusing links with the work being done in CLBP exploring the meanings that people ascribe to their pain. Writing for nurses Klagsbrun (2001) suggests that one area in which they can use Focusing is to enable patients to get a distance from the pain and sense how their bodies would feel without pain. She also sees

its benefits in dealing with the feelings that accompany pain, such as anger. Her support for this is provided by a single case report.

Focusing and chronic pain

There is very little literature looking at Focusing and chronic pain, and even less that addresses CLBP in particular. What is available is discussed below, much of it is in the form of personal stories or case studies.

In a DVD recording of a talk at a Focusing meeting (Wilson, undated) and article (van der Kooij & Wilson, 1998) the authors (British and Dutch) explore the impact that persistent neck pain has had as they partnered each other during Focusing sessions on the pain. They discuss the way using Focusing has changed from using it as a ‘delete’ button to try to get rid of the pain to finding Focusing enabling a development of an acceptance of the pain. This acceptance is something van der Kooij has to continually revisit, changing his outlook so much that he is able to say ‘I now feel [the pain] is part of a healthy and friendly process in which I am carried forward. The pain is still there [...] but my relationship with it has changed’ (van der Kooij & Wilson, 1998, p. 8). From Argentina Frezza (2008) writes of her 24 year experience of low back pain and reflects on the part that Focusing has played in enabling her to change the way she relates to the pain and on partnering other people who are Focusing with their pain. She comments on how much easier it is for people to search for a cause and treatments for their pain than it is to pay attention to what they are feeling inside. A description of a Focusing session in Australia with chronic neuropathic foot pain details how the sensation of the pain changed and, five weeks later, the person reported improved sleep, reduced medication use and the awareness of a different, more joyful, perspective on life (Stevenson, 1998). Ferraro (2008), in reporting an American case study, suggests that introducing Focusing to people with chronic pain works in four ways:

a) using *Clearing a Space*² enables people to become aware of their inner resources

² This is the first step in Focusing as described by Gendlin (1996). Taking as much time as needed the person quietly feels what is stopping them from feeling

-
- b) Focusing enables them to become active rather than passive
 - c) it instils an ability to identify and work with the pain experience
 - d) it engenders a sense of wonder at the body's ability to reveal the deep meanings of concerns.

There is a podcast available (Cornell, 2007) which mainly focuses on using Focusing with acute pain, but touches on practical aspects of using it with chronic pain. Cornell suggests that when Focusing with pain one needs to let go of the word 'pain' and sense into it without assumptions.

None of the scant literature above is of a robust nature, consisting of personal opinion or observation on single case studies. Within the arena of healthcare provision for pain there is a discussion in relation to the management of chronic migraine. Bärlocher (1999) briefly explains how his department in Switzerland combine cognitive, behavioural and body-centred approaches which include Focusing. They encourage patients to develop an inner relationship, not with their pain, but with their 'overall being' to enable people to connect to their own innate healing powers. Focusing is specifically mentioned in their patient information leaflet (Meyer, 2004).

Müller & Feuerstein (Müller, 2007; Müller & Feuerstein, 1999) describe using Focusing with chronic pain in a model they have developed with a German medical insurance company. Some details about the project are available as a conference slide presentation (Feuerstein & Müller, 2006). Focusing was part of a short pain management programme which included educational, cognitive and behavioural aspects. They report improvements in mood, and slight positive improvements in a 'readiness to change' questionnaire but say nothing about pain scores. There is insufficient information to properly assess the results and no 'control' or non-focusing group to provide comparison. The participants had 4 days training in the techniques preceded by an evening's introduction and

fine. Each problem (and there may be many) is acknowledged and eventually one is determined upon to take further with the Focusing process. IRF does not use this step but by taking time at the beginning to ground oneself in the body. One is then aware of the feelings that are there and then asks the body, 'Which sense needs my attention right now?'

followed up with a ‘maintenance’ evening. CDs and other support material were provided.

A recently published book, *Imagery for pain relief*, (Pincus & Sheikh, 2009) has a comparison of Focusing with hypnotherapy and metaphor therapy. Based on Gendlin’s writing the authors suggest that Focusing enables the client to access a lot of material in the subconscious (as does hypnotherapy) but, unlike hypnotherapy being awake then enables change to be made in the conscious processes. They suggest that Focusing is very similar to metaphor therapy but a crucial difference is that metaphor therapy relies on the therapist making suggestions whereas in Focusing the therapist (or companion if not in a therapy setting) stays out of the Focuser’s process. There is little evidence provided of the efficacy of Focusing with pain, it is engaging more with a comparison of the processes involved.

When considering the literature supporting the research in Focusing, it is notable that there is nothing published on Focusing and chronic pain in peer-reviewed publications. Although case studies may form the basis of qualitative research these seem to have been reported as anecdotes with personal observations rather than subjected to any rigorous analysis. The report of the pain management programme appears more audit based than research, and it was interesting to note that, although directly aimed at pain, any change to pain scores were not reported in the presentation.

Overall there is limited literature available, (there are no RCTs, just one cohort study and several case studies) some of which suggests that Focusing may be a useful tool in enabling people to manage their pain. However, as with a number of complementary approaches, if the standard method of assessing effectiveness of treatment as proposed by the evidence-based healthcare (see <http://www.medicine.ox.ac.uk/bandolier/> for further details) is taken, it is clear that the above literature is not of an appropriate standard. With research into ‘complementary’ approaches to CLBP it is frequently found that patients report positive experiences such as relaxation, which they find of benefit. Current models of effectiveness and cost-effectiveness struggle to assess these outcomes

with the conventional quantitative approaches (Thomas et al., 2005), so a study which combines both qualitative and quantitative outcomes may be in a position to assess both types of outcomes.

The role of Focusing in chronic pain management

As seen earlier the meaning that people ascribe to their CLBP and the beliefs they hold about it are important. Other areas of importance include acceptance and the use of active coping strategies. A new strand in the management of chronic pain which claims to address some of these issues is that of mindfulness, as discussed earlier in the chapter.

Detailing the advantages of MM McCracken lists: a sense of self as observer, a non-defensive approach to private experiences, creation of space between the observer and those experiences, allowing them to be seen without meaning, and showing the independence of the experiences and actions (2005, p. 81). It could be said that MM and Focusing are both non-judgemental, but they exhibit this in different ways. In mindfulness meditation one might notice that one feels anger; in Focusing the person might say, 'I am noticing there is a part of me (or something) that feels angry'. In MM one would acknowledge noticing the feeling of anger and then move on, in Focusing a response might be, 'I'm just letting that angry part know that I can hear it'. So instead of moving on to find distance, the distance is found through the feeling of anger not being you, but being just one part of you. This is known as holding that part in Presence, and it is this part of the process of Focusing which enables a safe curiosity about the issue. Whereas MM allows experiences to be seen without meaning the process of Focusing enables meaning-making through the process of description and resonating and the felt shift (Gendlin, 1962/1997). This ability to enable meaning-making, points to the possibility that Focusing may be a way to affect the meaning that people ascribe to their CLBP.

As detailed earlier in the chapter, MM is part of the ACT approach which has two main 'process' areas, that of mindfulness and acceptance processes, and those relating to commitment and behaviour change (see Figure 1.5). Both these are related to the processes of 'being present' and 'self as context'. Focusing too

has an emphasis on being present and it may be that an exploration of the processes of Focusing provides some possible links with this current movement in behavioural psychology in the management of chronic pain.

MM has a place within contextual CBT and the concept of effecting change earlier than within conventional CBT (which claims to impact at the level of cognitive content) is gaining ground with those looking at contextual change (Vowles, McCracken, & Eccleston, 2007). Building on the CBT model used earlier (Figure 1.4) the addition of Focusing may bring potential for change at the points shown in Figure 1.6.

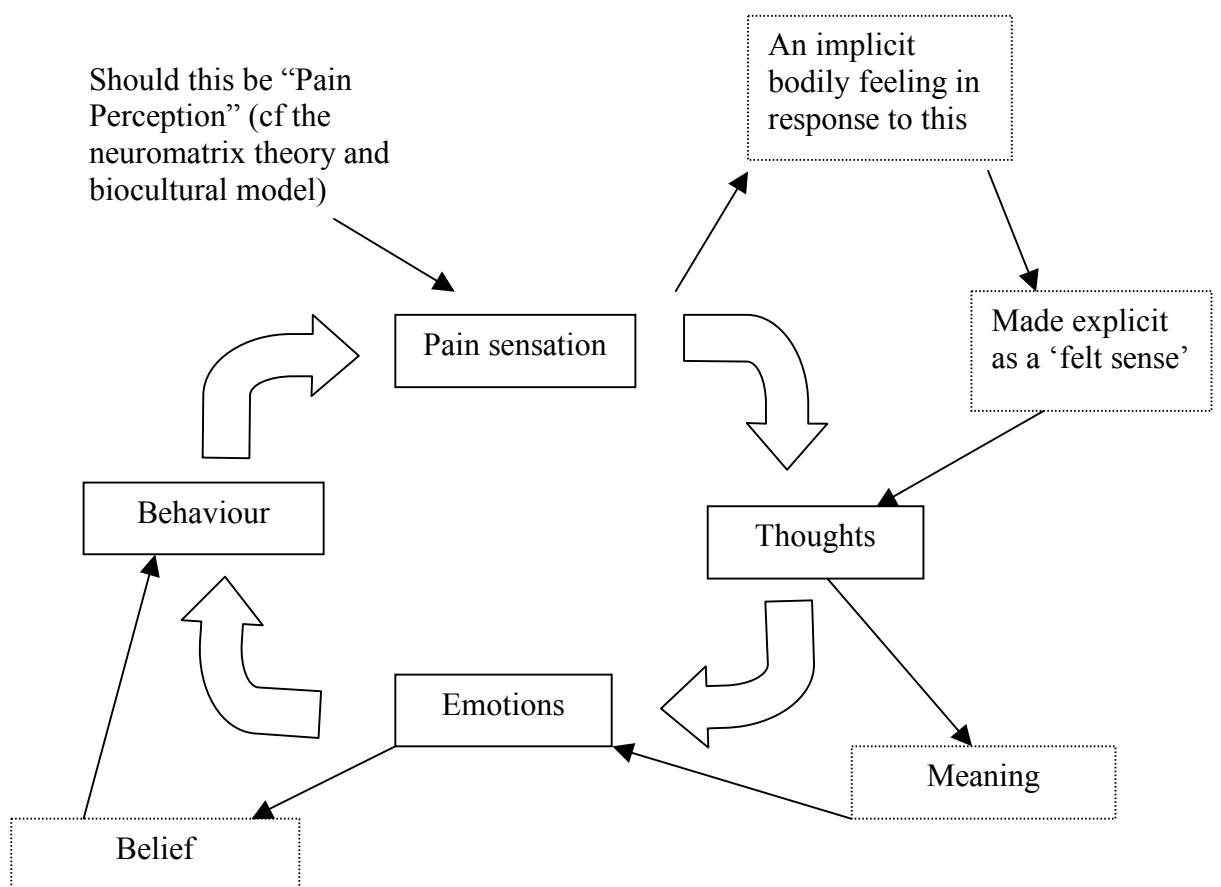


Figure 1.6: Incorporating Focusing into the CBT pain model

Developing the research questions

This brief exploration of CLBP and Focusing has identified a number of issues. It is clear that CLBP is a complex phenomena with physiological, psychological and social aspects, all of which have individual variations. Treatment and management options are manifold and rarely does one single approach work.

Recently MM has been incorporated into psychological approaches with some apparent effect. Focusing is a self-help psychological approach with some similarities to MM, but also some significant differences. There is little evidence of its efficacy but a examination of its underlying premises would seem to indicate that it may be a possible addition to the interventions available in the management of CLBP.

In reviewing the literature and current models of treatment for CLBP it becomes apparent there are two key research areas. Firstly, related to the emerging importance of meaning in CLBP, the primary question for this study became *‘What are the differences ascribed to the meaning of CLBP before and after using Focusing?’*

Secondarily, is it possible that any change in meaning can be measured? If so, by what and can those measurements be used to make meaningful decisions about the efficacy of Focusing? Would using Focusing bring any changes to pain scores? Would it affect any domains or areas of peoples’ quality of life? These are areas which have been measured in relation to studies of CLBP reported in the literature. Therefore a second question in this study is *‘Does using Focusing impact on pain scores and quality of life measures?’*

Summary of Chapter 1.

This chapter outlined the widespread nature of CLBP, with particular reference to the position in the UK. Defining pain itself was shown from different perspectives and this was followed by a discussion of current theories of pain, both from scientific and materialist perspectives. The neuromatrix theory will be used as the basis for this study. A consideration of models of pain introduced the concept of the biopsychosocial model, and some of its variants. Theories, definitions and models which promote a humanising approach will be used in this study.

The current management of CLBP was considered, including recent UK reports, and the huge variety of available treatment indicated the complexity of

managing, and self-managing, this condition. Current psychological treatments were explored in depth, with contextual CBT and mindfulness meditation being placed in context. The meaning of CLBP to the individual was reviewed and links made with quality of life. An understanding of meaning was suggested, based on Johnson's (2007) work which grounds meaning in the body, challenging the Cartesian dualism.

The available literature on Focusing, and its use in pain, was reviewed. It was shown that this is very limited but an exploration of the processes of Focusing suggest that it may have a place in the current management of CLBP and the possible places for these processes to interact were identified. Two research questions came from the literature review of pain and Focusing, one qualitatively based asking if Focusing changes meaning in CLBP, the second quantitative asking if using Focusing impacts on pain and quality of life scores.

Chapter 2 – Methodological considerations

Introduction

Living with chronic back pain is a real-life situation for many people. It therefore felt important that this study was based on an approach which enabled it to be embedded in people's day-to-day life. This led to two major governing issues. One was that whilst people were taking part in the study there should be no restriction on what they did outside of their Focusing during it. This can lead to a large number of issues, such as taking different medication with a change in effectiveness or starting to exercise more frequently, which may have some effect on the outcome of the study. Some studies attempt to control these issues, more of them seem to ignore them and not mention such changes in their results. So in this study the participants continued with their daily life, with all the variations that entails. But those variations are important and so there was a challenge to find a way of capturing those changes which seemed important to the participants in the data collection. Secondly, real-life for healthcare professionals means using both qualitative and quantitative measures to decide treatment options. A study which reflects this is more readily situated in the healthcare professionals context.

This chapter begins by considering the demands made by the research questions identified. They contain both qualitative and quantitative features and therefore a mixed methods research (MMR) approach is explored. As the question of meaning is the primary question an appropriate qualitative approach is first decided upon. Following this, appropriate aspects of qualitative and quantitative approaches will be explored and areas of possible conflict within MMR in relation to this study will be considered. Finally, using aspects from harmonic theory in music, a solution is offered to the possible conflicts identified. The conclusion of the chapter will lead to the decision to add a third question to the research study.

The research questions

What are the differences ascribed to the meaning of CLBP before and after using Focusing?

As shown in Chapter 1 there are many research approaches to eliciting information about the meaning CLBP has for people. Some of the studies used quantitative methods, such as questionnaires (eg van den Berg-Emons, Schasfoort, de Vos, Bussmann, & Stam, 2007) and others are based on experimental models of pain (eg Lamé, Peters, Vlaeyen, Kleef, & Patijn, 2005). Considering psychological approaches to managing pain there is a large body of quantitative work assessing the effectiveness of interventions (eg Ostelo et al., 2005). All these studies consider before and after differences and a number identify pre-defined meanings or beliefs that patients have before or after the interventions. So there is a substantial body of published work in CLBP which uses a quantitative approach to answer questions around meaning and pain.

The majority of the qualitative studies on the meaning of pain tend to capture the person with pain at a certain point in time (Walker et al., 2006; Paulson et al., 2002). Very rarely do they return to elicit changes; in fact qualitative research in CLBP is not often used to determine changes due to an intervention. This may be due to the methodological difficulties when using within-person comparative qualitative research, or the practical issues of dealing with the large amount of narrative data that is generated. However, in this study there was a desire to draw on the participants' experience both of living with their CLBP and of any change in that experience after they had been introduced to Focusing. It was important therefore, to find a methodological perspective which enabled understanding of the participants lives in the 'manner in which [they are] meaningfully lived' (Moran, 2000, p. 5).

Taking a quantitative approach (eg a questionnaire) would mean anticipating what this manner might be, quantifying it and then testing for changes. This approach makes it difficult for people to allow new areas to come into focus after an intervention. Asking people to identify their own specific areas (as in the respondent-generated QOL tools discussed in Chapter 3) is an improvement but still does not allow for different areas to be brought in later. A qualitative

approach would enable the participants to have control of the areas in their lives they feel are affected (or not affected) and be able to comment on them, using their voice and in ways which they find comfortable. So the challenge then was to find a qualitative method which would foreground this life-experience. Phenomenology was identified as a possibility and it is discussed more fully later in the chapter.

Does using Focusing impact on pain scores and quality of life measures?

This approach to this question was much more easily answered – a quantitative stance is almost assumed. Scores and measures are the language of numbers. Even with respondent-generated measures the outcomes are quantified and differences measured. The actual choice of the measures used in this study is discussed in Chapter 3, although how this choice challenged and impacted on the research approach is discussed later in this chapter. As the design of the study continued this question also seemed a little smaller in its place in the study and therefore less influential than the primary question about meaning.

These two questions require different approaches to answer them, needing a research methodology which encompasses both qualitative and quantitative aspects. The two aspects are not in the study to back each other up – to enable triangulation with one set of data confirming (or not) the other. In fact the overall title of the study – about the value of Focusing in CLBP – could be answered by either approach. Using a mixed methods research (MMR) approach brings something extra – a ‘more-than’ one or the other and also responds to the concerns in the opening paragraph that the research reflects daily life both of the participants and of healthcare professionals. However, before exploring the development and concepts of MMR, this chapter will discuss the choice of the qualitative methodology which became the theoretical driver for the study. Then MMR will be considered, including the choice of an appropriate MMR design, and finally some of the challenges this approach brings to the research study will be explored.

Phenomenology – a qualitative methodology

Why phenomenology?

There are a wide number of qualitative approaches to research, and a vast literature to support them. Some lend themselves less readily to the research question as framed in this study, so an approach such as ethnography would not sit comfortably. This study is not exploring people with CLBP as a particular societal group or looking at their behaviour in the pain clinic (interesting though those areas may be). One of the narrative approaches, such as content analysis, might offer a way of looking at the interviews in the light of the language and linguistic features – something that might sit well alongside Focusing which is a very language-based intervention. Although meaning is inherent in language, the formality of the content analysis approach would enable or capture a deep analysis of the terms and descriptors used, but it may not provide the breadth of the experience of living with CLBP. The experience of this way of life, and the experience of bringing Focusing into it seemed to me to provide a way of capturing data that would shed light on my questions. This led to the consideration of a phenomenological approach.

A description of philosophical Husserlian phenomenology

Phenomenology, as understood by Husserl, is a philosophy in which things are described as they appear to ones' consciousness, as they are actually experienced. It is a rigorous descriptive science, not one that provides causal explanations. In Husserlian terms phenomenology focuses on what appears to consciousness and should not rely on logical inferences or be mediated by previously held knowledge. A phenomenological approach to the here-and-now makes a move from the individual experience to the universal essence; Husserl claiming that 'the universal is *seen* in the individual' (Moran, 2000, p. 134). So a phenomenologist tries to understand something in terms of the meaning it has for a person – and, as such, this approach would appear to have something to offer in answering the question above. Phenomenology, as described by Husserl and the philosophers who followed him, is a philosophical enterprise. In its Husserlian form the phenomenological philosophical approach has a number of stages. These will be described briefly below, informed by Langdridge (2007) and Moran (2000) in particular.

Key to a phenomenological approach is the centrality of a focus on the experience itself and the correlation of how the world appears to the individual and his/her experience of it. The world, for Husserl, was a lived experience rather than an object to be studied. This move, from examining something outside of oneself, or one's consciousness, to an inner awareness or consciousness is termed *intentionality*. This has nothing to do with the common use of the word, meaning intending to do something, but to do with the relationship between what is experienced (the *noema*) and the way it is experienced (the *noesis*). Initially Husserl placed the subject, the 'I' in the noetic position, the person was experiencing the thing that was experienced. Later he took a slightly different position, suggesting that in taking a reflexive move one could stand outside the relationship between these two aspects (a transcendental position).

So a phenomenological philosophical investigation begins with a description of the experience which is perceived through the reflexive *noema-noesis* relationship. To investigate this experience further Husserl used a process called the *epoché* where the phenomenologist attempts to identify and move away from any preconceived ideas they may hold about the experience being investigated. This can be seen as questioning the 'basis of validity'; trying to suspend a natural inclination (or 'natural attitude') which tends to validate what is experienced. This position is known as *bracketing*, the phenomenologist brackets out his or her previous experience. The *epoché* is part of the phenomenological *reduction* where all experience is taken as genuine in its own right and not as correct or false. The experience is described in detail and often returned to repeatedly to uncover more layers of meaning and the *essence* of the phenomenon is identified. Invariant meanings are sought after the reduction by using *imaginative free variation*. In this aspects of the experience are subjected to being repositioned in the philosopher's imagination in an attempt to see which parts of the phenomena cannot be varied, thus allowing the essential structure to remain. This move captures the essential features of the phenomenon, what it is that makes it that rather than something else. Doing this enables a move from the individual to the universal, something Husserl called *eidetic intuition*.

Phenomenology in human sciences

In the above form phenomenology is not a means of researching human science. But the different strands within phenomenology (eg transcendental (Husserlian), existential (Heideggerian) or hermeneutic (Gadamerian)) have been adapted or developed into a number of different research approaches in the human sciences by scholars as diverse as Giorgi, Van Manen and Ashworth.

Phenomenology has had a long association with psychology, both were being explored and developed in the same historical period. In fact, Husserl was much influenced by Brentano who drew contrasts between empirical and physiologically-based psychology. So, it is not surprising to find Husserl's phenomenological stance transformed into a method which can be used for research in psychology and the social sciences. This has been done most closely by Giorgi with the development of his descriptive phenomenological psychological method (Giorgi, 1985; Giorgi & Giorgi, 2003). Van Manen (2006) reminds us that a proper understanding of phenomenology is only gained by doing it – and Giorgi's descriptive phenomenological psychological method brings the researcher in close relationship to the data, requiring him or her to orientate themselves phenomenologically and psychologically when using it. A detailed explanation of his method is found in Chapter 3. Hopefully this method will enable a text to be attained which 'thrives on a certain irrevocable tension between what is unique and what is shared, between particular and transcendent meaning' (Van Manen, 2006); each participant will bring their own unique perspective and the phenomenological analysis of them all will identify the shared experience.

In order to undertake a phenomenological analysis there must be data to analyse. Frequently, as in this study, the data is collected via a phenomenological interview which Van Manen describes as a 'means for exploring and gathering experiential material' (2008). This borrowing of others' experiences allows the researcher (and those who read the research) to be more experienced themselves in a vicarious sort of way (Van Manen, 2002). This experience gathering is important because it is related to Husserl's concept of intentionality, the way in which a phenomenon is experienced. For Husserl it was an examination of his

own experience and, in order to keep as closely to Husserlian phenomenology as possible, the manner of the gathering of the participants' experiences is important.

At times there is substantial blurring between phenomenologists and, although I plan to base the study on Husserl's ideas mainly, there may be occasions when a more interpretive phenomenology will be used.

Having made a decision about a qualitative methodology which fits the research question and also considered the choice of the quantitative measures (discussed in Chapter 3) it was then imperative to find a research model which accommodated these different approaches.

Finding a mixed methods research model

Mixed methods research

Mixed methods research has recently been defined as 'the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (eg use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration.[...] a mixed methods study would involve mixing within a single study..' (Johnson, Onwuegbuzie, & Turner, 2007, p. 123). MMR most frequently involves both qualitative and quantitative methods (Leech & Onwuegbuzie, 2007), although there has been some argument that it can be used to describe research which combines two qualitative methods (Giddings, 2007).

It is rapidly developing its own terminology and strategies – as evidenced by the increasing number of academic publications eg (Tashakkori & Teddlie, 2003) and the launch of the *Journal of Mixed Methods Research* in 2007 – but not without some contestation. Freshwater (2006) argues that MMR is not a new phenomenon in health-care research, although she acknowledges that it has become more visible in recent years. Much of this visibility has been in the production of papers and books considering the ontological and epistemological challenges in bringing together research techniques from different paradigms,

particularly in light of the ‘paradigm wars’ of the 1970s and 1980s. This period saw the rise of qualitative methodology in research – observed by some to be a reaction to the dominant methodology of the time, quantitative or positivist approaches. There were also changes in the 1970s and 1980s towards a more socially and culturally focused research, and the qualitative paradigm fitted that agenda (Tashakkori & Teddlie, 2003). However it is clear that mixed methods were being used at that time (if not identified as such) and Tashakkori & Teddlie (2003) argue that now, at the beginning of the 21st century, a methodological orientation for mixed methods has evolved with its own vocabulary and worldview.

Johnson and Onwuegbuzie (2004) outline mixed methods research as the third research paradigm. They make a plea that both quantitative and qualitative research are recognized as important and useful: ‘[t]he goal of mixed methods research is not to replace either of these approaches but rather to draw from the strengths and minimize the weaknesses of both’ (p. 14). If this statement suggests that mixed methods research has fewer weaknesses than either of the other two approaches Morse et al (2006) make it clear that this may not be the case. Creswell et al (2004) are rather more taciturn, but perhaps more confident of outcomes, when they say ‘used in combination, both quantitative and qualitative data yield a more complete analysis, and they complement each other’ (p. 7). Both these authors argue that the link assumed between methodology (the ideas and philosophy which support the research approach) and method (the tools used to acquire the data), needs to be explored in each study. Morse (2003) encourages the combination of qualitative and quantitative research but with a warning that ad hoc mixing may threaten the validity of the research project. She suggests this might happen when methodological assumptions are violated and calls for methodological congruence. The challenge of this in relation to this study is explored later in this chapter.

As made clear earlier, one of the over-riding considerations in this study was that of embedding the study in the real lives of the participants. Support for using a mixed methods approach in this environment comes from Mason (2006) who argues that our understanding of multi-dimensional life experiences may be

impoverished and inadequate if only a single dimension of the phenomenon is explored. She suggests that mixing methods can encourage researchers to ‘think outside the box’ and extend the ‘logic of qualitative explanation’ in their studies. In the same article Mason challenges some of the reasons given in using MMR – that it triangulates or corroborates findings, increasing validity by integrating data. She sees MMR as offering the capacity to enable researchers to think about things in a more creative manner, suggesting that integration should be reformulated by considering MMR as a ‘meshing method’. There is a warning that some control is needed so that the research does not sink ‘into a relativist mire’ (p. 20) but the benefit is that multi-dimensional explanations can be brought into the discussion, involving different axes and dimensions of the experience under investigation. This point is also made by Tashakkori and Teddlie when they suggest an advantage of MMR is that it enables one to ‘simultaneously answer confirmatory and exploratory questions, and therefore verify and generate theory in the same study’ (2003, p. 15).

It may be that a further strength of MMR is its ability to enable the researcher to communicate in multiple languages. CLBP is managed by a multiplicity of healthcare professionals, each of whom have a preferred research language. If Focusing is to prove to be a useful strategy it has to be presented to a multidisciplinary team in a way that will engage the stakeholders. A well-managed MMR study would be in a good position to achieve this. This stance, or rationale, is described as that of ‘utility’ by Bryman (2006); a suggestion, often in studies with an applied focus, that combining approaches is useful to practitioners. In his review of 232 social science articles in which both qualitative and quantitative methods were used, just 2 of them (0.9%) cited this rationale. This seems surprisingly few, and it may be that it is felt to be rather a mundane reason, so other more ‘academic’ ones are cited. From a healthcare practitioner perspective, research which is framed in a way which makes it accessible to a multiplicity of practitioners is possibly more readily applied.

Mixed method research designs

There are basically two designs seen in MMR, with a substantial number of variations. The studies are designed around the phases of the data collection.

This is either done sequentially or concurrently. An example of a sequential study would be one that used focus groups to collect qualitative data and this could be followed by the design and testing of a questionnaire. In a concurrent design both types of data are collected at the same time. The variations on these two basic approaches depend on the order of the qualitative and quantitative data collection, the priority given to the different data and, to a certain extent, the forms of analysis undertaken. Designs may also have one type of data collection used more prominently than the other. This is termed a ‘nested’ design with the smaller paradigm being nested within the larger (Creswell, 2003).

The methods used in this study are explained in Chapter 3. At this point it is sufficient to say that it involves collecting both the qualitative and quantitative data simultaneously, but the major theoretical drive for the study is exploratory, using a phenomenological approach as described above. The use of the qualitative data is to inform the main findings and to investigate whether they reflect the same findings – a useful piece of knowledge when making clinical decisions in ‘real life’. It is hoped this will provide a practical context in which the findings can be discussed. The data will be collected concurrently and the quantitative data will be nested within the qualitative. Creswell (Creswell, 2003; Creswell, Plano Clark, Gutman, & Hanson, 2003) describes it in a diagrammatic form, as seen in Figure 2.1.

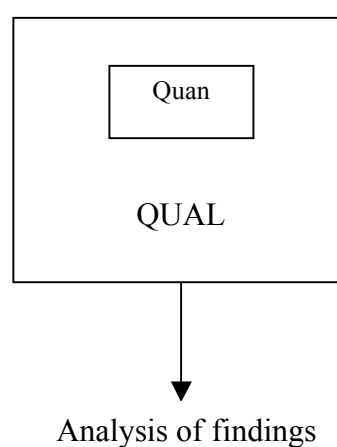


Figure 2.1:– Creswell’s concurrent nested design (QUAL = qualitative approach, the dominant part; Quan = quantitative approach, the smaller, nested part)

Interestingly Morse (2006) suggests this is a ‘worst-case’ scenario of a design in that it provides for both parts of the study to have equal dominance which she sees as impossible as there would be no clear theoretical drive. However this is not the case in this study; the qualitative data is the core component, the quantitative data being supplementary. To some extent this is required as the validity of the quantitative data is compromised by the smallness of the number of participants (see section below on validity).

Challenges of mixed methods research

These are manifold, as a critical review of the MMR publications will show. They cover many areas of the research process including sampling (Kemper et al., 2003); analysis (Onwuegbuzie & Teddlie, 2003) and writing up (Sandelowski, 2003). One area not discussed in the literature is the challenge of mixing a 1st person perspective with that of a 3rd person perspective. This challenge forms a continuing theme in the study, in both a practical and theoretical manner. It is returned to later in this chapter when issues around congruence are discussed. In relation to this study and its design there are two further areas which need further consideration. These are the areas of validity and integration.

Validity

Morse (2006) reminds us that the overall design of the research has to be considered in order to maintain validity. Much has been written about the validity of various qualitative and quantitative methodologies, and an extremely complex array of definitions has been developed. Within the quantitative research world the validity of a study relates to the extent to which it actually measures those things it says it measures. This definition, offered by Garrett in 1937 has been frequently quoted (see, for example LoBiondo-Wood & Haber, 1998) and spawned a number of related concepts, such as content, criterion and construct validity. Validity in the quantitative world has expanded and now includes not only the measurement related issues, but also design and statistical inference issues.

Qualitative researchers have taken a different path, seeing validity as a rather ambiguous concept, one that includes credibility, trustworthiness and

generalisability, and approaches to validity can vary, depending on the researchers' stance (Onwuegbuzie & Leech, 2007). In defining qualitative validity Ashworth (2000) uses the term 'descriptive adequacy'. Using a hermeneutic model he identifies three movements in the qualitative research process which are key considerations in the search for validity, or adequacy-checks. One set of adequacy-checks is based around the fore-understanding of the researcher. This includes their ability to reflect on their own presuppositions in the light of the area being researched; the degree of personal involvement in the area; and whether or not they are using a hermeneutic of suspicion or one of meaning-recollection. This Focusing study uses a meaning-recollection approach, allowing the meaning to emerge from the data. Secondly Ashworth considers the adequacy of the research interaction (for example recruitment and interviews) and data. He concludes that qualitative research is a human encounter, and the control of confounding variables is a project he describes as 'doomed to failure' (p. 146). Adequacy of the data analysis relies heavily on the attitude of the researcher in relation to the data. In this Focusing study the aspect is clearly outlined in Chapter 3. Finally Ashworth closes his hermeneutic circle by returning and reflecting on the description of the life world obtained in the data in the light of the researcher's fore-understandings.

With this complex field before them, it is not surprising that mixed methodologists have had difficulty in deciding on guidelines for validity in MMR. Frequently studies have tended to consider the validity of each part of the study. More recently it has been suggested that mixed method validity could be explored through the idea of inference quality, one that assesses the integration of the two sets of inferences generated (Teddlie & Tashakkori, 2009). This 'integrative framework' approach relies on the quality of the design of the study as well as the interpretive rigour applied by the researcher. A further framework to guide MMR has been suggested, the 'validation framework' (Dellinger & Leech, 2007), which has tried to be all-encompassing. This seems to have resulted in a rather unwieldy, and probably unnecessarily complex, model and introduces new terms incorporating features of previously defined terms. For this study it is proposed to use the outline suggested by Teddlie & Tashakkori (2009)

<i>Aspects of quality</i>	<i>Research Criterion</i>	<i>Indicator or audit</i>	<i>Comment in relation to this study</i>
Design quality	1. Design suitability (appropriateness)	<p>1a. Are the methods of study appropriate for answering the research questions? Does the design match the research questions?</p> <p>1b. Does the mixed methods design match the stated purpose for conduction an integrated study?</p> <p>1c. Do the strands of the mixed methods study address the same research questions (or closely related aspect of questions)?</p>	Yes. A phenomenological approach is appropriate for the question relating to meaning, and questionnaires will match the pain score question. The research questions are closely related.
	2. Design fidelity (adequacy)	2. Are the Qual, Quan and MM procedures of design components (eg sampling, data collection procedures, data analysis procedures) implemented with the quality and rigour necessary for (and capable of) capturing the meanings, effects, or relationships?	Thought has been given to the order in which the components are undertaken and the data was handled in a rigorous manner.
	3. Within-design consistency	<p>3a. Do the components of the design fit together in a seamless manner? Is there within-design consistency across all aspects of the study?</p> <p>3b. Do the strands of the MM study follow each other (or are they linked) in a logical and seamless nature?</p>	<p>Much time has been spent on this area. See the discussion below in this chapter for details of ensuring within-design consistency.</p> <p>The two strands of the study interweave at all times.</p>
	4. Analytic adequacy	<p>4a. Are the data analysis procedures/strategies appropriate and adequate to provide possible answers to research questions?</p> <p>4b. Are the MM analytic strategies implemented effectively?</p>	The data analysis is appropriate to the methodologies employed. Giorgi's phenomenological approach has been outlined above and the quantitative data was handled with due caution

<i>Aspects of quality</i>	<i>Research Criterion</i>	<i>Indicator or audit</i>	<i>Comment in relation to this study</i>
Interpretive rigour	5. Interpretive consistency	5a. Do the inferences closely follow the relevant findings in terms of type, scope and intensity? 5b. Are multiple inferences made on the basis of the same findings consistent with each other?	This is done and demonstrated in chapters 5 and 5a.
	6. Theoretical consistency	6. Are the inferences consistent with the theory and state of knowledge in the field?	Yes – they also provide new understandings within the field.
	7. Interpretive agreement	7a. Are other scholars likely to reach the same conclusions on the basis of the same results? 7b. Do the inferences match participants' constructions?	Comments from supervisors who have read this would suggest that the findings and conclusions are based in the results.
	8. Interpretive distinctiveness	8. Is each inference distinctively more credible/plausible than other possible conclusions that might be made from the same results?	The application of the free imaginative variation from Husserl's methodology has given credibility to this aspect
	9. Integrative efficacy (mixed and multiple methods)	9a. Do the meta-inferences adequately incorporate the inferences that are made in each strand of the study? 9b. If there are credible inconsistencies between the inferences made within/across strands, are the theoretical explanations for these inconsistencies explored and possible explanations offered?	The analytical framework used and the presentation of both data types simultaneously has enabled these criteria to be met.
	10. Interpretive correspondence	10a. Do the inferences correspond to the stated purposes/questions of the study? Do the inferences made in each strand address the purposes of the study in that strand?	Yes. The inferences in Chapters 4-6 are based on the questions of the study. The utility of the MM design is made clear in the conclusion.

		10b. Do the meta-inferences meet the stated need for using a MM design? (ie is the stated purpose for using MM met?)	
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Table 2.1: An integrative framework for inference quality (Teddlie & Tashakkori, 2009 p. 301)

shown in Table 2.1. (It has been published in various forms elsewhere and earlier but this is the most succinct). Returning to this framework at various stages in the research process will ensure that the validity of the study will be enhanced and weaknesses identified and strengthened. These links will be made clearer in the following chapter which considers the design of the study.

Teddlie and Tashakkori (2009) provide a solid framework with which the researcher can assess the validity of their study from the outside, so to speak. It is a check-list and has a very pragmatic and useable feel about it. Ashworth (2000) provides the researcher with a way to assess the validity from the inside, something which sits very comfortably with the phenomenological driver to this study. The position taken in this study will draw on both approaches, integrating them. Perhaps this in itself is an example of integration in MMR.

Integration

The data collection period of the study is integrated as the data is collected simultaneously. Questions about integration arrive before the data is collected. For example, sampling needed consideration, and more is said about that early in Chapter 3. In order to maintain integration throughout the study the analysis of the findings is also undertaken simultaneously, integrating or meshing the two approaches. This is a challenging approach as the qualitative and quantitative data come with their own distinctive analytic techniques. I will use the concept of ‘counterpart’ analysis (Yin, 2006) where, although different methodological techniques will be used, the same variables will be addressed. This could be looking at the verbal descriptors participants use when talking about their pain and the descriptors they chose from the pain score tool. Presenting data analysed in this way is a challenge and there are limited examples in the literature to follow (Sandelowski, 2003).

Bazeley (2009) argues that the debate around the ‘paradigm wars’ sharpened thinking about the differences in the research approaches but has meant that the progression of integrating methods has been slow. In fact she suggests that qualitative and quantitative can be seen as either end of a multidimensional continuum, and that separately defining them may make integration of the analysis more difficult. Yin (2006) is quite clear that integration is key to defining a research study as MMR. If ‘each method uses its own isolated procedures, the result will be separate studies using different methods. Though the studies may be complementary, they will not really represent mixed methods research’ (p. 46). A challenge for this study will therefore be around ensuring genuine integration at all stages. This challenge is explored further in Chapter 4 where the findings are presented.

But this is not the only methodological challenge encountered in considering the study.

Possible areas of divergence within this approach

As noted at various points above there are some areas within this research study which need further explanation and justification. Bringing the two paradigms of qualitative and quantitative work together requires the researcher to be aware of issues surrounding the congruence of the methodology and to develop ways of managing possible divergence. In this study there is an issue of being faithful to the descriptive phenomenological psychological method when using it over repeated interviews. Secondly, there are also issues relating, very broadly, to ensuring that the mixed method approach is used in a manner which ensures the production of robust data which can be analysed in a valid and productive manner. This entails considering the congruence of the two means of data collection and the order in which they are undertaken. Each of these areas is explored below.

Comparative phenomenology

The first research question asks about meanings ascribed to CLBP before and after using Focusing. This implies comparison between experiential positions. The comparisons will be between the experience of living with CLBP and the experience living with CLBP with Focusing in one’s life. There are three sets of

interviews – those done before the intervention, those immediately afterwards and those 4-6 months post-intervention. How can the data gathered at different times be handled in a phenomenological manner? Using Giorgi's (2003) method of analysis each set of interviews will produce its own structure, as shown in the description of the method in the following chapter, which relates to the question in the researcher's mind as the data is explored within the phenomenological attitude of *epoché*. This will produce data which will lend itself to comparative work (before the intervention compared with after) in both qualitative and quantitative results. It seems to me that comparison is likely to appear in four different ways. New things may emerge in the second and third interviews, some things may not appear, some may have changed and finally there may be findings that continue to be present unchanged.

Comparison underlies a statistical approach to data, but is less used in qualitative reporting. But this doesn't mean it isn't there at all. Morris (2005) states that both Hiedegger and Merleau-Ponty used a comparative approach when they considered an existential-phenomenological comparison of animal and human behaviour. A comparative approach can also be seen in religious studies and also in psychiatry – for example in a study where the eidectic differences between imagining, memory, hallucination and fantasy are distinguished, thus presenting 'an exercise in the comparative phenomenology of the mind' (Casey, 1976, p. 1).

So, although the descriptive phenomenological psychological method does not discuss comparative work, it is clear that comparisons have been used within phenomenology for a long time. In this study I will undertake the analysis of the first interview and use the insights / essences of that to inform the comparative discussion of the subsequent interviews.

Congruence

Congruence, as well as having a philosophical question within it, is also important for ensuring the validity of MMR, particularly in relation to the questions of design fidelity and within-design consistency as identified in Table 2.1 above. Some of the practical issues around this are discussed in Chapter 3

where the actual design of the study is considered in detail. In this section the more philosophical issues are addressed.

In returning to this issue of congruence, raised in the earlier section ‘What is MMR?’, it is of note that although this congruence of methodology and method is spoken about, either explicitly or implicitly, in a number of articles, it is difficult to find a practical example of the dilemma. Placing their writing firmly within a qualitative framework Holloway and Todres (2005) consider how flexibility and combining methods can lead to inconsistency and lack of coherence. They hold fast to the epistemological and ontological basis of each qualitative approach, and argue that researchers must make explicit the consistency of parts of the research within the overall project. There is no suggestion that one approach may be privileged above another when combining research methodologies, but an appeal for understanding of the underpinning philosophy of each. However, there is an implicit assumption that the worldviews of the qualitative methodologies are similar whereas, when methodologies from different paradigms are mixed, the worldviews of the different methodologies have differing perspectives. So a question which needs addressing is this: ‘is the quantitative tool congruent (or in harmony) with the overarching phenomenological approach?’ Or perhaps, bearing in mind Bazeley’s (2009) comments, should we be asking ‘where along the multidimensional continuum do we find a position that feels congruent?’

Philosophical congruence

McLeod (2001) argues that a characteristic of successful MMR is that it is conceptually coherent, stating that the integration of qualitative and quantitative findings is better when they are addressing the same (or similar) theoretical issues. At first sight this appears obvious, but it is not that simple to assert that the questions are addressing the same theoretical issue. This study considers the phenomena of the meaning of pain and any change to meaning, alongside the measurement of pain intensity. These are two different phenomena, even if at first glance they both seem to be about the same thing - pain. In trying to bring both phenomena together one could argue that both research paradigms share the goal of enabling researchers to understand the world in which we live (Hasse &

Myers, 1988) but this does, rather elegantly, side-step the issue. Sale et al (2002) identify other approaches to try and bring paradigmatic compatibility such as a shared commitment to understanding and improving the human condition or a need for a broad spectrum of methods when considering complex social conditions. They also identify a further pragmatic (or possibly defeatist) approach which says ‘just get on with the research and allow the theoretical debate to continue elsewhere’. Their concluding solution does not attempt to draw together the different epistemological and ontological foundations of quantitative and qualitative research, but suggests that they can be combined for complementary purposes, implying an ‘additive outcome’. Their conclusion seems to fall within the stance that Greene and Caracelli (2003) call pragmatic or context driven in that ‘what matters most is responsiveness to the demands of the inquiry context’ (p. 96). This is a practical approach which will resonate with many nursing researchers who come from a clinical background. But it sits somewhat uncomfortably, particularly in light of the earlier discussion on integration.

A different approach to searching for philosophical congruence is found in a dialectical manner, which is exemplified in a recent paper considering the compatibility of postpositivism and phenomenology (Racher & Robinson, 2002). Here the authors ‘invite the juxtaposition of opposed or contradictory ideas’ (Greene & Caracelli, 2003, p. 96), concluding that refocusing on linking the assumptions of the researcher, human beings and the research method will enable the dissolving of the ‘artificial boundaries between paradigms’ (Racher & Robinson, 2002, p. 477). This approach is based on a more theoretical understanding of the different research methods and a search to find bridges between them. In this example the bridge is found in the researcher and their unpacking of, and working through, the philosophies involved.

Methodological congruence

Morse’s (2003) definition of methodological congruence is that the assumptions of the major methodology are adhered to and that components of the method (such as data collection and analysis) are consistent. She has explored this concept of congruence in other articles (Morse et al., 2006; Morse & Singleton,

2001) arguing that if the theoretical drive is clear, the validity of a study is enhanced as the risk of using invalid strategies is reduced. Here the link between methodology and method begins to surface; sometimes the same tool can be used either qualitatively or quantitatively (for example data from a focus group may be used quantitatively – how often is pain mentioned? – or qualitatively – what was the meaning of pain?) so care needs to be taken when making assumptions about the use of data collection tools. Strategies need to fit appropriately within the design to ensure methodological congruence (Morse et al., 2006). However her position seems a little didactic and, it could be argued, may serve to continue to slow the integration of methods that Bazeley (2009) is so keen to see moved forward, in its insistence on theoretical fit. Congruence is not the same as integration but there are some shared values.

In Chapter 3 the section on the choice of a quality of life (QOL) measure shows there are a number of issues which can make the qualitative measure non-congruent (or to sit uncomfortably) with the overarching phenomenological approach. There is little literature to guide the mixed method researcher in exploring this conundrum or that suggests a model which may help. In order to address this consideration has been made of the concept of congruence as harmony within the musical world.

Harmony and a 'context of stability'

Congruence can be understood to be a condition of agreement or harmony. By considering the evolution of harmony in a musical environment it may be that a way of moving forward within MMR can be discovered. A multidimensional continuum was present in music, with harmony at one end and disharmony at the other. The development in the twentieth century of post-tonal harmony challenged the previous conceptions of what constituted harmonious sounds. In particular Schoenberg used dissonance as a way to develop new ways of establishing coherence and stability by harmonic means (Whittall, 2002). He challenged the commonly-held view that the rules of harmony were 'eternal', arguing that if the goal changed and something new was created then the rules would change too (Schoenberg, 1990). (Perhaps in human science research we have seen a change of goals in the introduction of MMR, and with it we should

expect a change of rules.) It is still a matter of debate as to whether or not Schoenberg's change of rules achieves a way of making his music pleasing to listeners, but many argue that he does achieve it by introducing a new consistency or coherence which sets aside the long-standing harmonic distinction between consonance and dissonance. Perhaps an understanding of congruence as harmony will enable a different way of considering the challenges within qualitative and quantitative philosophies.

One of Schoenberg's methods was to write a musical chord which would traditionally have been considered dissonant (or not harmonious). However, by relating it to surrounding musical events, often in ways not recognised earlier, he provided a context of stability in which he moved away from the need to stay within traditional harmonic coherence yet still made music. Instead of staying with the harmonic rules which looked for vertical coherence he took a wider, more horizontal approach, seeing this development as following on from the greater use of chromatic notes (those outside the key) by composers such as Wagner. So Schoenberg knowingly challenged the philosophical understandings of musical harmony and developed a method which depended on a different stabilising force. It is this search along a more horizontal continuum which leads to a search for support for MMR within this context.

This is a rather different perspective on congruence. MMR is considered a dissonant chord by some researchers and it may be there is a need to explore non-traditional methods to find a context of stability and develop a model of methodological congruence.

Schoenberg wrote: 'As I have said, the battle today, as always in music, is fought for the cause of dissonance and tonality, around concepts that are not even now clearly enough defined. For the phenomena which they are intended to reveal have been in continuous development since the beginning of music. This compels us always to conceive them in a new way. Therefore we shall try in the main to define them in relation to our time, according to present conditions, without claiming eternal validity.' (Monzo, 1999). Perhaps mixed methods researchers can see some hope in this statement, for MMR may be trying to

battle around concepts which are not clearly enough defined and the larger phenomenon of research is continuously developing. Maybe all that can be done is to define MMR according to our present conditions and not attempt to claim eternal validity. In fact this statement seems to fit exactly within the pragmatic philosophical approach on which many predicate their approach to MMR. So, how does Schoenberg's take on harmony relate to congruence in MMR?

Applying a 'context of stability'

The model of dissonance can assist in the decision of which tool or method to choose and provide support for a mixed methods approach. A traditionally harmonious musical chord is made up of notes which are pre-defined distances from each other. These are determined mathematically and, although they can be extremely complex, follow a definite pattern. Those who hold paradigmatically 'pure' research positions would argue that their studies form a coherent pattern which may be complex but follows certain 'rules' around the various aspects of the study. That, surely, is what research students are taught when they are asked to consider the means of data collection, analysis etc in their study. That is why some hold closely to congruence – it ensures a recognisable pattern. And there is nothing wrong *per se* with that approach. It demands a knowledge of, and adherence to, the 'rules'. In the world of harmony Schoenberg directly challenged this mathematical formulation, viewing the relationship between tones and overtones in a different way. He repositioned the mathematical formulation, providing for combinations which previously were just 'wrong'. The stability of his harmony came from hitherto unrecognised combinations of notes or tones which looked outside, along a different continuum, for their relationships.

If designed carefully, the mixed method research study design can be viewed as providing a context of stability. The links between the various parts may not be the traditional ones found in single paradigm research projects, but breaking with tradition does not mean something is 'wrong' – it just sounds different. So the harmony in this study will include phenomenology, pain scores, quality of life tools, small sample size, statistical analysis and Giorgi's analytical method. The more abstract parts such as validity and integration also play their part. Their

relationship with each other (as surrounding events) can be modelled on Schoenberg's model of harmony to enable the formation of a context of stability (a research design) in which the dissonance of mixed method research can be held. The stability depends upon recognising the distance that one 'note' is from another, and the relationship between all the notes, not just in relation to one part.

Monzo (1999) uses a technique he has developed, called 'Tonescape' to capture Schoenberg's relationships in a visual manner. An example can be found at Figure 2.2. In planning a MMR study a similar technique could be used to examine the relationships between the various parts of the study and to visualise the links that form the context of stability.

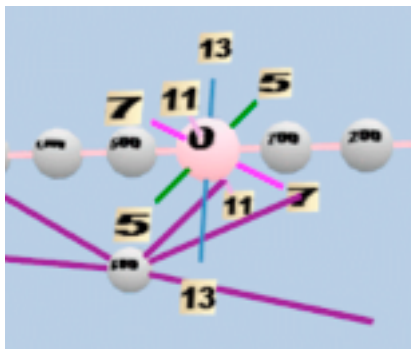


Figure 2.2: Monzo's (1999, p.5) tonescape of Schoenberg's description of the relationships in 12-edo (the octave divided into 12 equal parts)

This description of stability can be used not only to explore the relationships with the research design as the centre point. The stabilizing forces around various elements in the study can also be scrutinized. So, in relation to a quality of life tool a number of surrounding events can be identified which can provide stability. For instance, what is the relation of the measure to phenomenology? The more traditional QOL questionnaires might be considered the furthest from the concepts of phenomenology. The respondent-generated ones are nearer but are not closely related to the validity of the study. Thus, although initially there is a move towards stability, this is unsettled by the relationship with validity. The WHOQOL-PainUK (described in Chapter 3), although further from phenomenology than the respondent-generated questionnaires, has some relationship to it in the way it was designed and generated and reflects other qualitatively identified aspects of quality of life and pain. It therefore may be

considered to be closer to the validity point. In this way the researcher can create a model, linking the parts of the study in a way which explores the stability provided by choices made.

Order of data collection

A further important surrounding event is that the qualitative measures should not invalidate the phenomenological data collected. Identifying the optimal time for completion of the questionnaires is an important issue. Within the mixed methods literature it appears that no studies have explored this issue. It is reasonable to assume that completing the measures immediately prior to the unstructured interview may set some parameters of what might be important to the researcher in the mind of the participant; the priming effect. This is a factor that relates to all the tools discussed, although the impact may be greater with some than others. How might this aspect be stabilized within a phenomenological approach where the lived experience of the participant is the data required, and surrounding events which might invalidate, or over-emphasize, facets of that experience should be avoided?

A model based on the ‘context of stability’ outlined above can be made, using James’ pragmatic rule of testing ‘every concept by the question, “What sensible difference to anybody will its truth make?” [Doing this places you] in the best possible position for understanding what it means and for discussing its importance’ (Gunn, 2000, p. xvii). If it is true that doing the questionnaires first would influence the interview then it is clearly important to not do that. If it makes no difference at all then it will not matter in which order things are done, and the interview may as well be done first. The relationships between the notes or positions can be examined and stability sought within the dissonance.

Using this model of a ‘context of stability’ works alongside the more traditionally produced concepts of validity and design (as discussed previously) to produce a creative approach, and one which can assist in defining potentially problematic areas as well as resolving them. This new methodological development will be assessed in this study and the findings are presented in Chapter 5a.

Conclusion – and 3rd research question

The decision to design a MMR study has proved challenging and presented a number of areas where divergence may occur and in which there is little guidance. These include practical ones, such as timing data collection, and theoretical ones, such as the congruence between different elements. There are also stylistic areas like the presentation and discussion of the findings as there are few studies to showcase such an integrated approach. Exploring these issues has led to the consideration of a new model in considering the challenges, one based in a different academic world – that of music rather than human sciences.

Searching for a cohesion in this study led to the decision to add a third research question '*Does using a mixed methods approach add to the study?*'. The exploration in this chapter points to possible theoretical additions to the mixed methods methodology, particularly in identifying ways in which the different elements of a mixed methods study relate to one another. In relation to the practical discovery and exploration of the two previously identified research questions the literature suggests that the use of mixed methods in the design, integration and analysis of the study will add layers of understanding that would otherwise be missed and that a more complete picture of human experience will be obtained (Morse, 2003).

Summary of Chapter 2

This chapter has set out the requirements for the methodology to be used in the study, basing it in the real-life experiences of people with CLBP. The research questions ask both qualitative and quantitative questions, leading to the exploration of a mixed methods approach. Before the type of MMR approach was decided the overall theoretical driver for the study was identified as phenomenology and this approach was described.

Discussion of the position of MMR within human science research showed it to be a growing approach. Its strengths lie in an acceptance of the strengths of both qualitative and quantitative streams in research and an ability to answer both exploratory and confirmatory questions, verifying and generating theory in one study. It can speak to a variety of people and this is considered an advantage in researching an area where a mixture of professionals are involved. However

some difficulties with the approach were identified – particularly that of integration and congruence.

The choice of the concurrent nested design was explained and an approach to ensure the quality of the design and interpretation was outlined. The question of congruence in bringing together phenomenology (a 1st person approach) and questionnaires (a 3rd person approach) was interrogated and a possible way forward, taken from the world of harmonic theory, was proposed, leading to the concept of a ‘context of stability’.

Finally a third research question was posed, asking if a using a mixed methods approach adds to the study.

Chapter 3 – Design and development of the study

Introduction

This chapter describes the design of this mixed methods study and shows the links between the design, the research questions and the methodology. It is written in a more personal style than other parts of the thesis to show the interpersonal dynamics of much of the decision-making. These are particularly obvious in the later section on recruitment. In Chapter 2 it was stated that the mixed methods model most congruent with the aims of the study was that of the concurrent nested design (Creswell, 2003). In this chapter the outworking of that design will be demonstrated and interrogated in line with Teddlie and Tashakkori's (2009) model outlined in the previous chapter. The challenges encountered in implementing the study as first designed will be highlighted and the steps taken to ensure the continuation of the study, although slightly altered, within the original framework. The study, although not recruiting through the National Health Service, was subjected to review by the Dorset Research Ethics Committee and approval given in December 2007. (See Appendix A for copy of the approval letter). The decision to get REC approval related to ensuring good ethical governance and the expectation of some post-study publication in health journals (for which REC approval of published studies is required).

The study was designed to collect information on the impact of Focusing on CLBP; there were a number of points at which data was collected: before the intervention, during it, immediately afterwards and at follow up. This is a journey in which the participants, data and researcher all took part. In exploring the design questions this chapter will follow each journey, looking at specific issues for that part of the journey and also wider research issues, such as ethical and methodological considerations, as they relate to that aspect of that journey. The participant journey will be taken first, followed by the data journey and lastly the researcher journey. Although a slightly unusual format this approach is commensurate with the story telling embedded in the entire study.

Participant journey

The planned journey for the participants is shown in Figure 3.1. This section discusses issues relating to the design regarding recruitment (this will include sampling, consent and finding the participants), the interviews, the questionnaires and the Focusing sessions. The difficulties encountered and changes implemented will be explained.

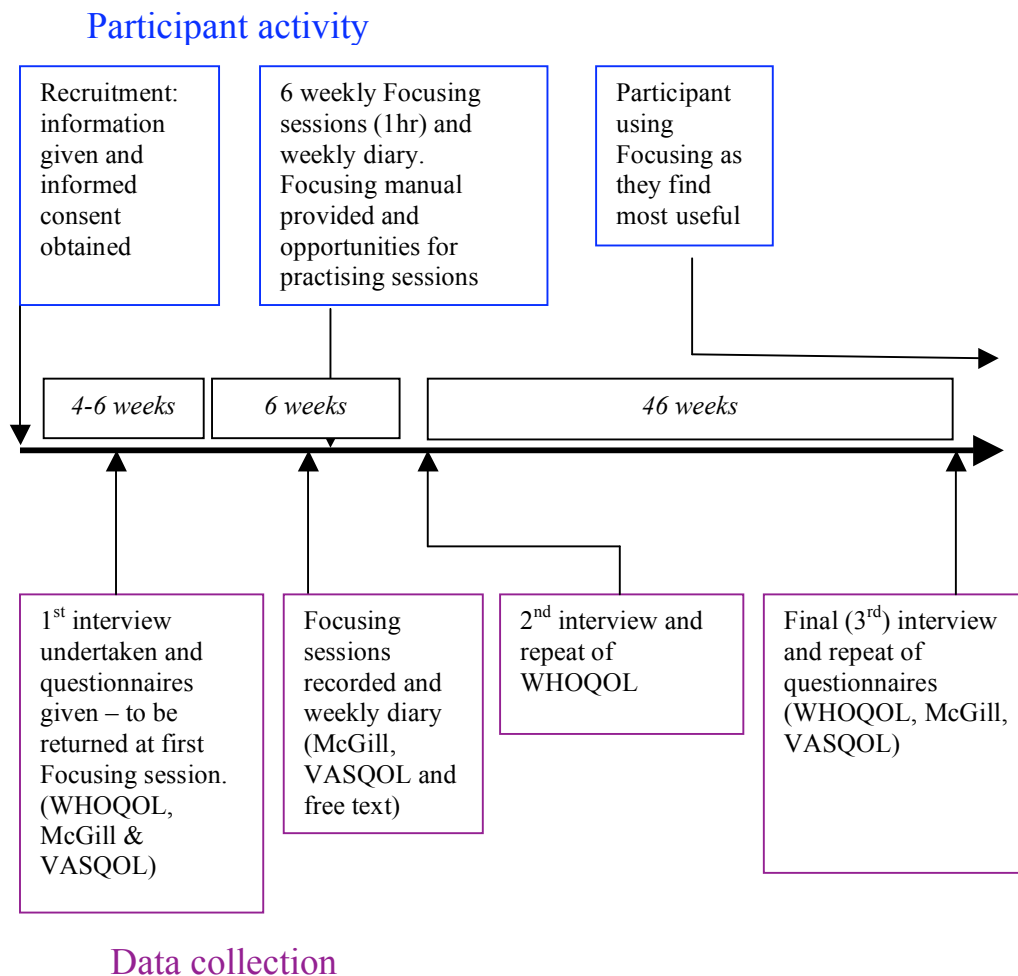


Figure 3.1: Participant pathway as first envisaged and presented to REC. (WHOQOL, McGill & VASQOL are abbreviations for the questionnaires discussed more fully later in the chapter)

In the initial planning for the study it was envisaged that each participant would be involved for a year. Obtaining consent, undertaking the first round of data collection and making dates for the Focusing sessions would take 4-6 weeks. Six Focusing sessions per participant were planned (a number commensurate with the number of acupuncture or physiotherapy sessions someone with CLBP might

expect from a pain clinic). During the Focusing sessions (which were to be recorded) further questionnaires were repeated weekly. After the Focusing sessions the participant was re-interviewed and the full set of questionnaires completed. They then continued without active intervention and a third set of data collected at the year end. The year was taken rather pragmatically, studies in CLBP vary in follow up. The qualitative studies very rarely have follow up and most quantitative studies have a follow up of 4-6 months, with few reporting follow up data of more than one year. This design was aiming to be robust in its long-term data point. However the progress of the study was rather slow (see below) and the follow up data collection had to be brought forward to 4-6 months in order to complete the study.

Recruitment

This section considers a number of issues leading up to, and including, the recruitment of study participants.

Sampling

A critical consideration was how many participants were required for this study. Sampling issues are practical and it is in this area of research that ‘theory meets the hard realities of time and resources’ (Kemper, Stringfield, & Teddlie, 2003, p. 273). They suggest seven criteria with which to interrogate the sampling for a research study in mixed methods. These criteria are identified in Table 3.1; see column two for details of how the criteria are applied to this study. With this sampling framework in mind it was decided that six participants would be a suitable size for a phenomenological approach, and the $n=1$ approach to the quantitative data, along with repeated measures, should provide a sufficient database. $N=1$ trials uniquely use each single patient as their own control. It is frequently used for chronic conditions and gives an estimate of the effectiveness of the treatment that applies to that individual participant. They can be used in randomised cross-over trials, but have also been used effectively in trials of complementary therapies (Zucker et al., 1997). A recently published study (Jackson, MacPherson & Hahn, 2006) used this approach with a Bayesian randomised effects model to estimate an overall population treatment effect. This is not appropriate in this study as the sample size is too small, and it would diverge from the overall qualitative methodological driver.

Criteria (from Kemper et al 2003)	How applied in this study
The sampling strategy should stem logically from the conceptual framework as well as from the research questions being addressed by the study	The framework for this study, as outlined in the previous chapter, is that of a concurrent nested design. The major theoretical drive is from the qualitative aspect, so the sampling reflects that. Phenomenological studies report from one participant upwards, many have 6-12 and (in a personal conversation) Giorgi suggested 4 was the minimum he would suggest with his methodology
The sample should be able to generate a through database on the type of phenomena under study	Each participant was going to undertake 3 interviews at key moments in the study in order to evaluate the value of Focusing. Within the phenomenological framework this should generate sufficient data. The questionnaires will be repeated regularly during the study enabling other data collection points
The sample should at least allow the possibility of drawing clear inferences from the data; the sample should allow for credible explanations	The use of repeated measures from the questionnaires allows for inferences to be drawn in a <i>n=1</i> methodology. Returning to the participants for 3 interviews allows the researcher to check back her understanding and ensure that explanations are credible
The sampling strategy must be ethical	The participants were given information about the organisation of the study, about the intervention itself and its potential benefits, and informed consent was obtained. There were no inducements to take part
The sampling plan should be feasible	The sample size was such that all the data could be analysed within the available timeframe
The sampling plan should allow the research team to transfer/generalize the conclusions of the study to other settings or populations	Kemper et al state that in studies with a qualitative focus this means that the researcher knows about both the sending context (where the research took place) and the receiving context (where the results are to be applied). With many years experience of listening to people with CLBP and working with them in the health care context I hope to be able to achieve this
The sampling scheme should be as efficient as practical	There is a balance here between the depth and breadth of the sample. Within the framework of this study I have opted for an approach which demands depth, and this is reflected in the sample size
Table 3.1: sampling criteria	

Purposive sampling through community groups with an interest in CLBP was initially decided upon (although this changed later). Community groups were chosen as it had been decided to place the study outside of the medical arena as most people with CLBP currently self-manage their condition. It was anticipated that in doing this the sample might more readily reflect the general CLBP population rather than those with very severe disability who are the CLBP population in a chronic pain clinic. This is not the usual recruitment strategy in CLBP studies (only Blyth et al, 2005 use it) and the difficulties of this strategy were not anticipated. Groups such as local arthritis and back support groups were approached. A specific mixed methods sampling strategy was not used, as these seem to be predicated on a sequential approach with larger numbers and it was felt that a strategy based on the dominant theoretical drive would provide the best methodological congruence. From a practical perspective it was not going to be possible to recruit a large number of participants as the financial support (paying the Focusing practitioners) was limited. As Focusing is a technique which is heavily language-based it was felt that in this early research study participants should be fluent in English. In line with other CLBP studies participants also had to self-report low back pain with a duration of at least 12 months. This is rather arbitrary, but, as discussed in Chapter 1, the use of a time to define chronic pain varies.

identifying potential participants

This began in January 2008. It was initially decided to undertake the study in south west England as an experienced Focusing practitioner was based there. (The availability of Focusing practitioners has put some constraints on the location, there are only 26 practitioners on the British Focusing Teachers website, and they have a variety of experience.) Nearly 100 leaflets were distributed via local community organisations and local groups of national organisations (for example the national osteoporosis society group, and the local association of disabled people). Recruitment was slow, with just one person undertaking the study by the middle of February 2008. The Focusing practitioner was unable to continue involvement after May 2008 and the participant was unable to complete the study (cancelling sessions at short notice 50% of the

time). She agreed for her incomplete data to be used as a pilot study, but has failed to return her questionnaires.

These circumstances led to a move to London for recruitment where there were two practitioners happy to be involved in the study. At this stage further REC ethics approval was sought to enable recruitment through the NHS, and GP surgeries and osteopaths in the area were approached to advertise the study in their surgeries. Information about the study was also placed on two national websites for pain support groups. This led to two enquiries, one of which got no further than initial interest. The second consented but then withdrew following the initial interview but prior to commencing the Focusing sessions. Eventually, by word of mouth, three participants were recruited. Of these two started the study in late summer 2008, completing in 2009. One withdrew following the initial interview due to other commitments.

Due to the slow recruitment a change in sampling was put in place. It was agreed by the university following discussion with my supervisors to widen the sample to include people who already used Focusing and had CLBP. Details were posted on the website of the British Focusing Teachers Association. Two Focusing practitioners who had CLBP but had never used Focusing with it were keen to be involved and completed the study. This change allowed for some parallels to be drawn between those who were new to Focusing and those who were experienced.

Further reasons for these difficulties are discussed in the ‘researcher journey’ section of this chapter.

Consent

Potential participants were given an information sheet about the study (see Appendix B) and were given the opportunity to speak to me about it. They were then asked to complete the consent form, making it clear that the interviews and the Focusing sessions would be recorded. The REC also required that the participant’s GP should be made aware of their involvement in the study. For the Focusing practitioners who joined the study later the information sheet was given

as it had the practical details of the study, but the GPs were not informed. As Focusing was not a new intervention to them it was not felt to be required.

Identifying Focusing practitioners

There are a number of different emphases in Focusing (outlined later in this chapter) and a decision was taken to use an ‘inner relationship’ stance. This further limited the choice of practitioner. Following a number of enquires I became aware that some of the practitioners on the website had recently qualified and had limited experience. By the nature of the condition people with CLBP can present in quite complex psychological ways and I was keen that the study should offer the best available in Focusing in the UK. Personal advice was sought from a very experienced practitioner before approaching someone to become involved in the study. Their CVs were seen by the REC and in the end three practitioners were involved, one with the pilot study, another teaching Focusing in London and the later taught a participant by phone.

Interviews

As shown in Chapter 2 the unstructured phenomenological interviews were a key part of the data collection for this study, as it was from these that qualitative data to address the question about the meanings ascribed to CLBP before and after Focusing was to be drawn.

In line with a phenomenological approach the interviews were unstructured, enabling the participant to describe their experience of living with chronic pain in any way which they found comfortable. I followed Van Manen’s (1990; 2008) suggestions for a phenomenological interview, aiming for an experiential account rather than opinion, keeping the intent of the interview in mind and trying (not always successfully!) to obtain concrete stories of situations. Each of the participants undertook three interviews during their involvement in the study. These took place before embarking on the Focusing sessions, immediately after the sessions and 4-6 months later. (In the original design this was to have taken place at 12 months, but time constraints brought it into line with more of the published CLBP studies) The opening question for the first interview tried to be experience-near: ‘Could you tell me something about the experience of living

with CLBP?’ The other interviews asked participants to ‘talk to me about the experience of living with CLBP with Focusing in your life.’

From an ethical perspective the REC were keen that interviews with the participants should take place at the Focusing practitioner’s rooms, from a personal safety perspective. When this was not possible I used a colleague’s rooms and telephone reporting back in to a friend. Due to the distance that some of the participants were from the researcher a number of the interviews were conducted over the telephone, an acceptable way of conducting phenomenological interviews (Van Manen, 2008). However all the participants were interviewed at least once in a face-to-face situation. For three of the four participants this was the first interview. The geographical distribution of the participants spread from the South West peninsula to North London and the North Midlands.

Questionnaires

In order to gather data to answer the second research question of the study questionnaires relating to pain and QOL had to be identified. Some of the issues around the identification of the QOL measure have been discussed in Chapter 2, where the importance of methodological congruence was explored. The attributes of the questionnaires used are discussed here.

Pain Scores

As discussed in Chapter 1, chronic pain is a multidimensional phenomenon. But very often people with pain are only asked about its intensity (such as ‘on a scale of 0 to 10, where 0 equals no pain and 10 the most intense you can imagine, please rate your pain’). Useful as this is for a quick assessment, as a unidimensional measure it doesn’t capture any of the complexity of the pain sensation which, as discussed in Chapter 1, is a multi-dimensional experience.

The Short-Form McGill Pain Questionnaire

The Short-Form McGill Pain Questionnaire (SF-MPQ) was developed for use in clinical and research situations where time for obtaining information is limited (Melzack, 1987) and is based on the longer McGill Pain Questionnaire. The MPQ was developed as a tool which would capture the multidimensional nature

of pain, asking people to choose from a selection of words which described the sensory, affective and evaluative aspects of pain. In the SF-MPQ 15 written descriptors of pain, 11 sensory and 4 affective, are ranked on an intensity score of 0-3. The descriptors are from the MPQ and were selected on the basis of the frequency of their use by patients with acute, intermittent and chronic pain (Melzack & Katz, 2006). It was felt that this tool provided some congruence with the overall methodology as, although it does not allow participants to describe their pain in their own words, the descriptors are taken from consultations with people with pain.

The SF-MPQ also includes a visual analogue scale (VAS), a 10cm line bounded with the words 'no pain' and 'worst possible pain'. A six point Likert scale measures the present pain intensity (PPI) with verbal descriptors from 'no pain' (0) to 'excruciating' (5).

The SF-MPQ is simple to complete, taking 2-3 minutes, and offers a means of capturing both the intensity and some descriptions of pain. It is widely used in both clinical and research arenas and is well validated.³ It is included in appendix C.

Other pain scoring tools were considered such as the Brief Pain Inventory (Keller et al., 2004) which consists of 15-items that assess severity of pain, interference of daily activities due to pain, and impact of pain on mood and enjoyment of life. Originally designed for use in cancer the study by Keller et al validated it for use with low back pain. It measures items other than pain and these functional areas would be captured in a QOL measure.

³ Since the commencement of this study the Short-Form McGill Pain Questionnaire-2 has been published with the addition of pain descriptors for neuropathic pain (such as 'cold-freezing pain') and an intensity score of 0-10. The interpretable sub-scales have also been amended in order to produce 'a comprehensive measure of pain quality that can be used in studies of the epidemiology, natural history, patho-physiologic mechanisms and treatment response of both neuropathic and non-neuropathic conditions' (Dworkin et al., 2009)

Quality of Life Measures

QOL measures are being more widely used, perhaps as a tool to validate the shift within medicine away from science and technology alone providing improvements to a more holistic view which combines science with people's values and perceptions (Verdugo, Schalock, Keith, & Stancliffe, 2005). Using a quality of life (QOL) measure has the potential to offer a different description, giving the participant the option of 'commenting' on an area of life which might not be broached by them in the unstructured interviews. The vastness of the literature can be seen in that in March 2007 a search on Medline with the search term 'quality of life' elicited 98,072 hits; 'QOL and pain' engendered 10,322 and 'QOL and chronic pain' just 2,289. Less than 3 months later the latter had increased by 183 further hits.

This suggests one of two things – either it is a simple and easy to apply concept which is being integrated into many studies (and many of the funding Councils such as ESRC ask for QOL measures in studies they support) or it is so complex that there is no agreed definition or method of measuring it. The literature suggests that the latter is correct. In relation to the quality of QOL research in renal medicine Rapley (2003) says it is 'at best mixed and at worst unacceptably poor'. There is little evidence that the position in pain research is any different. As Rapley (2003) points out, one of the difficulties is the lack of agreement on what QOL is (population-based, individual, a policy tool, a media catchword), what should be measured (what areas of life are important, are they the same across nationalities or diseases) and how it is captured (short/long questionnaires, interviews, self-determined areas or decided by experts). Health-related quality of life (HRQOL) is frequently seen as a particular slant on QOL. For example Donald (2003) defines QOL as 'people's emotional, social and physical well-being, and their ability to function in the ordinary tasks of living' and HRQOL as 'the impact of treatments and disease processes on these holistic aspects of a person's life.'

Given this plethora of studies and measures consultation of the web-based directory *Patient-Reported Outcome and Quality of Life Instruments Database* (www.proqolid.org - accessed June 2007) elicited three measures for back pain

and 13 for pain generally. To these were added six generic QOL measures. To be considered measures had to be available in English, and, if designed for QOL and pain, to include general chronic pain or back pain. Next those relating to areas such as neuropathic pain were discarded. Also omitted were measures designed to provide economic or QALY (quality-adjusted life years) evaluation as this study is based on a personal, not population or policy perspective. Published expert guidance was also reviewed to assist in identifying measures. However, looking at the guidance on the choice of measures to use in back pain research (Deyo et al., 1998; Ehrlich, 2003) merely demonstrated the lack of agreement amongst researchers as both teams of experts only agree on one functional measure. This provided a short list of six tools; discussion of those which appeared most methodologically congruent follows.

Many QOL tools are designed to be used for noting change or a position in QOL in a large population and are therefore not useful for perceiving change in individuals. A self-administered tool, frequently used in pain research (the SF-36), has been charged with just that point (Gatchel, Polain, Mayer, Robinson, & Derch, 1998; Rogers, Wittink, Wagner, Cynn, & Carr, 2000), and has been augmented to try to overcome that problem with the modifications provided by the Treatment Outcomes in Pain Survey (TOPS) (Rogers, Wittink, Ashburn, Cynn, & Carr, 2000). TOPS has been designed to monitor the impact of a multidisciplinary pain programme, not a self-help intervention, and the areas in which it shows greatest sensitivity (total pain score, pain symptoms and satisfaction with care) may not be particularly relevant to my research which is focused much more on the meaning of the pain.

As the overarching approach to this study is phenomenological, based on the lived experience of the participants and their description of this, I next considered the possibility of using a respondent-generated QOL tool. These differ from the majority of available QOL tools in that they attempt to incorporate personal values which are generated by the individual participant. From a phenomenological perspective these appear very attractive. The Patient Generated Index (PGI) and the Schedule for the Evaluation of Individual Quality of Life (SEIQoL) appear to lie comfortably within a phenomenological approach

– they offer the patient the opportunity to define what is important to them as an individual. However, it is clear that many people struggle to define these areas without some prompting and to weight the identified areas. To overcome these issues the tools are interviewer-administered. If the same researcher was to do both the unstructured interview and the QOL measure the participant may feel that they are repeating the same things over again, and that time is not well spent and there may be the possibility of the two types of data impacting on each other. So, although it may seem that participant-generated tools offer methodological congruence it seems to me that there is a real danger of invalidating the data, making these tools inappropriate.

The World Health Organization Quality of Life-100 (WHOQOL-100) is a generic profile for subjective measurement of QOL in adults and has been described as an exemplary health-related QOL instrument (Rapley, 2003). Recent work, based on focus groups in the UK, has developed a pain and discomfort module to use with this (Mason, Skevington, & Osborn, 2004). Some of the facets identified link very closely with qualitative research considering the meaning or experience of pain. For instance the WHOQOL-PainUK includes questions on uncertainty (eg a lack of diagnosis) – a facet identified in other phenomenologically focused research (May, Rose, & Johnstone, 2000). It is self-administered, taking about 30 minutes, and is designed to be used by people who have had pain for more than 3 months (Mason et al., 2004; Skevington, 1998). It is also suitable for use to explore inter-personal changes (Skevington, 2007). It therefore fitted several criteria for this study but is too cumbersome to use as a weekly measure and therefore a global VASQOL was also considered. Like the pain VAS it consists of a 10cm line bounded with descriptors. The validity and reliability of this tool has been established in comparison to multi-item questionnaires and it is recommended for use in clinical trials.(de Boer et al, 2004). The global measure is included in Appendix C, but not the WHOQOL-PainUK which is subject to copyright restrictions.

Initially it was planned to have a diary, or ‘free text’ element to the weekly questionnaires but a review of the pilot data showed no useful data to be collected in this way. This element was therefore omitted in the main study.

Focusing sessions

In order to enable an understanding of the process the participants undertook a fuller description of Focusing is outlined below, using part of a Focusing session which took place during the study.

In the self-help guide to Focusing there is a promise to introduce the reader to a natural process which enables the person to ‘make contact with a special kind of internal bodily awareness’ – a felt sense (Gendlin, 1978/2007, p. 11). This process was identified by Gendlin and his colleagues when they analysed why it was that some clients in psychotherapy did better than others. Those who were more successful were able to refer to bodily felt experience (Hendricks, 2001). This idea of a ‘bodily felt experience’ is captured in the following extract from a participant’s focusing session:

Paula: I feel very... very in my head, above my shoulders

Focusing Companion: so you are noticing there is a lot there in your head and shoulders

P: and it feels excited

FC: and you are noticing there is something there that feels excited, something like that

P: it feels, it feels a bit like... it’s like it’s going before an exam when you know you won’t know anything more than you do at the moment... sort of anticipating

FC: so you are sensing it feels like going into an exam and knowing that you won’t know any more, like there’s some anticipating there

P: but its... yes... yes it’s something to do with like training, being trained, limbering up, limbered up

(Paula, 5th focusing session, p 6)

In order to use Focusing a person has to be able to develop an awareness and attention to the sense within their bodies – in the above example Paula was aware of a feeling of something, “I feel very ...”, in her head, above her shoulders. As she stayed with that unclear sense she found a handle to describe it – the quality of it was that of excitement. With the help of her focusing companion Paula went back and forth between her description and the felt sense, resonating the words with the feeling. Anticipating, training, limbering up; and she continued until she realised that she was so much enjoying being with this feeling that she didn’t want to move away from it.

FC: in fact you're finding it very difficult to move away. So you might like to really just take some time and to sense how that feeling feels in your body

P: I feel really quite planted and relaxed... and ready

By sensing, or asking how that feeling feels, and spending time with it Paula becomes aware of a change, the excitement has changed into a feeling of plantedness, of readiness, and she was able then to move into another Focusing cycle in which she explored some difficult areas around a situation in which she had found herself.

The above cycle of Focusing clarifies a number of issues in describing the process. Firstly one takes time to become aware of the felt sense (which may be a word or an image), then there is a time of describing it as carefully as possible, resonating back and forth, followed by a gentle asking of 'how' not 'why' and finally there is a feeling of receiving or a 'felt shift' (to use Gendlin's term). It is possible to develop awareness of a felt sense about a particular situation or to come in an open way just asking what is there. It may be clear to the focuser what the felt sense is about, at other times there may be nothing to which it seems to relate. The felt shift can occur when there is no particular situation – as in the example above. Sometimes the cycle does not come to a tidy conclusion and then the blockages to that conclusion can become something on which to apply further Focusing.

As Focusing has been used it has also developed different emphases; during this doctoral study contact was made with people who used inner relationship Focusing (IRF) (Cornell & McGavin, 2008), wholebody Focusing (McEvenue & Fleisch, 2008) and bio-spiritual Focusing (Campbell & McMahan, 1987/1999). IRF was the method mostly used in this study because 'IRF is not a method that is aimed at particular problem areas, but is adaptable to any issue that a client has, including relationship issues and even the suffering caused by pain and physical symptoms' (Cornell & McGavin, 2008, p. 21). Wholebody Focusing is based on physical movement and bio-spiritual Focusing on a belief in a spiritual world; these aspects could have been difficult for potential participants to deal

with. However one of the Focusing practitioners who took part did use some elements of wholebody Focusing in their sessions.

In the original design, outlined above, six 1-hour Focusing sessions were planned for each participant. It was anticipated that these would take place face-to-face and the researcher would be present for them. An opportunity to practice Focusing skills by telephone with the researcher was planned – although this was offered none of the participants completing the study requested it.

Six sessions were chosen as this reflects the number of treatments a CLBP patient may expect to get for a treatment such as acupuncture or the amount of time spent in a multidisciplinary outpatient pain management programme on relaxation or mindfulness. It is not sufficient time to enable someone to learn to be a Focusing Companion, but it was suggested by a Focusing Practitioner that it was sufficient to enable someone to acquire some Focusing skills themselves. Each Focusing naïve participant was also given a copy of *The Focusing Student's and Companion's Manual* (Cornell & McGavin, 2002) as providing written information in addition to verbal enables people to retain information. If they were interested there were also other books available for them to borrow. Both the Focusing naïve participants made use of these.

One newcomer to Focusing participated in face-to-face sessions for which she travelled to London, all the other participants had telephone-based sessions. This is an accepted way of Focusing, and one which is used widely both for learning and using the technique (Cornell, 2009). It was also a practical way of managing the research – there are few Focusing practitioners in the UK and recruiting near them proved difficult. With the participants new to Focusing the precise content of each session was left to the practitioner although there had been discussions between them and myself about the sessions being based broadly on an inner relationship approach to Focusing. Those participants used to Focusing followed their usual approach.

All the participants were able to contact me at any time if any problems were to arise during the sessions, and for the two learning Focusing, the practitioners teaching them were also able to contact me if needed.

Data Journey

Any study is dependant upon the quality of the data collected, its analysis and interpretation. It is imperative that care is taken with the data during all these stages. The techniques used to ensure sound data are outlined in the following sections: collection and transcription, analysis techniques, security and audit trail.

Collection & transcription

The data (interviews and questionnaires) were collected in the timeframe outlined above. Times for the interviews were arranged by telephone and took place at a time and place which suited the participant (within the REC stipulations). Appointments for the participant who undertook the Focusing sessions face-to-face were planned week by week, co-ordinating the participant's, practitioner's and researcher's diaries. The telephone Focusing sessions were co-ordinated between the participant and the practitioner. For those participants undertaking the sessions by telephone I sent them all six weekly questionnaire sheets and asked them to fill them in before the Focusing session and without looking at the scores they had filled in the week before. At the end of the sessions they posted them back to me. The participant who did her Focusing on a face-to-face basis returned the weekly sheet at each session and was given the next one at the same time.

The data from the SF-MPQ and QOLVAS were entered into an Excel spreadsheet. The data from the WHOQOL-PainUK was initially entered into SPSS where it was transformed (using the syntax file provided). It was then copied into Excel for the analysis.

The interviews and Focusing sessions were recorded using digital recorders and then transcribed, using voice recognition software (iListen) into Word documents. Each participant provided six one-hour Focusing sessions and up to 3

hours of interview data. The transcription of the Focusing sessions for each participant are in Appendix D, on the CD attached to the thesis.

Analysis

Interview data – The descriptive phenomenological psychological method

There are a number of ways of approaching narrative data in a broadly descriptive phenomenological manner. Well known is that of Giorgi (Giorgi, 1985; Giorgi & Giorgi, 2003), whose approach is based on Husserl's phenomenology, adapted to accommodate a scientific (rather than philosophical) and psychological focus. It is sometimes called the Duquesne school of phenomenology – as it was here that Giorgi was working when he developed it. This method is described below, linking Giorgi's steps with the theoretical concepts found in Husserl's approach and outlined in Chapter 2. The method described below aims to be rigorous and to avoid biased and subjective accounts. This may seem pedantic, but it is key to bear in mind that the 'subjective account of experience should be distinguished from the account of subjective experience' (Gallagher & Zahavi, 2008, p. 19). So the narratives or interviews collected during the research are subjective accounts but the application of the phenomenological method means that, in the end, the researcher has identified an account of the subjective experience. Moving from one to the other in a scientific and structured manner is what Giorgi's method seeks to provide for the phenomenologically and psychologically focused researcher. The steps taken in this approach are outlined below and a completed example from an interview is at Table 3.2.

Reading for a sense of the whole

The interview or description is read by the researcher in its entirety, enabling an overall sense of the description. No attempt to delineate parts or themes is made at this stage. It is merely a soaking of oneself in the data, letting it wash over one as a whole. This step is not required by Husserl as in the philosophical approach one is generally dealing with experiences which appear to your own stream of consciousness. Repeated readings enabled me to form a naïve grasp of the participants' experiences. Personally I found this a useful stage in helping me towards a position of bracketing, or *epoché* in Husserl's terms. This is a position

in which the researcher attempts to remove themselves from the preconceived ideas they may have about the subject being researched, trying to approach the narrative with a sense of freshness and discovery. Quite how possible this is, is hotly debated in phenomenology. The transcendentalists follow Husserl's approach (saying it is possible to transcend your own world and see it as another might) and the existentialists follow Heidegger and Merleau-Ponty (saying one should try but it is never really possible to bracket off all one's preconceptions and attain that transcendental view). The existentialists stress our own embodiedness in our world. This idea of embodiedness is also found in some of the qualitative work in chronic pain (Williams, 1998; Osborn, 2006). Langdridge (2007) suggests that Giorgi proposes a transcendental approach, but Giorgi himself acknowledges that this position is not possible outside the philosophical level, stating that the scientific phenomenological reduction is mixed one (Giorgi & Giorgi, 2003, p. 249). I take this to understand that Giorgi takes a rather more existential position, where the 'I' remains embodied in the *noema-noesis* relationship rather than stating that one is standing outside of it.

Establishing meaning units

Once the overall sense has been grasped the researcher continues to approach the data in this attitude of 'bracketing' - suspending what she knows about the phenomena from previous experience, opinion and culture in order to move through the data to examine the 'essences' which may be found there (Holroyd, 2001). The description is re-read with this perspective, keeping the phenomenon being researched in mind, and shifts of meaning within the data are marked, breaking the entire description into a number of 'meaning units'. These may be a sentence, paragraph or longer depending on the content and the aim of the study. Some parts of an interview may not be relevant at all. There is no specific right or wrong here – different researchers may well have some differences in the meaning units identified. Giorgi calls these meaning units constituents, on their own they make little sense, but put in context with the other parts they establish a meaning.

Transforming meaning units into psychologically sensitive expressions

At this stage the researcher goes through each meaning unit identifying and

transforming the psychological insight more directly. Giorgi defines psychological insight as ‘the subjective meaning that people bring to situations’ (Giorgi, 2008). The aim of this part of the analysis is to make the meanings given by the participants psychologically explicit in relation to the phenomena rather than in revealing them in relation to the participants’ life. This part can be seen as a type of phenomenological reduction, paying attention to the relationship between the object being experienced (eg chronic pain) and the experience itself (eg unbearable).

Section	Meaning Unit	Psychological insight	Revelatory constituent
DB39	<p>R: so how have you, you’re still involved with the West Gallery and things I gather, so how have you adapted to what you do there?</p> <p>D: I’ve doggedly insisted on doing as much of what I used to do as I can. So, we don’t dance, but we still sing, we do a lot more singing, I do a lot more singing. Because I sing in folk clubs and festivals and all that sort of stuff as well. So we carry on doing that and we, I take cushions to sit on if I know chairs are going to be bad and, we sort of get on and cope with it. We camp less at festivals and bed and breakfast more, although we still do some camping because that was another thing, we did a lot of, at the summer folk festivals we would always take the tent, big tent, and do it properly. Because it’s cheaper and more fun, but now we tend to bed & breakfast.</p>	<p>D has managed the limitations placed upon him by ‘doggedly’ trying to do as much as he can. So he and his partner don’t dance but do a lot more singing in folk clubs. He manages this by taking cushions to sit on and using Bed & Breakfast accommodation rather than camping.</p>	<p>Continuing to do things despite CLBP means planning in advance for eventualities and changing some patterns of behaviour.</p>
DB40	<p>R: it kind of feels there’s an edge of sadness as you</p> <p>D: oh yes. I’m starting to say “I used to do that, I used to be on Morris dancer, we used to go ceidilh dancing.” I can’t think of any others but it’s all that “I used to”. Yes, I used to be able to touch my toes, you know, all that stuff.</p>	<p>Daniel describes himself as a ‘used to do that ...’ person. This is not a position in which he expected to find himself.</p>	<p>CLBP makes one define oneself by what one used to do.</p>
DB41	<p>And that’s what happens when you get older, but I wasn’t quite ready for it yet.</p> <p>R: so it feels as they you’ve arrived at that point before you “should have done”</p> <p>D: Oh yes (some unclear muttering) and I don’t, at the moment I don’t see it as irreversible, I just haven’t worked out how to reverse it yet.</p>	<p>Daniel says that this is something he expected to do when he was older, not now, and he hasn’t worked out how to reverse it.</p>	<p>CLBP makes one feel older, but it may not be irreversible.</p>

Table 3.2 Part of an interview transcribed to show some of the moves made with the data as described above. (**R** = researcher, **D** = Daniel)

The determination of the structure

Finally the researcher synthesises and integrates the transformed meaning units using *eidetic* variation or imaginative free variation to strip away the unessential properties of the identified unit. By imaginatively varying elements of the experience the essential part, or essence, is helped into view and the non-essential parts are left behind. These essences are then related to one another and organised so that a consistent statement or structure of the phenomenon being researched can be written. This statement, or structure (as Giorgi calls it) contains the constituents identified through the meaning units. I have not included an example of the structure here as it is a fairly long paragraph – but they can be found in Chapter 4 where the findings are described.

Once this structure is in place it can be analysed and incorporated into the discussion of findings in the data. The structure should convey ‘what is truly psychologically essential about a series of experiences of the same type ... [it] is not meant to be universal but only general or typical’ (Giorgi and Giorgi, 2003 p258). This is a more tentative position than that of Husserl who claimed that the universal could be seen in the individual.

It is interesting to notice how didactic Giorgi is about the structure of his method. He is critical of variations introduced by other researchers such as Moustakas (Giorgi, 2006); this stance has a certain resonance with Husserl’s experience later in life where he felt that others had taken pathways that were independent of and different to his own. The descriptive phenomenological psychological method can be seen to be highly structured, almost scientific in its processes, and this is clearly one of its advantages as it seems to provide a method for considering the question posed in a way that can reflect the real-life situation of people as they live with chronic pain and also as they learn and apply Focusing. It is not a method which provides comparisons; each aspect will need a separate structure, but the structures themselves will provide a starting point for the discussion of any differences which are identified. It is an approach which stays close to the data. Finally, it has a definite psychological slant, something that may be useful as links with chronic pain and psychology have already been discussed in Chapter 1.

Focusing sessions

These were an intervention and so are not being analysed in a formal way, but will provide examples that illuminate and further the discussion of the findings from the interview and questionnaire data.

Questionnaire data

With a small number of participants it would be inappropriate to perform inferential statistical tests on the data which seek to identify relationships between the variables or trends etc. In the clinical world that type of trend data may be part of what one uses in deciding treatment for a patient, but it is the individual response which decides whether or not to continue it. This is described as $n = 1$ and is the approach to the quantitative data that will be taken in this study (Jackson, MacPherson & Hahn, 2006). Descriptive statistics were generated using Excel to perform the analysis and create the charts and graphs.

Counterpart analysis (Yin, 2006) will be the approach taken in linking all this data so that it is presented and discussed in an integrated manner, commensurate with the methodological underpinning of the study.

Security and audit trail

In line with university research governance arrangements, and taking an ethical approach to the data and participants, the data will be stored for 10 years. During the study data will be collected in both paper and audio format. At the completion of the study the MP3 audio files of the interviews and the Focusing sessions, which are currently stored on CDs, will be destroyed. The transcribed paper copy of these will be stored with the university. The audio files contain the transcribed data but also have some parts of conversations etc which are not relevant to the study and it is for that reason they will be destroyed to maintain confidentiality. It is also possible that voices may be recognised. The participants' names have all been changed in order to assist with confidentiality.

The questionnaires will be kept in their paper format with the transcriptions.

The data collected from the participants who then withdrew will be destroyed.

The consent forms and written communication between the researcher and the participants will also be lodged with the university.

During the duration of the study the collected data was stored either on a password-protected computer or in a lockable filing cabinet.

Researcher's journey

The researcher's journey covers a number of separate but related phases; taking ownership of the study, developing the skills required and delivering the results. Although the general area of the study was already identified prior to the commencement of the research, the journey I have taken as the researcher has made the study my own. My desire to keep it close to the participant experience brought challenges around confounding variables as discussed in Chapter 2. The wish to use mixed methods, as reflecting clinical practice, was also my decision and the difficulties and errors that stem from these decisions rest with me. My journey, with the participants and the data, in the design and delivery of the research form the basis of what follows.

Growing as a researcher

Although a competent clinician I began this journey as an inexperienced researcher. In this section I outline the research skills I developed in relation to the design and delivery of the study, my need to learn about Focusing and what was gained from what became the pilot study. Finally some practical issues around the design are reported.

Research skills

In order to design the study I needed to develop the skills I already had in the area of literature reviews, to enable me to devise appropriate research questions. This also meant having an understanding of the mixed methods approach when it became clear that the questions would require this approach. The ethical issues surrounding the design took some thought. For instance, what was it reasonable to ask participants to do in the way of questionnaires? In this study, and with my previous understanding of the impact CLBP has there was some concern that participants would complete the questionnaires. This concern was realised during the pilot study. The storage of data was a further issue as it was being collected

over a wide geographical area and, at some points, help by practitioners and participants before coming to me. Setting up good governance procedures included making arrangements to meet to exchange recordings etcetera. Some of these dilemmas were advised by those more experienced in research, some by rules already in existence and some by imagining myself in the participants' shoes.

Interview skills

The importance of developing competent interviewing skills has been highlighted (Van Manen, 1990). In order to practise interviewing I asked an acquaintance to spare me some time, and this was very useful. It also provided practise data for the phenomenological analysis. Initially I had thought to undertake the interviews somewhere the participant felt comfortable – their home for instance. This is something which, as a competent clinician with a wealth of assessing and interviewing patients, I had undertaken in my work previously. However the REC felt this would put me at risk and so a decision was taken to use the Focusing practitioner's premises or a colleague's rooms. Undertaking some of the interviews on the telephone was also a development I had not anticipated at the beginning and was, I found, very challenging. I had used the telephone for follow-up consultations in the clinical arena but in that environment there is a very structured format. In this study I was undertaking unstructured interviews and it has meant that as a researcher I have developed a number of practical skills in this type of interviewing. Over the period of time I interviewed each participant three times. As we got to know each other the feeling of the interviews changed and became more relaxed. Ironically this meant that eliciting concrete experiences from the participants, who slipped off into generalisations very easily, became more difficult. I tried to adopt a 'discussion' strategy (Schostak, 2005) but feel it was only partially successful. I found the advice by Van Manen (2002) very useful, trying to keep the aim of the interview ('The experience of living with CLBP' or 'The experience of living with CLBP with Focusing in your life') at the front of my mind, returning to it frequently.

Learning Focusing

Early on it was thought to be useful if I learned Focusing myself to enable an in-depth understanding of the process and application of it. I undertook a five

month course and achieved the BFTA certificate in Focusing skills. I also learned so much from Barbara McGavin whose advice and insights were invaluable, and a weekend workshop with Ann Weiser Cornell brought many Focusing aspects together for me. However learning Focusing was not without challenges – at times I found myself with people who had a very different worldview to my own, and that of the medical world in which I work. At times I was challenged to see how Focusing could fit into the world of chronic pain. However, without learning Focusing I would have struggled to understand some of the happenings in the Focusing sessions.

Pilot study

In retrospect I think the design of the study should have included a more formal pilot study as a number of practical issues were raised with the first person who agreed to participate. Much of this related to the commitment required – this participant cancelled sessions the morning they were due. This led to unexpected financial implications (I had to travel a round trip of 300 miles to attend and also pay the practitioner and the room hire). So checking with the participant the day or so before the sessions became a useful addition with subsequent participants. Recruitment, as outlined above, was problematic. On reflection, and as it affected the subsequent direction of the study, I think commitment was one of the issues involved. Others were around the difficulty in defining Focusing and the use of the medical model.

The name ‘Focusing’ does not really give any clues about what it might be, and in fact could be counterintuitive in pain management where there are some approaches which specifically ask people NOT to focus on their pain (distraction techniques etc). Although I have tried to explain it, or put it into contexts which may provide some help such as meditation or mindfulness, I feel this has been a real stumbling block in the recruitment (and discussions with Focusing practitioners lead me to think it is a factor in the wider acceptance of Focusing generally). Add to this the fact that there were no earlier studies which offered possible outcomes for people with CLBP who used Focusing and it had limited attraction.

The original study was based on a medical model which I tried to unmedicalise as much as possible. Traditionally the doctor will suggest to the patient that they try such-and-such a treatment, and, even if it is not helpful, it comes with a certain authority. The published studies on mindfulness and pain come from patients who are within a pain clinic and are recruited from within a system in which they are already involved. Although self-management techniques are taught, the motivation comes from being in the system rather than self-directed. Perhaps my approach was too ambitious in its crediting of self-motivation.

Changes to the sampling

On reflection I feel the sampling technique that most closely resembles that used for the Focusing naïve participants is that of opportunistic and snowball. An acquaintance asked about the study and, after I had explained about Focusing, then asked if she could be part of it. She told her friends, thus snowballing the recruitment. The slow recruitment was the most difficult of all the frustrations I faced – leading to changes in the type of participants and the length of time to follow up.

Incomplete data

There is also some incomplete data – two focusing sessions are incomplete due to problems with using new equipment half way through data collection. This was due to the university requiring its telephone recording equipment to be returned and the new equipment I purchased was not familiar to the practitioner doing the recordings. This was a disadvantage of the change to the design to incorporate telephone as well as face-to-face sessions. There was also a week's missing data from a questionnaire during the Focusing session. This was because the participant forgot to bring it with her to the session, and had not completed it and could not do so in retrospect. Finally one participant did not return the final set of questionnaires although the interview was done. The life-circumstances of this person at the time made it inappropriate to continue to chase for the data.

Conclusions on the study design

The study was designed to answer both the qualitative and quantitative research questions using a concurrent nested mixed methods model, as shown in Chapter 2. Overall the design flows well, capturing data as participants move through the

study and capturing both types of data consistently. This is in line with a concurrent nested design. The analysis of the interview data is rigorous and, I believe, one that sits congruently with the intervention being studied. It is presented transparently, as are the quantitative data, and the linking of both strands is consistent.

The design, although undergoing some pragmatic alterations, does respond to the design quality criteria identified by Teddlie and Tashakkori (2009) and detailed in Table 2.1. The design is suitable for answering the research questions, there is fidelity to the different qualitative and quantitative components and consistency within the design. Finally the data analysis is adequate to provide possible answers. It is not perfect, but care has been taken to ensure it is robust and takes an ethical approach to the participant, data and researcher.

Summary of Chapter 3

This chapter has linked the design of the study with the methodological approach of a concurrent nested study outlined in Chapter 2. It has done this by taking three perspectives, that of the journey of the participant through the study, the data and the researcher's journey. Common threads, such as ethical issues, are discussed in the appropriate areas.

The participant journey covered the design areas of recruitment (specifically considering sampling and consent), the interviews, questionnaires and Focusing sessions. The data journey considered the collection and transcription of the data, its analysis (including consideration of Giorgi's method in the light of Husserl's philosophical plan) and issues around security. Finally the researcher's journey considered the skills developed and the steps taken to deal with the problems encountered.

Overall it was suggested that the design, albeit not perfect, answers the criteria for design quality in mixed methods studies suggested by Teddlie and Tashakkori (2009).

Chapter 4 – Findings

Introduction

The presentation of the findings in this chapter is based on a mixed methods approach to the data; one using Yin's (2006) concept of counterpart analysis. This means that both the qualitative and the quantitative data will be presented and analysed simultaneously. This approach is discussed more fully in the next section of this chapter.

Chapter 4 is organised in a chronological fashion, following the time line of the study. The participants are introduced – using pseudonyms to protect their identity – and their life situations briefly covered. Throughout the chapter the voices of the participants are foregrounded. The findings from the first round of data collection are then presented. To convey the real-life experience of living with CLBP there is a short, reflective piece of creative writing, based on the participants' experiences but filtered through the researcher's perspective, to help the reader to enter the world of the participants.

The data collected during the Focusing sessions and the immediate post-Focusing interviews follows this. Here a new structure of the participants' life experience of using Focusing with CLBP is explored and related to the pre-Focusing experiences. A similar approach is taken to the final data set. Only interview and questionnaire data is used in the analysis chapter – the Focusing sessions are used in the following discussion chapter to expand and further portray the findings presented here.

The two research questions being explored here are 'What are the differences ascribed to the meaning of CLBP before and after using Focusing?' and 'Does Focusing impact on pain scores and quality of life measures?'

Counterpart analysis

In Chapter 2 the concept of counterpart analysis was introduced – using both qualitative and quantitative data to look at the same variable. In the analysis and presentation of the data from this study a counterpart approach has been taken. It

becomes more apparent as the chapter proceeds, the pre-Focusing data sets the scene providing the framework in which the two post-Focusing data sets can be analysed. The counterpart methodology is more apparent in these later presentations and the discussion chapter that follows. For instance, in the analysis of the data immediately following the Focusing sessions, the description and sense of the participants' pain is described and interrogated using both the qualitative data and the pain scores from the quantitative data.

Presenting both qualitative and quantitative data in this way is unusual. This attempt to integrate the presentation of the data has not been easy, but doing it in this way has been a response to the challenge of undertaking as fully an integrated mixed methods research study as possible. Having collected the data in a concurrent manner it seems logical to analyse and discuss the findings in as concurrent a way as possible, enabling the findings to be considered together in an integrated manner, as a whole and not separate parts (Teddlie & Tashakkori, 2009). This seems to me sympathetic with a phenomenological approach where one is trying to gain an insight into the personal experience. The quantitative data provides another voice or perspective from the participant, albeit one that has some directive filter already in place. This approach to finding meaning in measurement is one that Husserl explored in his book *The Crisis of European Sciences and Transcendental Phenomenology* where, amongst other things, he considered the history of mathematics from his phenomenological perspective. Mixing measurement and meaning is a pathway taken before, and one that I believe will offer extra layers of understanding to this study.

Participant profiles

Paula (P) is a 61yr old divorced woman who recently retired from secondary school teaching. She now does some child care for her daughter 1.5 days per week. Paula has had CLBP for 5 years, reporting continuous pain in her lower back and spine, legs and pelvis. She has not sought specialist management for her CLBP.

Daniel (D) is a 58yr old man, living with his partner and working full time as a consultant engineer. He has had CLBP for 3 years, which he reports as

continuous pain in his lower back and spine, legs and pelvis. He is being treated at the local specialist pain clinic.

Joanna (J) is a 57yr old single woman who is a self-employed Focusing teacher and practitioner. She has had CLBP for 20 years which is continuous on movement in her lower back, spine and legs. She has had no specialist management but has used complementary therapy.

Teresa (T) is a 58yr old woman, living with her partner and working as a Focusing teacher and artist. She has had CLBP for 10 years which she reports as intermittent in her middle and lower back. Like J she uses complementary therapies and has had no specialist management.

Pre-Focusing sessions: questionnaire responses

Table 4.1 shows the Short-Form McGill Pain Questionnaire (SF-MPQ) scores as recorded post-interview but prior to beginning the Focusing intervention. Details of this questionnaire can be found in Chapter 2 and ranges are shown within the figure.

	Paula	Daniel	Joanna	Teresa
Affective (range 0-12)	1	0	2	0
Sensory (range 0-33)	6	6	18	8
VAS (range 0-100)	29	21	15	38
PPI (range 0-5)	1	1	1	2

Table 4.1: Participant responses to the SF-MPQ Pre-Focusing

It is of interest that the sensory descriptors of the Short-Form McGill pain score were identified more than the affective descriptors, two participants not identifying any affective elements to their pain using this measure.

Table 4.2 compares these baseline scores with those from a recent paper investigating the Norwegian SF-MPQ (Strand, Ljunggren, Bogen, Ask, & Johnsen, 2008) where a musculoskeletal group (low back pain, neck pain and widespread pain) of 58 patients was included. Notwithstanding the possible

cultural differences it makes for an interesting comparison. The standard deviation for the sample from the Focusing study is not included as it is too small to make any meaningful contribution.

Variables	Strand et al n = 58	Day n = 4
Women, men n (%)	45 (78), 13 (22)	3 (75), 1 (25)
Age, years: mean±SD, min-max	40.6 ± 8.5, 23-59	58.5, 57-61
(N)SF-MPQ		
Total (0-45): mean±SD, min-max	16.9 ± 6.5, 2-38	10.25, 6-20
Sensory (0-33): mean±SD, min-max	12.8 ± 6.5, 2-27	9.5, 6-18
Affective (0-12): mean±SD, min-max	4.1 ± 2.9, 0-11	0.75, 0-2
PPI (0-5): mean±SD, median, min-max	2.9 ± 0.5, 3, 2-4	1.25, 1, 1-2
VAS (0-100): mean±SD, min-max	60 ± 15, 19-94	26.5, 15-38

Table 4.2: Comparison of demographics and baseline scores

It is clear that the sample from this study report lower pain scores than those from the Strand study. This is not surprising as Strand *et al* recruited from a group of people who had been referred to an outpatient spine clinic, whereas this study's sample came from the community and only one (Daniel) had been seen by a medical specialist. However the wide range of scores make it clear that there was a large variation in the scores from the Strand study, indicating how variable pain scores can be in this particular group of patients. It has not been possible to find figures for a community, non-referred back pain sample in the UK or abroad to provide comparison with the figures.

The Global VAS was measured on a 100mm line anchored with 'worst possible QOL' (left) and 'perfect QOL' (right). The pre-Focusing global QOL scores are shown in Figure 4.1. For comparison the overall score from the WHOQOL-PainUK is also included. Both are percentage scores with the higher numbers indicating better QOL. It is of note that three of the participants have similar scores for both overall measures, indicating that there may be some correlation between the measures. This has not been investigated elsewhere in the literature and it is a very tentative suggestion. However Joanna's scores are very different, the reasons for this are unclear.

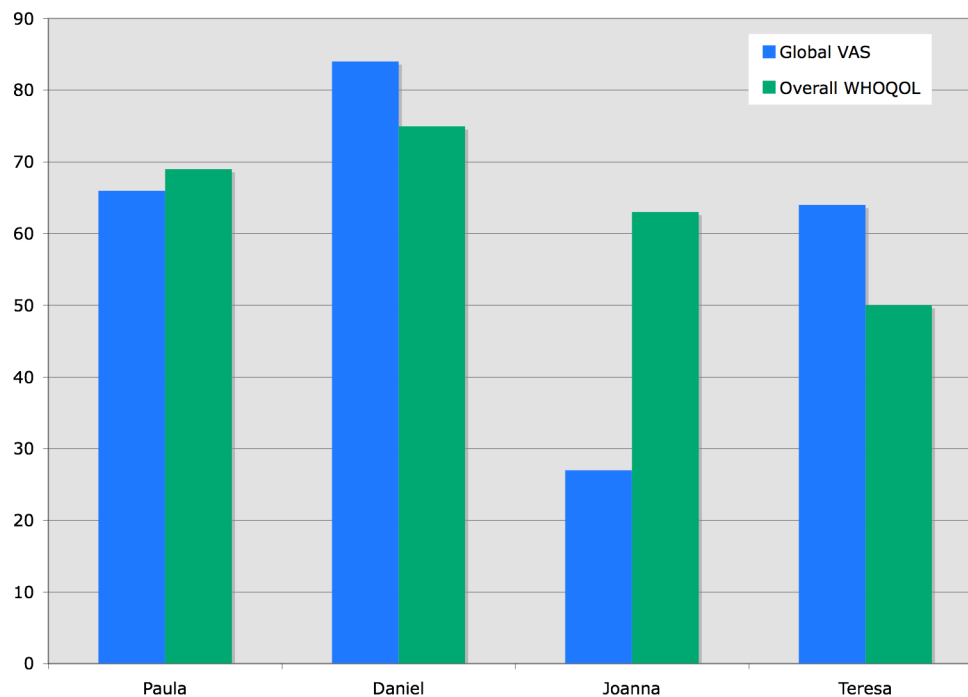


Figure 4.1: Pre-Focusing global quality of life scores (range 0-100)

Pre-Focusing sessions: interview analysis

The participants were asked to talk about their experiences of living with chronic low back pain (CLBP). The analysis was undertaken using Giorgi's (2003) framework, approaching the interviews with the question "What here is revelatory about the meaning of the experience of living with CLBP?" As a working definition of meaning Johnson's (2007) three elements of meaning as relational or interconnected, social and grounded in the body was used. After identifying the meaning units and the constituents (using imaginative variation) from all four interviews they were brought together to form a description of the overall narrative structure of the phenomena. This general structure of the phenomenon of living with CLBP is followed by an exploration of the six facets or particular phenomena identified within the general structure.

The structure of the experience of living with chronic low back pain (CLBP)

For these participants, who have 38 years of CLBP experience between them, the experience has a number of meanings. They live daily with this changeable pain; a pain which appears to them as a veil through which they have to push forwards, seeing life through this hidden opacity. The

physical toll of the pain limits movement, exercise and activities but insists on changes in position; it leaves one exhausted from the effort of completing tasks. The pain can be at the root of misunderstandings between partners and friends, making both the person with pain and the other uncomfortable; expectations are questioned. It is hard to find words to describe CLBP; it is not fair but demanding; it brings feelings of sadness and despondency, fear, frustration and resentment, guilt and envy. Many things help but nothing gets rid of the pain; managing it requires multiple strategies, all themselves demanding of oneself and, on occasions, other people, but doing nothing is not a choice. CLBP takes away youthfulness, controls what one does and changes how one defines oneself; diminishing both one's world and sense of 'me-ness'.

Within this overall structure are embedded six phenomena that appeared from the interviews. These are:

- “Living through a veil of pain” – describing the pain
- “The straw that broke the camel's back” – the meaning of the pain physically
- “I didn't mean that” – the meaning of the pain socially
- “CLBP is NOT fair” – the meaning of the pain emotionally
- “Many things help but nothing gets rid of the pain” – the meaning of managing the pain
- “But I am not me” – the meaning of a diminished self and world.

These are explored below, embedded in the interview data but filtered through the research perspective.⁴ Each of the six phenomena is presented firstly with data from the study and is then followed by a reflective paragraph, presented in different typeface. This second part of the description of the phenomena is not related to a particular participant but a reflection by the researcher on what was explored. It is an attempt to convey the lived experience of the participants to

⁴ In the text I have used letter and number codes to identify specific meaning units. The initial letter identifies the participant, B identifies it as the interview before the focusing and the number the meaning unit of that interview. Later in this chapter A identifies the interview immediately following the Focusing sessions and F the follow-up interview.

those who have not had the experience of living with chronic pain. This approach was influenced by Van Manen (2002) who suggests that such a vicarious approach can enable people who read the research to become more experienced themselves. To clearly differentiate these sections they are produced in a different typeface.

Living through a veil of pain - describing the pain

everything is done through this veil of pain. I'm not dragging it along behind me, I'm kind of pushing it along in front of me, I'm trying to get through it.

(DB 23)

Chronic low back pain is changeable, varying in intensity (PB17), constantly keeping the person with it on their toes, unaware of its next move. It seems to become something in its own right with the ability to suddenly appear for no apparent reason. They may have been doing something they have done many times in the past, as simple as standing up, and this time the pain just appears (DB49). Or it may materialise as a different sort of pain, one that feels quite different from the 'normal' pain, causing the person to crease up (JB10). It can be triggered by small, usual things that one does from day to day, picking something up or bending over (TB14). For some people the pain in their back is supplemented by chronic pain in other parts of the body and treating these can make the back pain worse (TB52).

Worse than this the pain is both hidden and hides. It cannot be seen by others – merely the effect it has. So the sudden appearance of pain, maybe when standing, only manifests itself to the person with pain as they move and remains hidden from others until there is an outward response; a cry or movement. The pain itself has been hidden, crouching in the body, to become unleashed at an unknown time and, at times, with an unexpected ferocity. At other times even the effect is hidden from the outsider but the person carrying it is aware of it almost constantly. It becomes a veil that surrounds them, that separates them from the world and others, that changes the view of their surroundings with an opacity filtered through the pain. The veil becomes a multi-layered creation; layers in place to hide the pain from others; layers that distort the ability to see the way ahead, making everything murky and difficult; a veil that is variable and has finer places where the pain does not occlude, but these swirl around and change daily. It is a

veil which provides no sanctuary and eludes the attempts to grasp it and rip it from top to bottom; one that demands to be worn.

The straw that broke the camel's back – the meaning of the pain physically

Things are so heavy. You think, 'well, it's only a thing of juice', and somehow that extra bit ... suddenly I'm in much more pain

(TB68)

Physical reasons for the pain are sought, poor posture, sedentary activities and movement may be blamed. The pain is a response to putting stress on the body, resulting in physical tiredness or even exhaustion (JB3, TB6, PB21, DB1). CLBP takes away enjoyment from activities, making them difficult to undertake and transforming them from something to be anticipated with joy to a concerned anticipation (JB8). The pain can demand frequent changes in position but also determines how those movements are made. These newly-learned ways of moving can affect other parts of the body negatively causing further pain (PB16). The physical nature of CLBP makes one more aware of one's posture. Pain is full of contradictions, the pain is reduced by doing nothing (JB5) and by undertaking exercise (PB10). However the options for exercise are reduced (DB14) even when using analgesics to reduce the physical impact of the pain (JB9). Carrying loads and performing other tasks can be difficult, may have to wait for another time or be done in stages (TB8). They certainly have to be undertaken with greater care, rushing to do things to get them over quickly and reduce the pain leads to accidents (TB7) and doing extra on days when one feels good can lead to more pain as enthusiasm overcomes common sense (DB61).

There is an embodied physical response to CLBP, like that of the Arabian camel. Forced to wear shoes, the camel was loaded beyond its capacity to move and adding the final, seemingly insignificant, straw led to a burden that was too much to bear. Like the camel's shoes CLBP alters the way one moves, transferring weight to other joints, bending awkwardly to try and navigate the movements that cause pain. How can one avoid that final straw? How can one tell what it will be – for it varies each time; once carrying a pint of milk, another time standing to do the washing up, yet another picking up a child. Nothing big, nothing that would have been problematic before the back pain; now the inconsequential has consequences beyond what could have been imagined. How can one know what today's 'straw' will be, or if there will not be a straw at all and one can do

the things one wants? Why should the physical movement constrain enthusiasm, cause mistakes and accidents, make decisions? And being so burdened brings such a weariness, a tiredness which penetrates the painful bones in a body which doesn't allow stillness, that insists on movement which both eases and worsens the pain and interacts with feelings, making the camel's hump insignificant. Why does he have to wear those shoes?

I didn't mean that – the meaning of the pain socially

If I see a pained expression on somebody else's face it doesn't make me feel any better, it just means I start worrying about them

(DB59)

CLBP brings social limitations, reducing options for holidays because of carrying luggage and standing at the check in (TB28), it makes travelling long distances while seated difficult (DB53). This can mean seeing less of one's family. It has an impact on relationships, becoming part of the changing dynamic of grandparent and grandchild (PB27), of partners (DB37) and friends (JB32). The pain can transform everyday circumstances into ones that become irritating, exacerbated by thoughtlessness (TB35). Because the pain is changeable others can find it difficult to believe that what one can do varies from day to day (JB36) and may be surprised at the activities undertaken (DB11), questioning your strategies. Not wanting to put others out or ask for help one may do things that make the pain worse (TB29). But friends can provide an impetus to do things one enjoys and offer a different view on things (JB32).

Dance, which used to be such a big part of life, has almost disappeared. The meeting with friends, the shared pleasure of music and movement, replaced by times of waiting for others to dance and trying to avoid the looks of sympathy. Those looks which are meant to show understanding but really engender a feeling of guilt that one's inactivity and pain is disturbing others. The behaviour which gives others the possibility of seeing the pain and judging. What is expected? The daily changes in the pain mean that what is done today may not be done tomorrow, the walk to the café for cake and coffee may have to be deferred, leaving a social life at the beck and call of a painful back. But friends and family are important, are part of life both before and with CLBP. They can see things from a different perspective and their energy buoys one up. But, oh the things that irritate – the endless queues where those in front have all day to stand and chat, the people who talk

unceasingly of their complaints, the public spaces with no seats and the airlines with unending corridors. So one gets grouchy and moans, then is led by social pressure to say, 'I didn't mean that'. But I did.

Chronic low back pain is NOT fair – the meaning of the pain emotionally

I can hardly get down the stairs ... [and] I kind of, you know, I negotiate using both banisters. And I'm 61, for God's sake. You know, it's, it's rubbish really

(PB12)

The emotional impact of CLBP is wearing and tiring (JB23), bringing with it feelings of anger, frustration and resentment (DB22). Frustration at the things that can't be done (TB60); a sense of despondency and a burden of sadness (JB16) over the resented limitations it imposes. Alongside this there are many fears, fear that the pain may put one in a situation that seems unmanageable (TB38); fear that there are 'new' areas of life that CLBP will curtail (PB30); fear of sharing these fears with others (TB38). It makes one envious of others' abilities, seemingly taken for granted (JB17) and guilty about not doing what is expected of oneself by others (DB54). It imposes hated strategies to get round the limitations (PB9, TB67) but sometimes it is possible to feel pleased, even through the resentment, that the limitation has been managed (TB19).

Sometimes the pain just makes me want to stand in the middle of the room, close my eyes and shout "It's not fair. Why can't I?" But that is usually the day when standing is so painful I want to be sitting or lying. How I hate the pain, hate the way it governs what I do, hate the way it makes me feel, hate the way it makes me hate. And I don't like this anger, I'm not ashamed of it, but I don't like it. At least it has energy and I know I'm alive, at other times the burden of sadness and loss just drains me. And I try, I try so hard to manage all the changes, but I still resent the fact that I have to change, that the pain imposes its changes on me. I look at friends who walk to the shops without a second thought and I envy them – and it is easier said than done to be grateful for what I can do when at the back of my mind I wonder how long I will be able to carry on. What is the next thing I won't be able to do? That fear stalks me and I fall prey to my imagination – will I have to use a wheelchair to get about? Will I have to ask for help? And the fear becomes a knot in my stomach that tightens into anger and frustration; it's not fair.

Many things help but nothing gets rid of the pain – the meaning of managing the pain

So yes, it's a question of managing...I felt like I had to get through the little tasks I was doing [so I] just gritted my teeth and got on with it.

(JB4)

People with CLBP look to themselves and others in trying to manage both the pain and the impact it has on their lives. Help is sought from healthcare professionals and complementary therapists and people often have more faith in one approach than another (TB48, DB4). A lack of clarity and explanation around diagnosis can be confusing and frustrating (JB20, DB43) and decisions about medical management may be constrained by risk factors (DB7). The relationship with the practitioner is paramount (TB50). Analgesics are used but some pain is not helped by them (TB75); they seem to lose their effect (TB74), affect mental function (DB26) and have unpalatable side effects (DB48). They can be useful in certain situations (JB7) and, although taking them regularly might improve the pain, there is a reluctance to do so (DB44). In looking to their own resources people with CLBP plan activities around the constraints of the pain (TB18, DB39, PB39), doing things differently (PB20) and bringing in another layer of decision-making into day-to-day tasks (DB25). This leads to a reduction in spontaneity (PB2) and a daily adaptation to one's environment at work, home and leisure (DB21&17, TB41). Doing nothing is not a choice (TB23) and practical solutions are manifold.

Before venturing out one has to go through a mental list – where are the public benches if a quick sit is needed? what to do if the comfortable seats are taken at Costa? rucksack to carry back any unexpected purchases? couple of co-codamol in the purse just in case there's a sudden onset of pain? When looking at the choice of seats in the café so many decisions to make – is it too high, too low, the right depth of seat, has it cushions so there is a little flexibility, is it positioned so the less-than-smooth movements are not on view to everybody? At work they have been helpful and chair and desk of the right proportions have been provided, but there are still days when the only way to manage is from bed at home. Gone are the days of spontaneity, carrying large presents for the kids on the bus – but ask for help? Never! The doctors say they are not sure what the problem is, there are lots of things in the back that can go wrong, but their advice is the same whatever – take the pills and keep going. Surgery is too risky and probably wouldn't help. The osteopath is

much more helpful, with scary explanations of overlapping vertebra, but at least he tries. So, carry on then, getting manipulated, taking as few pain killers as possible and planning ahead. Always planning, never just going.

But I am not me – the meaning of a diminished world and self

And it, it just makes me feel less free, and less me really.” “And then I think, if I’m feeling this now and I’m not 60 yet, how am I ever ... I don’t want to see my world reducing

(PB3, TB72)

There are no good points about CLBP, it leads to giving things up, diminishes freedom, controls what you do and how you define yourself (DB58, TB70, PB14, DB40). CLBP makes one feel older and makes one’s body behave in an ‘old’ way (PB1, JB18). But there is hope that this is not irreversible (DB41) and that the adaptations made may only be temporary (TB22). However, as time goes on, it feels as though CLBP becomes ingrained in life (TB11) reducing risk-taking and independence (TB57), restraining one (PB4). CLBP challenges assumptions of future situations (PB29) but the hope for improvement leads one to refuse to plan for a future of pain (DB62).

I always imagined how I’d be as a grandmother – taking my granddaughter to the park, pushing her on the swings, playing hopscotch, catching her up in my arms as she ran towards me. We would laugh together and I would remember the happy times I had with her mother. OK, I might not run quite so fast, or push the swing for quite so long, but I’d be doing it. And now ... well I don’t run, I push about 5 times and catching her up in my arms is hopeless, it just brings a searing pain and the joy is gone. I’m not the grandmother I want to be, I’m not me. This pain is in every pore of my body and most sentences seem to start, “I used to...”, or “Before I had the pain I...”. So I don’t get to do the things I expected to, and I don’t always go to things I plan to – sometimes a trip to the theatre has to be put off and my tickets given to a friend. But I will still buy them because I refuse to plan to do nothing because of the pain, and it may be a good day and I can go and enjoy *Hamlet*. But I don’t buy them as often as I used to, so my world gets a little smaller. And don’t I feel old – I know my mother used to say she was a young person in an old person’s body, but she was 70 then. I’m in my 50’s and feel less able to do things than she was at 70. Old – my body feels worn out and I feel robbed. Robbed of what is just normal, things everyone expects to do. The pain has stolen my life.

Pre-Focusing: conclusions

The pre-Focusing data presents some variation within the participants, but more strikingly there is considerable agreement between participants. This is noticeable in the narrative data where the various meanings of the pain, and the impact it had, contained similar aspects for all four people.

Focusing sessions

Following the interviews and questionnaires explored above each participant took part in six Focusing sessions. This being real life they varied slightly and the details of each are outlined below.

Paula travelled to London over a 14 week period to undertake 6 sessions with a Focusing practitioner based there. Holidays, missed appointments and other engagements meant it was completed over a longer period of time than initially planned. The researcher was present at each session, recording it.

Daniel was keen to be involved but there was not a Focusing practitioner available nearby. After some discussion it was decided to go ahead using the telephone. As stated above, this is a recognised way of engaging in Focusing. His sessions took place over six weeks, as planned, with the Focusing practitioner recording the telephone sessions. The researcher made contact during the time with both Daniel and the practitioner to ensure that both were happy with the process. During the time he was learning Focusing Daniel had some unexplained abdominal pain which was thought to be related to gall stones.

As both Joanna and Teresa were both experienced Focusers they were not in the relationship of learner and teacher (which was the experience of Paula and Daniel). Their partnership in the study was that of a Focuser and a Focusing companion. So Focusing itself was not new to them, what was new was using it specifically with their CLBP. Joanna completed six telephone sessions with Teresa over an eight week period which were recorded. Concurrently she was having acupuncture and making other life-style changes that were suggested by the acupuncturist. Due to a change in equipment part of her final focusing session was not recorded.

Teresa completed seven telephone sessions Focusing with Joanna over an eight week period which started after Joanna had completed her sessions and interviews. The first session was lost due to the problem with the equipment discussed above. This was picked up by the researcher when downloading the sessions. The first Focusing session is therefore unusable but the following six were in full. Doing seven sessions was due to a counting error by the participants. During the sessions Teresa had a car accident resulting in a visit to see an osteopath to deal with the subsequent whiplash injury.

The Focusing sessions have not been analysed but will form part of the supportive data in the discussion part of this thesis. They are reproduced in full in appendix D (on the CD provided with the thesis). During the Focusing sessions the participants completed the SF-MPQ and global QOLVAS six times, between each of the sessions and after the last but before the follow-up interview. This data is described in the following section.

Immediate post-Focusing sessions: data analysis

An unstructured interview format was used again with an opening question asking the participants to tell me about the experience of living with CLBP with Focusing in their lives. I had re-read their pre-Focusing interviews and occasionally asked about something in relation to them if it seemed appropriate. The interviews were analysed using Giorgi's method as before, approaching the transcripts with the question "What here is revelatory about the meaning of living with CLBP with Focusing in your life?" From this came the structure below as well as other more general comments about the study and focusing generally.

The structure of the participants' experience is presented and described first, then each identified phenomena explored with the participants' pre- and immediate post-focusing data. The quantitative data is presented with the qualitative, where appropriate, commensurate with a Yin's (2006) counterpart approach.

The structure of the experience of living with chronic low back pain with Focusing in one's life

The participants were a mixture of people, some had been using Focusing for many years, and for others it was an entirely new experience. All participated and came to the experience in an open-minded way. For three of the four Focusing exceeded their expectations. Although initially their pain might increase when attention was given to it they all experienced a reduction in pain. The fourth participant found the pain increased when attention was given to it, but it did not reduce. There were no untoward side effects and all four enjoyed the time spent Focusing, legitimising their pain and spending time with it. The three who found it beneficial also found they increased their exercise and Focusing enabled them to find and release the energy which the pain had exhausted. Tearfulness was reduced and an aliveness found. They were able to be with their pain and discovered an acceptance that was not there before. Focusing helped them listen to their pain; and a willingness to meet it provided the possibility of healing. The balance of their world changed and facilitated a moving on, rather than a picking over of things. All four expressed a desire to explore it further.

Five phenomena were identified from these immediate post-focusing interviews.

These are:

- “The painful part doesn’t have to shout so loudly” – focusing and the sense of my pain
- “Sometimes I feel like a tortoise” – focusing and the physicality of my pain
- “I’m not giving up on myself” – focusing as part of my pain management skills
- “I have found smaller ‘mes’ that make the ‘big me’” – focusing and myself
- “When focusing ‘clicks’” – personal benefits of focusing.

The painful part doesn't have to shout so loudly – Focusing and the sense of my pain

bringing my attention to something means that it gets heard, as it is, without any judgement. It gets really heard. And when that part of me is heard it doesn't have to scream so loudly, because I am listening. So the pain reduces.

(JA49)

Focusing with chronic back pain can increase its intensity (DA9, JA15) and Focusing on back pain may be a starting point in identifying other painful areas in the body of which the person may not be aware (DA7, JA36). These other painful areas may improve even without Focusing on them specifically (TA6, TA43). Although most participants found using Focusing reduced their back pain (PA2, TA29, JA22) one found that it did not cure or reduce the pain (DA6) or enable him to ignore it (DA10). Those who found it useful were surprised by the reduction in pain (PA17) and a change in the nature of the pain (JA19), even experiencing some pain-free times (JA31). The painful area felt easier and connected to the rest of the body (TA18). When focusing on a particular painful place a regular sensory pattern was experienced (TA12) and a sense of aliveness was noted in the back (TA28). Taking time to listen to the painful part may be directly related to the reduction in pain (JA49).

The VAS score from the SF-MPQ is a measurement of pain intensity and the sensory and affective scores measure the nature or type of pain. The VAS scores from the participants are in Figure 4.2 and show a wide interpersonal range for Joanna and Paula in particular. An attempt to explore any correlation between the VAS scores and time was undertaken using Pearson's correlation coefficient. This computation produced a r^2 of 0.36 and a significance of 0.11 hinting weakly towards a trend. The limited number of participants is a major limitation in making any comment about relationships within the statistical data. The individuals' correlations are shown in Table 4.3, Teresa having the only correlation of any significance.

It is of note that Daniel, who indicated in the interviews that he had not found any improvement in his pain using Focusing, has the smallest range in his pain VAS of any of the participants.

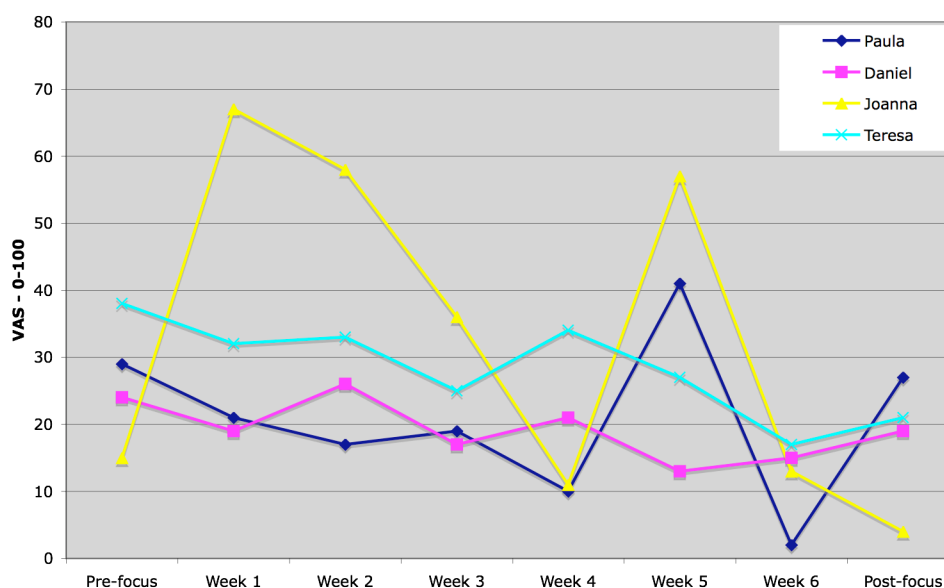


Figure 4.2: Participants' pain VAS scores before the intervention, during and following it. (Week 1 data for Paula an estimate)⁵

Participant	Pearson coefficient (r^2)	Significance
Paula	0.012	0.79
Daniel	0.36	0.11
Joanna	0.19	0.28
Teresa	0.69	0.01 *
All participants	0.36	0.11

Table 4.3: Pearson correlations between VAS pain score and time with focusing. (*indicates significance, $p = <0.05$)

Looking at the pain & discomfort facet and the pain relief facet of the pain and discomfort module (PDM) from the WHOQOL-PainUK results provides both confirmation and some possibility of change not identified in the SF-MPQ.

⁵ Paula did not complete the weekly diary after week 1 and this was not picked up until after the 2nd focusing session. It could not be completed in retrospect so the missing data was imputed using the unconditional mean imputation method (see Hardy & Bryman, 2004, ch.5)

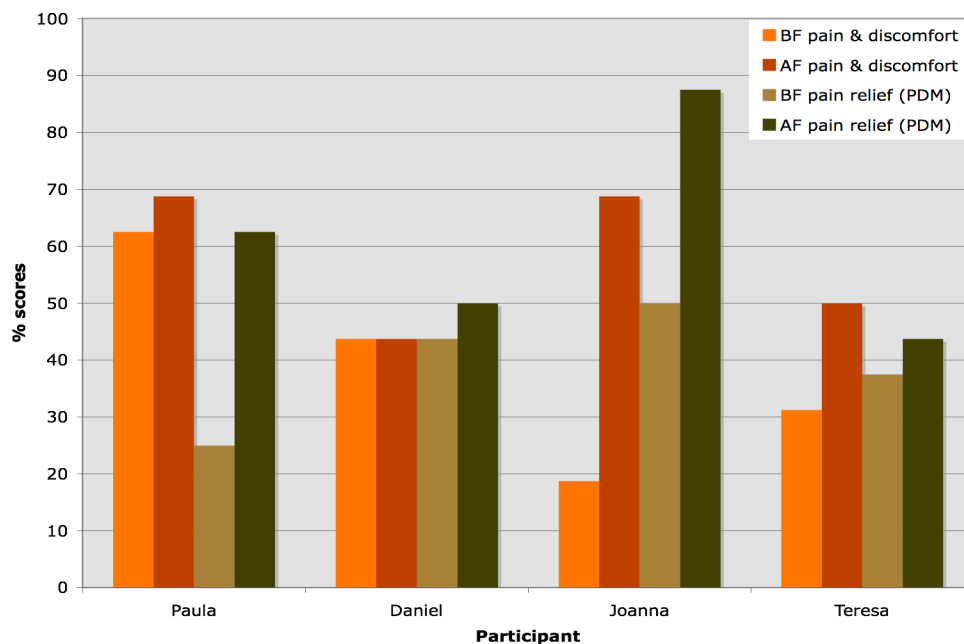


Figure 4.3: Participants' pain scores from the WHOQOL-PainUK measure. (BF=before Focusing sessions, AF=after Focusing sessions, PDM=pain and discomfort module) A higher score indicates improved QOL.

It is of note that in Figure 4.3 all participants show an improvement in the report of their pain relief following the Focusing sessions. Although Daniel in particular had reported in his interview no improvement there is a slight indication here. This will be explored in the next chapter when the Focusing session transcripts will be also reviewed in the light of the findings from the interview and questionnaire data.

One participant, Joanna, indicated a change in the nature of the pain 'And I'm no longer getting shooting pains down my leg, I'm back to the level I was like three years ago. It's fantastic' (JA19). The SF-MPQ sensory and affective scales reveal the number of sensory and affective terms identified over the weeks of Focusing (Table 4.4).

Interestingly, for Joanna, her use of the terms 'shooting' and 'stabbing' in the MPQ dropped over time from scoring both at 3/3 in the beginning to 0/3 at the immediate post-Focusing data collection. This would seem to support what she

	Paula		Daniel		Joanna		Teresa	
	S	A	S	A	S	A	S	A
Pre-Focusing	4	1	3	0	7	1	4	0
Week 1	*	*	1	0	7	1	2	0
Week 2	4	0	2	0	5	1	1	0
Week 3	3	0	1	0	6	1	1	0
Week 4	2	1	2	0	4	1	2	0
Week 5	4	1	1	0	4	1	1	0
Week 6	0	0	1	0	5	0	1	0
Post-Focusing	2	0	3	0	0	0	1	0

Table 4.4: Frequency of choice of descriptive terms from SF-MPQ from pre-Focusing to immediately post-Focusing (S=sensory; A=affective; *data missing)

said about the change in her interview. The number of terms she chose also reduced, the affective one remaining until week 6. By the post-Focusing data collection none of the participants were identifying any affective elements to their pain.

When Focusing with their pain the experienced Focusers found patterns emerging; Teresa described hers thus: ‘I didn’t expect to get that pattern of numbness and tingling and heat, and then the cold tingling, and then the sense of dispersion’ (TA12). Although some of these terms may be used in describing pain itself, this is an interesting sensory description of the effect that she found Focusing to have on her pain, leading to a dispersal, or reduction in the underlying pain. This change in the nature of the pain for her led to feeling ‘looser and alive’ (TA28) in her back. The experienced focusers also found the ‘voice’ of their pain. Joanna found she had to listen ‘enough for my body to be able to tell me what it needs’ (JA51) and she discovered that “it needs me to sit like this. Or change something. There were specific instructions I got from it” (JA50). The inexperienced Focusers found this more difficult. Daniel said, ‘my approach to the pain is that it hurts and it’s trying to tell me something, and what it’s trying to tell me is that it hurts. And the message goes one way. There is no way I can send anything in the other direction that says “No it doesn’t, shut up”.’ (DA19) Although he was not able to ‘engage to the point of having conversations with my back pain and asking it how it felt and all that kind of thing’ (DA8) he

‘was able to sense the pain, quite dramatically. About, it must be about the fourth or the fifth session [...] I certainly found I could really kind of turn it up. You know, I could concentrate inwardly, search around to whatever it was that was hurting [...] and in the concentrating on it, feel it getting more prominent [...] and conversely, by not focusing on it, feel it subsiding’ (DA9).

Teresa was surprised to find that spending time Focusing with her back pain seemed to have relieved pain elsewhere ‘I don’t know about my feet as I said, it just had happened at the same time I was doing this my feet were the best. I could walk. I went for a walk earlier and I had no pain in my feet at all.’ (TA43). On the other hand all the participants found that spending time Focusing with their pain meant they identified other painful areas in their body – ‘the back pain is always there but I had pain in my knee, pain in my toe on one occasion, I had pain from a gallstone at one point’ (DA7).

In summary this part of the findings provides some results, both qualitative and quantitative to support the suggestion that using Focusing can affect the perception of CLBP in the way that it is described and sensed. For three of the four participants there is a reported reduction in both the qualitative and quantitative data in the intensity of their pain and in the terms used to describe it. The reduction in the intensity is a particularly unexpected finding; and the changes in the choice of words to describe it will be discussed further in the following chapter.

Sometimes I feel like a tortoise – Focusing and the physicality of my pain

And I have got very bad posture. I have got a very curved back and a very curved neck, and I have had ever since I was little. And I have images of being a tortoise quite often and wanting my head to come out. Part of me wants to pull my head out too.

(TA4)

In reporting the impact of Focusing on the physical elements of CLBP participants shared a variety of findings. Focusing on the sensory input increased a sense of connection in the body (DA38, TA15) and made one aware of the parts which are not connected (TA19). This can lead to an improvement in posture and flexibility (TA36) and gave a feeling of increased energy (JA46, TA44). Sleep improved (PA4), general activity increased (TA30, JA20) and

Focusing provided the motivation to increase exercise (TA40). More household tasks were completed such as washing up and gardening (TA33, JA18). But the need for a supportive environment, such as comfortable seating remained (TA35). Participants felt more ‘in touch’ with their physical bodies (TA3); even though one may not be able to ‘converse’ with them (DA8). For others Focusing enabled one to allow the body to share its wisdom of what it needed (JA43). Focusing offers the opportunity to raise questions about links in the body (DA21) and to enter the physical structure of one’s body (TA4).

Two of the domains within the WHOQOL-PainUK are particularly relevant to these findings. The physical domain includes three facets – pain and discomfort, energy and fatigue and sleep and rest. As outlined above, participants identified increased energy and improved sleep. They also identified improved ability in general activity and activities of daily living – areas picked up in the level of independence domain of the questionnaire. Figure 4.4 shows the changes reported via the questionnaire data.

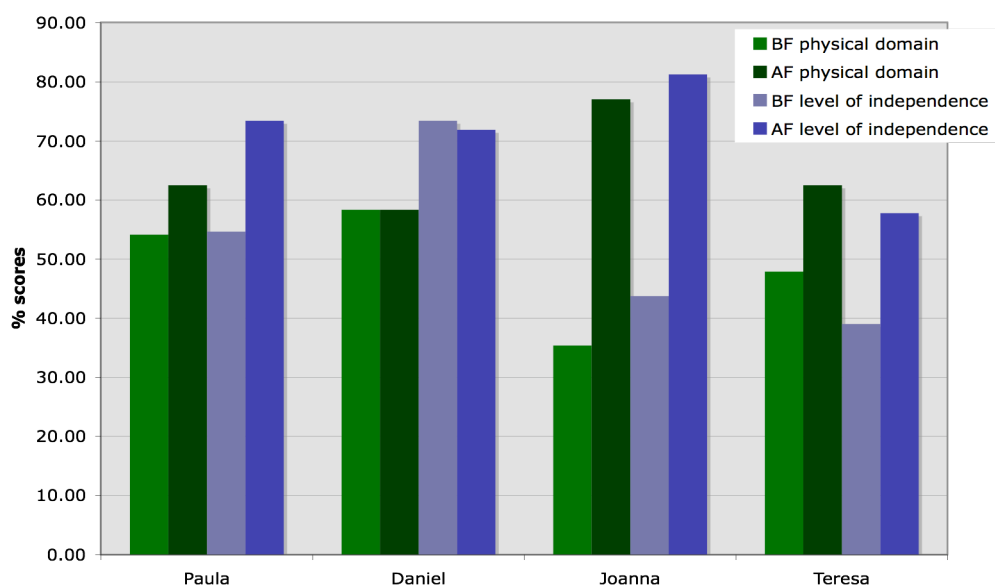


Figure 4.4: Participants’ scores from the WHOQOL-PainUK physical and level of independence domains (BF=before Focusing sessions, AF=after Focusing sessions)

Daniel shows no improvement, in fact there is a very slight but not significant worsening of his level of independence score. The other three participants demonstrate an improvement in both domains, reflecting the reports in their interview data.

Teresa reported that Focusing improved her general sense of her body and health and that she felt ‘more motivated to exercise [...] I’ve been more vigorous in the swimming pool [...] and I’m going to start cycling again’ (TA40). Joanna found that following the focusing sessions she was ‘enjoying [her] walks more, and walking further without pain’ (JA18). Pre-Focusing they had been aware of the need for exercise but found it painful, here they are suggesting a greater ability to do it, alongside an improvement in the ability to perform general daily activities. Teresa was able to save money – ‘the person I was paying to do the hoovering and the housework, she came yesterday and I said, “well actually, I don’t need you because I can do more now”’. (TA31).

Paula’s opening comment in the post-Focusing sessions interview included ‘But it is certainly loads better in so far as the pain doesn’t wake me up in the night’ (PA3), so that aspect was clearly one that had made a real impact on her. But she didn’t find this only when Focusing specifically on her pain, in fact she told of a time she used her newly learned Focusing skills to understand why she felt ‘narked’ with someone, and the resolution of that enabled her to get off to sleep. (PA5-8).

A new area opened up in the interviews was that of making connections with one’s body. When using Focusing Daniel became more aware of parts of his body ‘and I was more in connection with my feet and heels when they were resting on the bed than I was with other bits of me when I was doing that.’ (DA38). Teresa, with a greater experience of Focusing, found that she felt ‘much more in touch with my body and much more in my back. What came over to me was that my back was like a kind of shield and I wasn’t really in it in some way. And actually, Focusing on it, it was like something that had been compressed, like lots of layers. It had been compressed and Focusing seems to loosen and make one go into the different layers more easily. Of one’s structure, and one’s

attitude to one's structure' (TA3-4). So there is an idea from some of the participants of Focusing enabling a closer relationship with one's physical body. Joanna found that what came from that closer relationship was 'what it needs, as well. You know, it needs me to sit like this. Or change something. There were specific instructions I got from it. How did it need me to be? So I got information from it' (JA50).

So within this aspect of the phenomenon of using Focusing with CLBP the physicality of the pain experience can be found. This relates to both the person's relationship with their body, but also to more obviously tangible changes around an enhanced ability to exercise and engage in daily activities. This certainly hints towards Focusing enabling the CLBP to be less restrictive for some participants, and opening opportunities of a different relationship with one's physical body for those to whom Focusing was an established skill.

I'm not giving up on myself – Focusing as part of my pain management skills

If I'm not willing to meet the pain then I've got less possibilities for healing.

(JA41)

Focusing increases pain management skills (JA34), provides a willingness and the resources to enable one to deal with difficult situations (JA27), to not give up (JA4) and can reduce tearfulness and tension (TA38). It can help one to think around CLBP and provide the possibility of then leaving it one side (PA19), rather than returning to things and picking them over (PA10); changing how one thinks about something (PA49). CLBP is exhausting and Focusing can help to release energy lost in the pain (JA30). But it can be difficult to find time to do Focusing (DA28) and one may feel that one's pain is not severe enough to try a new technique (PA50). However Focusing does link with other interventions (JA23, PA38) and some people may find it easier than some interventions (PA24). It can make a difference in many areas of life, not just pain (TA21, PA52) and enables people to be with their pain in a new way (TA27).

In the development of the WHOQOL-PainUK pain and discomfort module the two facets of vulnerability and uncertainty were added to the psychological domain (Mason, Skevington & Osborn, 2008). Vulnerability related to concerns

about pain related disability and fear over medication and its continued efficacy. Uncertainty related to managing situations outside a person's control such as a lack of diagnosis, concern about the future and the possibility of having to cancel plans. In Figure 4.5 the scores for the overall domain and the two subscales from the

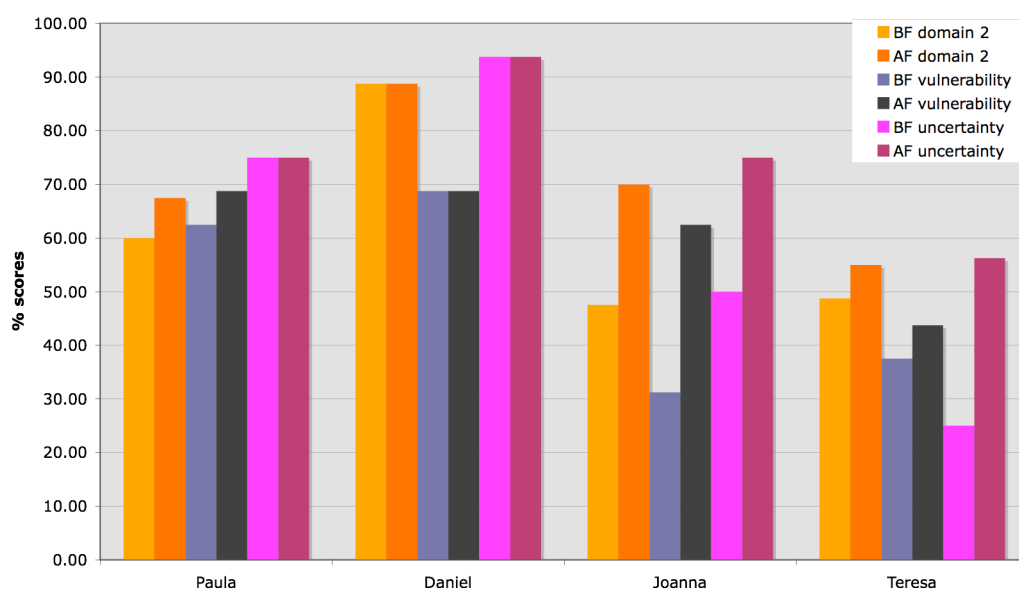


Figure 4.5: Scores for WHOQOL-PainUK domain 2 and vulnerability and uncertainty facets of the pain & discomfort module. (BF=before Focusing sessions, AF=after Focusing sessions)

pain & discomfort module are shown for each participant. Interestingly there is little change in the participants who were new to Focusing. However, for the experienced Focusers there were changes in both vulnerability and uncertainty facets, indicating a reduction in concern over associated disability and an improved feeling of control over situations such as lack of diagnosis. It is also of note that the two experienced Focusers recorded a lower score in the psychological domain overall.

Teresa had found it difficult to stand in queues, almost to the point of bringing her to tears. Following the Focusing sessions she hasn't 'been feeling so tense and almost tearful standing, and giving up' (TA38). Joanna also mentioned not giving up. Her previous experiences with healthcare practitioners had not led to any improvement in her back pain and left her 'thinking, "well, nothing is

working, it's not getting any better, nothing is happening, I might as well give up". So that's the moment that it is helping the most. That I am not giving up on myself. It is really encouraging me to value myself enough' (JA4). This idea of value and worth was important for Joanna who found that Focusing gave her improved self-worth and enabled her to find the resources to meet her pain (JA41). Paula felt that, as a skill, Focusing linked with other life management skills she had, and that using Focusing was like having a coach (PA39). Teresa appreciated that Focusing on her pain helped her to move more quickly into the problem and this was a different approach for her as she usually waited for her body to identify an issue, rather than taking the Focusing to the issue (TA11) and this enabled her to be 'in my back in a way that I haven't felt I was before' (TA27) bringing an aliveness and awareness that she hadn't been aware of previously. Paula discovered that if she was able to find the right descriptive term or word the feeling went or changed (PA6). Joanna, in particular, felt that Focusing enabled her to locate resources within herself to be with the parts of her that felt that they couldn't cope with the demands the pain put upon her (JA28) and in a practical way noticed that she was coping with 'Christmas trees and decorations, cleaning the house and tidying up, you know, it was very, very physically but I wasn't grisly or gritting my teeth' (JA21).

However, it can be costly to put the time and energy aside to do the Focusing, other activities may have to give way (JA26) or come in and replace the time one has been spending Focusing: 'personally, I was seriously disappointed at week seven. But unfortunately [...] there are different commitments and I didn't go through the same process myself and have an hour and try to do it on my own' (DA27).

'Not giving up on one's self' is an important aspect of the findings – linking as it does with strategies for pain management which help in day-to-day life, standing in queues etcetera. It enables a feeling of self-worth and the discovery of resources within oneself to manage the pain and the impact of it. But it does take time, and this can be difficult to put aside sometimes.

I have found smaller ‘mes’ that make the ‘big me’ – Focusing and myself

Well, but I became very aware that there were parallel threads of thoughts going on. And because I could switch from one to the other and be aware of both, it inferred there was a third one that was doing the switching [...] I’ve always thought there was one big me that was living in here, the kind of airy fairy driving force, that inhabits the body. And in fact there isn’t, there’s several. Not that I’m schizophrenic or anything, but these parallel threads can go on.

(DA16,17)

Focusing allowed participants to step outside themselves and look at themselves from a different perspective (PA44) helping one to learn about one’s self and what is going on in one’s body (DA14); bringing together fragmented parts (PA74). It enables an exploration of pain beliefs (DA22, JA37) and bringing attention to the pain in an accepting way changes the pain (PA20, PA22, JA32). Focusing can reduce the ageing feeling of CLBP (PA21) and the feeling of disability which accompanies it (TA41). Focusing enables a valuing of one’s self (JA3) which is important when working with pain (JA25), allowing one to be with parts that feel under-resourced and resist change, resulting in things feeling different in an intangible way that is more than just being relaxed. (JA29, JA9, JA16).

Facets of the WHOQOL-PainUK which may be considered to relate to this area are found in the psychological domain, particularly the facets of self-esteem and body image and appearance. The overall scores for domain 2 were shown above in Figure 4.5; the individual scores for self-esteem and body image are shown in Figure 4.6.

Three of the participants reported a slight increase in self-esteem, Daniel’s remained unaffected with the top score available. The area of body image and appearance was more ambivalent, only Joanna showing any noticeable change.

Daniel described this realisation of ‘smaller mes’, the other parallel threads, in software terms that make sense for him. It was as though there were lots of equal programmes running – not one big one which had a number of subroutines (DA33). But this left him with the thought that if one is aware of a process then

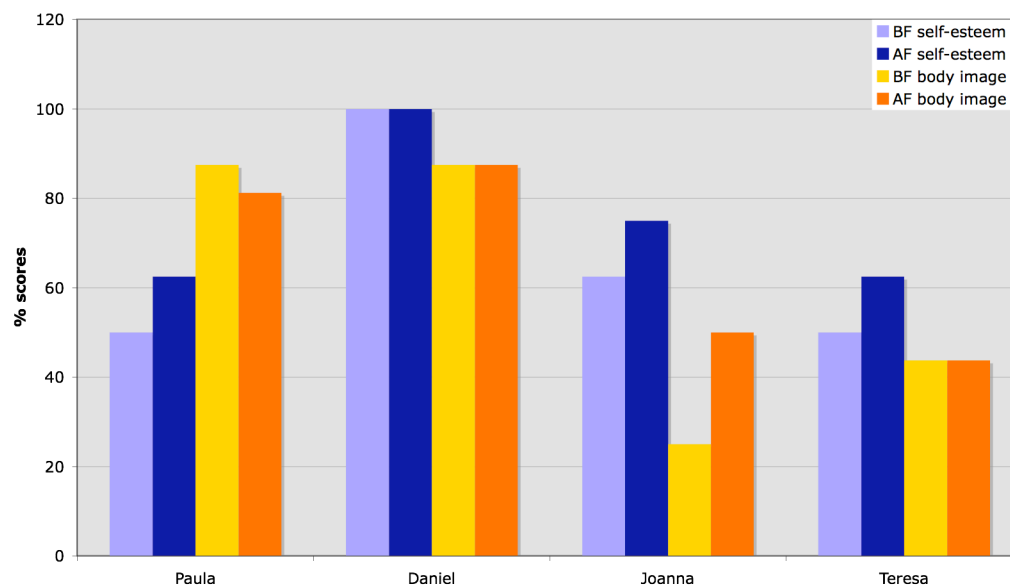


Figure 4.6: Scores for the facets of self-esteem and body image and appearance from the WHOQOL-PainUK domain 2 before and after Focusing (BF=before Focusing sessions, AF=after Focusing sessions)

there must be a bigger process and so on, a bit like going out from the middle of an onion, through the layers (DB34). However he was adamant these were not separate parts, so the language of Focusing at times proved problematic. But this idea of a greater awareness was one which intrigued him. Paula described Focusing as something that enabled her to step outside of herself and look at the way she made decisions and interacted with people, allowing her to make connections (PA44). She used the word ‘consolidating’ to describe the way the parts connect (PA74). For both Paula and Joanna Focusing enabled them to accept their back pain: ‘if I said something like, “it’s a part of me and I don’t need actually to worry about it so much any more”, then I think that might give a little bit of the flavour. It doesn’t need to impinge. It’s an accepted part and therefore not something I’m coming up against’ (PA20). ‘Just simply by bringing my attention to something in a completely accepting way, symbolizing it accurately, something shifts [...] bringing your attention to the pain in a very accepting way, it can release’ (JA32, JA33). This idea of acceptance is one that is growing in importance in the management of CLBP and will be discussed more fully in the following chapter.

In looking at one's self, Paula in particular found that using Focusing reduced the feeling she had previously of her body being older than it 'should' be and Teresa was very definite that she felt 'a sense of feeling more... I certainly feel more physically less disabled' (TA41). Joanna was very clear that Focusing enabled her to value herself more so that she was able to work with her pain (JA25), an aspect that relates strongly to the area of self-esteem. Perhaps it is not surprising therefore that Joanna showed the largest change of anyone in this area.

This aspect shows how Focusing can enable participants to view themselves from a different perspective, seeming to allow for acceptance of the pain and valuing of themselves in a different way. And the Focusing may also enable people to feel less aged and disabled with their pain.

When focusing 'clicks' – personal benefits of Focusing

I tell you when it clicked for me. [...] I just felt pleased and happy and absolutely at one with everything and everybody. So excited. And I didn't want to leave that place. And it was the moment that I realized that I did not want, I was having such fun, I did not want to go away from this.

PA 43

All the participants identified personal benefits from using Focusing with their CLBP and reported that they were continuing with it or wished to (DA3, TA5, PA4, TA38). The two Focusing experienced participants reported more about the development of their processes. Teresa in particular found that the images she had when Focusing enabled her to work with the pain at different levels (TA26, TA46) and that the images may deepen when Focusing, but their fundamental significance remains the same (TA49). She also reported that coming and Focusing on a specific issue was a different approach for her. (TA20). Joanna was quite clear that Focusing enabled possibility in what had seemed impossible (JA33) and that, by Focusing specifically on her pain she changed her technique when she focused alone (JA2). She found it particularly supportive to have a focusing companion for her and her pain (JA1). Both Joanna and Teresa found an hour a long time to Focus (JA14, TA53) and will use a shorter time when they continue.

Daniel and Paula reported more about the process and surprise of learning Focusing. Daniel found that putting aside an hour for Focusing meant that taking

time for himself became legitimate (DA24) and, although he found it difficult to understand what Focusing was (DA1), he found it a comfortable process (DA12). Both he and Paula had similar experiences with the language. Both found it useful to have words repeated back (DA13, PA40) and the challenge of finding the ‘right’ words to describe a feeling. Paula in particular found that naming led to an acceptance (PA33). Daniel found the concept of having a conversation with a ‘part’ of him alien (DA13) and Paula also found some of the invitations given by her Focusing companion alienating (PA12) such as ‘thanking’ your body.

There was a suggestion that Focusing is a journey (TA56) and Paula felt that Focusing provided a way of carrying on: ‘And I think the thing to do is just to acknowledge it, and move away. To carry on with that knowledge is much more beneficial and healthier [...] rather than keeping on picking at the sore. I think it’s much, much better’ (PA9,10).

No negative aspects of undertaking Focusing were identified; when asked directly Paula only identified guilt that she should be using it more often. Daniel said ‘if you had found a process that cured the pain in six one-hour sessions, there is money to be made. But at the same time I was entirely open to the possibility that something might happen. I’m not disappointed, either way it was useful.’ (DA43).

Immediate post-Focusing sessions: conclusions

The quantitative data, although very limited and used tentatively, does show that Focusing has some impact on pain scores and facets of quality of life scores. It certainly has very little negative impact, and some of the participants in some facets demonstrate notable improvement in the immediate post-Focusing sessions data. Within the WHOQOL-PainUK measure the physical, psychological and level of independence domains show changes across most facets.

These changes in the questionnaire data have also been seen to be present in the interview data as well, although there are aspects in the interviews which are not found in the questionnaire data. All four participants were positive about the

experience of Focusing, although the two who learned it from scratch had some issues in learning it. The experienced practitioners found this approach had an impact on their Focusing processes and no negative side-effects were identified.

Follow-up to the Focusing sessions: data analysis

Participant differences

In the initial study design the follow-up to the Focusing sessions was planned to take place a year after each participant enrolled in the study. The difficulties with recruitment and the time limitations of the PhD have meant that the year was foreshortened. Table 4.5 shows the timelines for each participant showing the overall time of each participant's involvement in the study, and the time between completing the Focusing sessions and the follow-up data collection.

	Paula	Daniel	Joanna	Teresa
Total time in study (in weeks)	43	38	40	26
From completing Focusing sessions to final interview (in weeks)	21	26	19	14

Table 4.5: Weeks in study for each participant and follow-up period in weeks.

This is not ideal, but pragmatically was the best that could be done within the PhD time constraints. A minimum of 3 months follow up is better than some published studies and most participants had a 5-6 months follow up. However this discrepancy must be borne in mind when considering the data.

During the period of time from the completion of the Focusing sessions to the final data collection Daniel had undergone major abdominal surgery following investigations of his abdominal pain (noted during the Focusing sessions). He was still recovering when interviewed and he said that his CLBP had taken a back seat over this period of time. Daniel participated in the interview but did not return his final questionnaires. In the circumstances it was not appropriate to continue asking for them. No other participants noted major life events between the end of the Focusing sessions and the final data collection.

In these interviews the two participants new to Focusing (Paula & Daniel) tended to offer opinions about Focusing rather than speaking about their experience and

Joanna and Teresa were more reflective. The Focusing practitioners had continued to spend time together Focusing with their pain and this continuing experience is reflected in their data. Generally the findings are similar to those immediately post-Focusing indicating that the changes made are sustained.

The structure of the experience of living with Focusing with CLBP: 3 to 5 months later.

For three of the four participants using Focusing with their CLBP had brought pleasing and surprising changes to their pain and activity which others noticed. It enabled a change in attitude towards the pain and surrounding issues, placing the Focuser in control, not the pain. Using Focusing resulted in an increase in physical activities and enabled participants to feel more ‘like themselves’. It can be difficult to prioritise time to spend Focusing and challenging to spend time with the pain. Although useful it is not intuitive to use Focusing with CLBP and it is easy to forget its efficacy. The fourth participant found that Focusing was interesting but it didn’t affect his pain.

Whilst expanding on the findings above from the narrative data some of the qualitative data from the WHOQOL-PainUK questionnaire will be presented. Figures 4.7 - 4.9 show the percentage point changes for each participant immediately after the Focusing sessions and then at the follow-up data collection. The pre-Focusing data provides the zero points for each participant’s score and the change is shown in positive and negative scores. Where there is no change the graph shows a blank; note that Daniel’s follow-up data is missing as explained above.

Also, rather than formulate new areas from this final structure, the new findings will be discussed in the same areas that were identified in the immediate post-Focusing data. Some of the findings confirm earlier findings, but there are also new aspects within the broad areas. The areas are:

- “the pain changes” – focusing and the sense of my pain
- “it doesn’t impinge” – focusing and the physicality of my pain

- “Focusing is part of my pain package” – focusing as part of my pain management skills
- “my attitude has changed” – focusing and myself
- “Focusing helps me feel more like me” – personal benefits of focusing

The pain changes – Focusing and the sense of my pain

“keeping my attention there [with the pain] and attempting to describe what’s there is in fact a healing thing to do, because it then changes.”
(JF24)

Months after first using Focusing with their CLBP participants were able to become aware of different pains (DF3) and also enabled to use their increased awareness of their painful sensations to begin to differentiate between them (JF23). There was some thought that Focusing might be able to help pain other than CLBP (TF20) and an acknowledgment that, although the back pain might be improved, there were other pains that continued (TF1,3). The sensation of an increase in pain initially, followed by a reduction, was mentioned again (JF13)

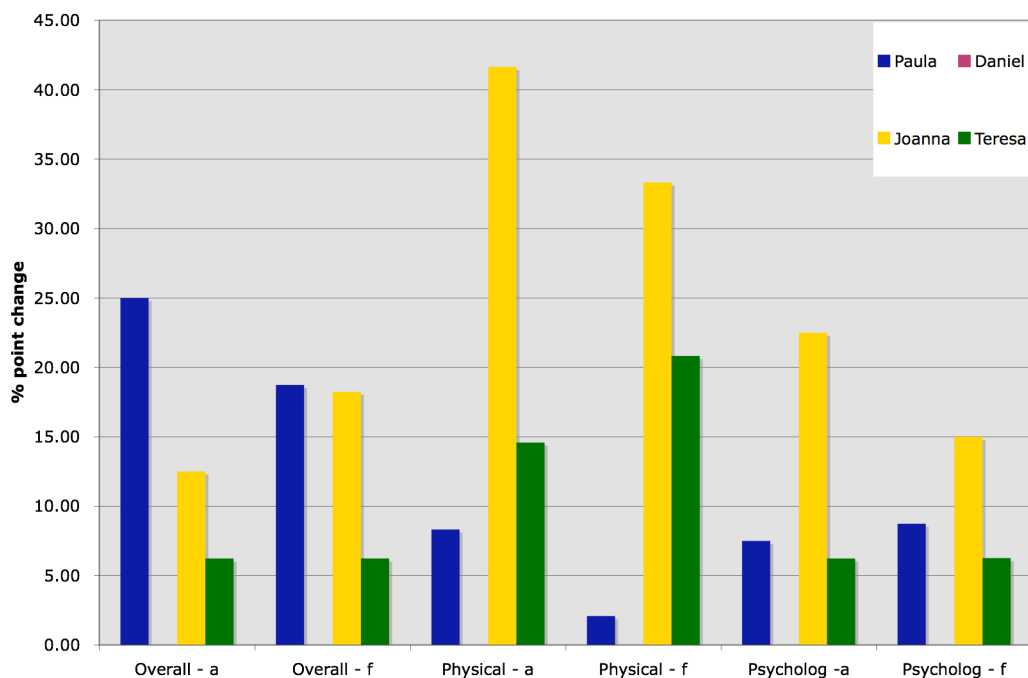


Figure 4.7: Percentage point changes in WHOQOL-PainUK, overall, physical and psychological domains (a = after Focusing, f = follow-up; follow-up data from Daniel missing)

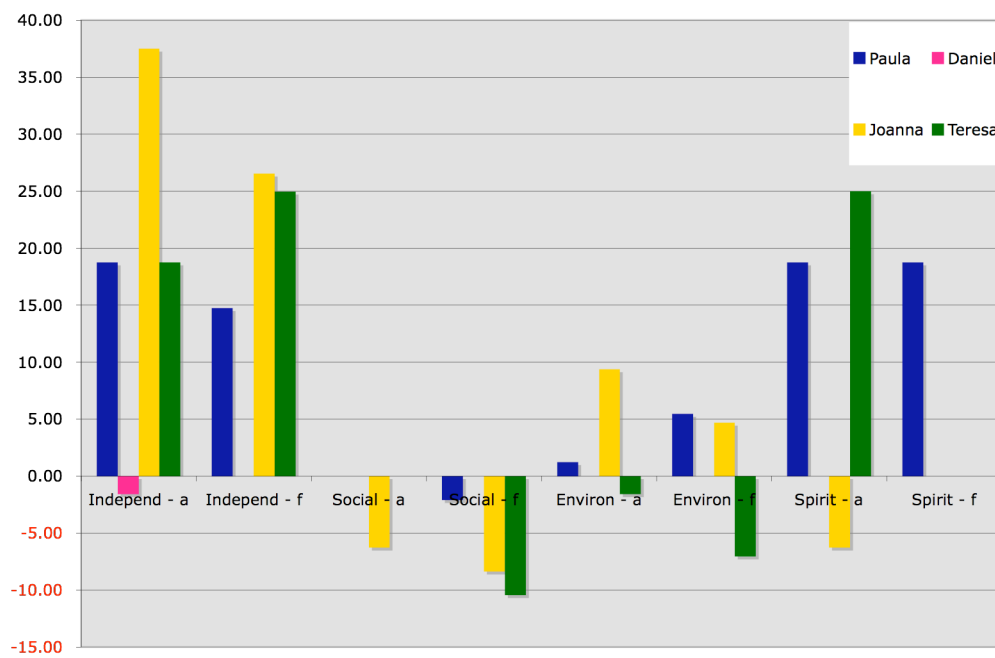


Figure 4.8: Percentage point changes in WHOQOL-PainUK, independence, social, environment and spiritual domains (a = after Focusing, f = follow-up; follow-up data from Daniel missing)

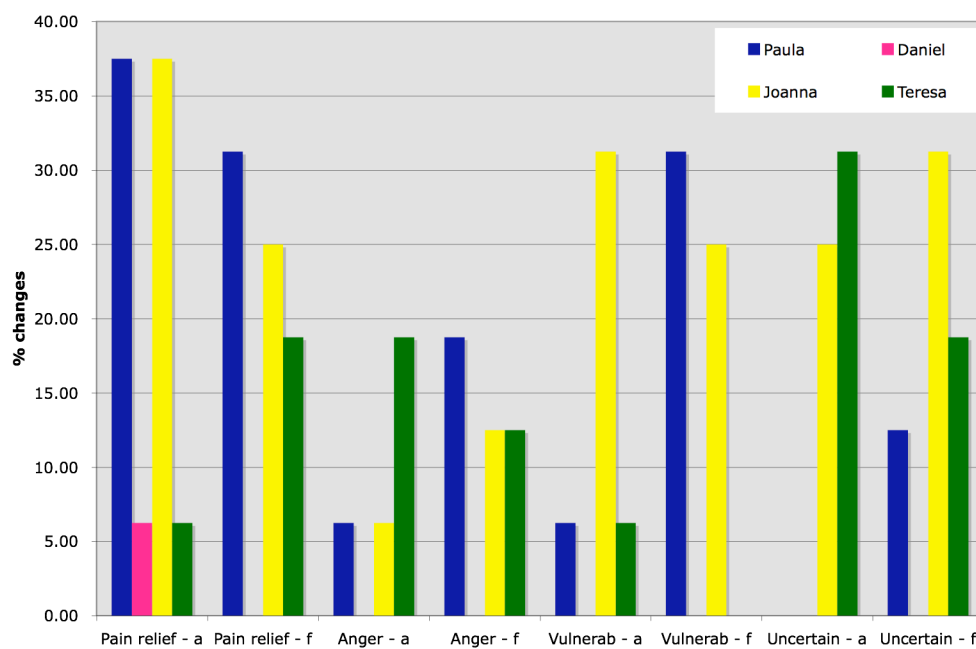


Figure 4.9: Percentage point changes in WHOQOL-PainUK pain & discomfort module (a = after Focusing, f = follow-up; follow-up data from Daniel missing)

and one participant still found that even though there was an increased awareness of the sensation of the pain, there was no alteration to it (DF6).

When the VAS score from the SF-MPQ is considered a slightly more mixed picture emerges. In Figure 4.10 it is clear that Paula's reported pain is greater at the end of the study than at the beginning. She says, "to be honest it's a lot worse than it was at some stages when I was doing Focusing and other times it's fine. It still wakes me up at night, but again that doesn't irritate me." (PF19). It would seem for Paula that it is not a change in the sensation of the pain but in its effect on her – she seems more accepting of it.

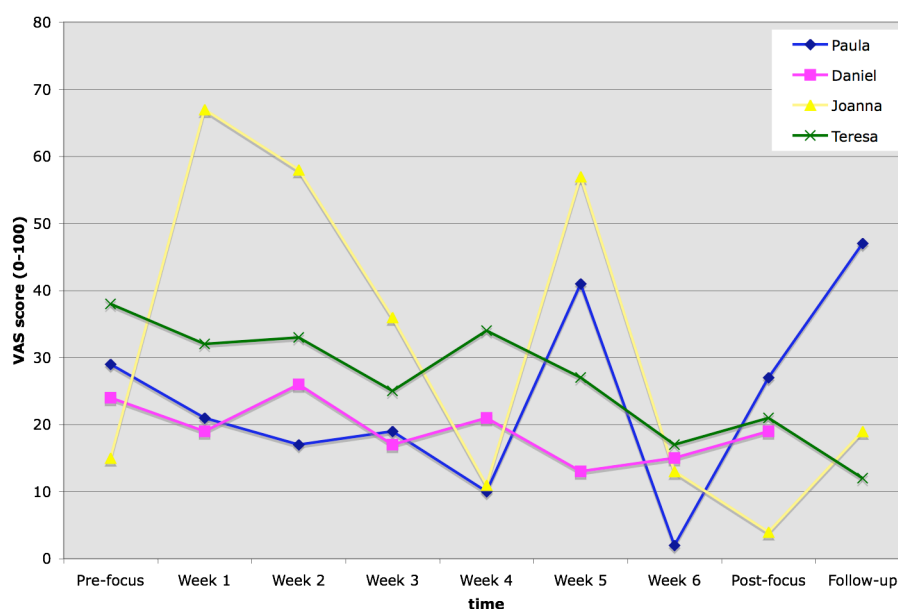


Figure 4.10: Participant pain VAS scores over period of study (week 1 data for Paula an estimate as before, follow-up data for Daniel missing)

Both Joanna and Teresa report a reduction in their pain since using Focusing. 'But what has happened is this huge reduction in the pain since I have been Focusing with it' (JF8); 'my back has still been better, since the Focusing. And it hasn't gone back to how it was before' (TF1). Teresa's comments are replicated in her VAS score, with a steady reduction apparent over the period of the study. Joanna's is a little more ambivalent, her VAS fluctuated over the study period.

Pain is one of the facets in the physical domain and Figure 4.7 shows that three participants reported improvements in this domain. There is a variety in the range of improvement; Paula reported a small improvement which reduced to nearly pre-Focusing levels and Joanna continued to report better QOL in this area than before she started to use Focusing although there was a slight reduction from immediately after to follow-up. Teresa continued to make improvements (although her follow-up was shorter than the others).

The pain relief facet of the pain & discomfort module (PDM) reflects the importance of being able to achieve pain relief through whatever means are available to the person. Again the three participants who completed showed continuing improvement in this area (see Figure 4.9), reflecting their confidence in their ability to make use of the available means to affect change to and manage their pain. Again Teresa continued to show an improvement and the other two still held a noticeable improvement even after 20 weeks. Joanna felt that using Focusing with her pain changed her awareness of her pain but spending time with it was really important as it enabled her to get to know her pain (JF19) and the variety of sensations there (JF23).

It is of interest that Daniel, although he found no difference in his back pain, had found that Focusing enabled him to describe his post-surgical pain, and be aware of it and describe it in a precise manner. ‘before the encounter with Focusing I probably wouldn’t have been aware of it as acutely as I am. I would have said, “well it hurts a bit down there, it must be the scar.”’(DF9).

‘The pain changes’ provides some results that continue to support the findings from the earlier data that Focusing can affect the perception of CLBP in the way it is described and sensed. Although the reported intensity may have increased the perception for three of the four participants is that their CLBP is improved.

It doesn't impinge – Focusing and the physicality of my pain

And now it's not that I think, 'blow it, I'm going to carry on anyway', it just doesn't enter my head. It doesn't impinge at all.

(PF18)

In this follow-up data the participants spoke more about the increase in their physical activities. The change to Teresa's posture and movement was noticed, not only by herself, but also by others (TF5). This brings external affirmation to the participant of the changes they themselves have noticed. Using Focusing with CLBP reduced the limitations around activities (TF22) enabling them to increase (TF36). Paula found that using Focusing had unblocked some of the hang-ups she had about activity (PF23) and Joanna also reported an improvement in physical outcomes (JF9).

For these three participants there was an improvement in all the facets of the independence domain (see Figure 4.8) and the final data from the uncertainty facet of the PDM (see Figure 4.9) also shows improvement for all three participants. This latter facet has been shown to be more highly associated with the independence domain (Mason, Skevington, & Osborn, 2008) and relates to the situations where the outcome is outside the persons control such as making plans for the future. Daniel had shown a slight decrease in the independence domain immediately following the Focusing sessions – but this was very small and as his data is incomplete it is difficult to comment on it.

Changes in physical activity included sitting positions (TF36, PF23), increased time spent cycling, swimming, gardening and washing up (TF19) and walking further with greater enjoyment (JF9). These activities cover both leisure pursuits and activity needed for day-to-day tasks. The previously mentioned area of connection with one's body was not amplified in these interviews.

The maintenance of the improvement over baseline in this important practical area indicates that these participants found Focusing with their CLBP enabled tangible differences in levels of activity in this area of 'my pain doesn't impinge'.

Focusing as part of my pain package – Focusing as part of my pain management skills

And the silly thing is it works. And one forgets to do it. You think of all sorts of strategies, and then you think, 'I'm just not focusing on it, all I have to do is focus on it.

(TF26)

Paula, Joanna and Teresa all commented that Focusing could be, or had become, part of a package they could use in their pain management (TF8, JF10, PF20) although there was an acknowledgement that it wasn't always something they remembered to use. There was an improvement for all three participants in the facet of the WHOQOL-PainUK that relates to dependence of medication (a part of the independence domain) and the changes to the pain relief facet of the PDM has already been mentioned above.

My attitude has changed – Focusing and myself

Certainly my attitude has shifted and I think it was part of the process of actually giving time to the difficult feelings around being semi-invalid, or limited, or in pain, or one's body cracking up, or age, all these things.

(TF28)

Daniel made no comments in this area, but the other three participants expanded on the previous findings saying that Focusing helped them to deal with issues surrounding the pain (JF5, PF14, TF25). These issues included areas such as anger and frustration (TF25), dealing with the limitations imposed by the pain (PF19) and the distress around the pain (JF12). It was also noted that using Focusing enabled a change in attitude to exercise (TF35). The idea of Focusing putting the person in control of their pain was spoken of (PF15) and this drive for change and control was said to be in the person rather than imposed upon them from (TF33). It was suggested that this was enabled because the changing of beliefs and attitude was grounded in the body (TF32).

The psychological domain in Figure 4.7 and the facets of anger and vulnerability from the PDM – Figure 4.9 – are most closely aligned with these findings. Anger is self-explanatory, but vulnerability relates to areas such as fear about the associated disability related to pain, an increase in medication and decrease of efficacy. The improvement seen in these areas are likely to impact on the overall improvement in the psychological domain, although these changes were not as marked as those in the physical and independence domains.

In relation to the finding that Focusing enabled a change of control Teresa described it thus: ‘whereas before [...] there was part of me that felt I should stand upright this time I feel there is a part in me which really is ready to stand upright [...] Not from an external perspective’ (TF6). Paula also felt that using Focusing had enabled her to take control of her pain and the issues surrounding it (PF15) and being able to control how she felt about it (PF21). This led to her saying “Instead of it being a restrictive process through life, you realise that things are going to change” (PF22).

Joanna and Teresa emphasised the importance of listening to the parts of themselves that had feelings about the pain; and how important this was in the changes they found. Speaking about working towards resolving issues around her pain Joanna said when she listened to the part that was having a difficulty, ‘it feels heard and accompanied. It sort of softens. So it is not impacting on me so heavily’ (JF6). Reflecting on the change in her pain Teresa said, ‘I don’t think it was the pain going that’s changed my attitude. I think it was being with the part that actually had the feelings about it. I think I worked on parts that had feelings about the pain. And I think this was partly an outcome of that, the shift in attitude.’ (TF51).

The change in attitude is not only directed at the pain, but at the issues that surround it. One might suggest that these wider differences would be manifest in a more global measure. The Global QOL data is shown in Figure 4.11 for the duration of the study. Significant correlations are found for Teresa and Joanna which link with their narrative data (see Table 4.6). Paula, who also spoke about improvements, does not reach a statistical significance, although it would appear that from a personal perspective there was an impact on the issues surrounding her pain.

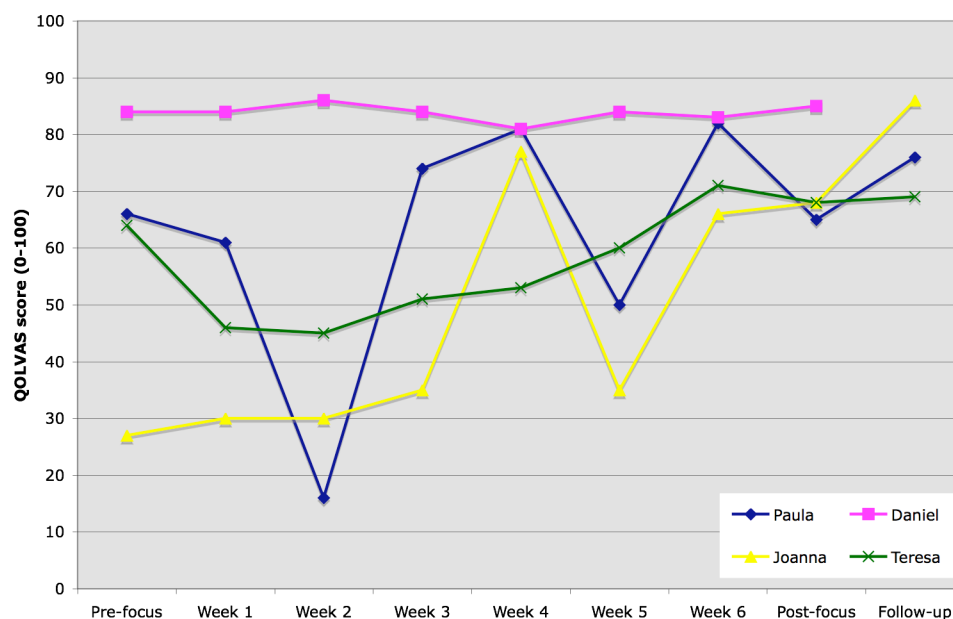


Figure 4.11: Global QOL scores over the study for all participants (Week 1 data for Paula an estimate, Daniel data missing for follow-up).

Participant	Pearson coefficient (r^2)	Significance
Paula	0.13	0.35
Daniel	0.02	0.79
Joanna	0.67	0.006*
Teresa	0.44	0.05*

Table 4.6: Pearson correlations between global QOL score and time with Focusing. (*indicates significance, $p < 0.05$)

The findings presented in this part show individual changes in relation to the attitude taken to the pain and the issues that surround the pain for the three participants who found Focusing helpful. There was no change noted for the other participant, either in a positive or negative direction.

Focusing helps me feel like me – personal benefits of Focusing

I don't feel that Focusing has been a searing experience at all, it has been quietly revelatory

(PF26)

All four participants identified personal benefits from Focusing. Daniel felt that it enabled him to describe his pain more fully and accurately (DF9). Paula

reported that she found Focusing with her pain to be quietly revelatory, and that it had enabled her to feel more herself, ‘... the thing I hated most about it [the back pain] – and I say that in the past tense – was the way it didn’t make me feel like me. And that is absolutely no longer an issue. It really isn’t’ (PF11). She felt it was a technique worth trying (PF24) and it helped her not dwell on the pain (PF12).

Teresa and Joanna, although experienced Focusers, were surprised at the personal benefits. Joanna described her experience of this using the image of a baby penguin learning to walk on ice (JF22), using this as a metaphor for what she was learning to do. She found the experience of using Focusing with her pain very supportive (JF16) but one that was demanding on time (JF11). Teresa also spoke of the need to commit oneself to making time available (TF10) and said that she found it tiring at times (TF15). She felt that using Focusing regularly was helpful (TF9) but also noted that she didn’t find it intuitive to use Focusing for pain (TF44) and that it was easy to forget how efficacious it had been (TF26).

There is no quantitative data that specifically relates to this aspect of the experience of using Focusing with CLBP. As in the immediate post-Focusing interviews the participants did not identify any negative aspect to using Focusing, other than the time involved.

Other findings related to the WHOQOL-PainUK

The three domains of the WHOQOL-PainUK not discussed above do not relate easily to any of the areas raised by the participants in their interviews. However, for completeness they need to be addressed. They can be seen in Figure 4.9 above. In the social, environment and spiritual domains the results are much more mixed. For Daniel these domains showed no change at all over the study. For the other three participants there are some changes. All three domains started with a higher QOL than the others previously discussed, indicating they were areas in which it may be more difficult to find an improvement, or that they are areas which are not particularly affected by CLBP.

In the areas of spirituality Paula showed an improvement at the end of the study, while Teresa and Joanna fluctuated a little but ended at the same point at which they had begun.

The environment domain includes areas such as personal safety, home, finances and transport. Here Paula and Joanna made small, but maintained improvements but Teresa reported a continuing worsening of six percentage points. There was nothing in the narrative data to explain this.

In the social domain all three reported a worsening – from two to ten percentage points. This domain covers personal relationships, social support and sexual activity. Again there was no narrative data to throw any light on these areas, although they are ones that are connected to the impact of CLBP as shown in Chapter 1.

Conclusion

The research questions asked if Focusing changed the meaning people ascribed to their CLBP and also if there was any impact on pain and quality of life scores. From the findings reported above it appears that, for these four participants, Focusing was a self-help technique which brought a variety of benefits in these areas. One participant found it interesting but not particularly helpful with his CLBP. The other three participants reported a number of areas in which they found Focusing to be beneficial, particularly in how they felt about the pain and the impact that it made on the issues surrounding the pain such as physical activity and attitudes. No significant negative side-effects were reported although some areas within the broad quality of life measure worsened slightly. However, overall the three individuals showed an improvement in their quality of life.

Summary of Chapter 4

This chapter has presented the findings, both qualitative and quantitative from the study. It has done so using Yin's (2006) counterpart method where both types of data are considered simultaneously when looking at the same variable. The data from each of the three parts of the study are presented chronologically. Before commencing the study it was found that the participants had similar experiences of living with CLBP. It is changeable, takes a physical toll and can

cause misunderstandings. The pain is not fair, overly demanding and nothing seems to get rid of it. An attempt to convey the reality of living with this pain is made in the creative writing included at this point.

Six Focusing sessions were undertaken by each of the participants, either face-to-face or by telephone over periods of time which varied from 8-14 weeks.

Immediately following the Focusing sessions it was apparent that three of the four participants found it helpful, reporting a reduction in pain, improvement in physical activities and an acceptance. The qualitative data reflected these findings and no negative side effects were reported. At the final data collection the findings remained much the same, showing a sustained improvement for three of the participants. Quality of life measures showed a continuing improvement.

Chapter 5 – Discussion

The research questions in this study related to two different areas. One was the impact of the intervention, Focusing, and the second area related to questions of methodology. To discuss both in the same chapter felt somewhat unwieldy, but working within the integrated character of a mixed methods study there was a desire to indicate some integration of the two areas. Hence the decision to include Chapter 5 and Chapter 5a; each related to a different area, but together falling under the umbrella of discussion.

Introduction

As can be seen from the findings in Chapter 4 a number of areas pertinent to the research questions have emerged. Two of these are considered more fully in this chapter, relating as they do to areas of growing interest in the chronic pain literature. The role of acceptance has been considered in Chapter 1, particularly in its use of mindfulness meditation within the ACT model. In looking at ‘accepting and being with the pain’ issues around the processes of Focusing and their relationship with current thinking in pain management will be discussed. It will be shown that this study reveals a new understanding in considering the processes of acceptance in CLBP. In the second part of this chapter the language of pain will be explored. ‘Listening to and describing the pain’ provides a discussion on the importance of language in Focusing and how a reconsideration of this may offer different perspectives on the use of language in pain. Possible links with the emerging area of narrative medicine will be considered.

Following these two discussions the chapter turns to consider the differences ascribed to the meaning of CLBP after using Focusing and the value of Focusing in the physical, psychological and social areas of the participants’ lives. This leads to the practical issues around the implications for practice identified in the research. The limitations of the research will be outlined and finally the contributions to current knowledge in the areas of self-management of CLBP made by this study will be identified.

The approach to writing

In the following explorations the discussion is based on findings already outlined in Chapter 4. Fuller use is made of the Focusing sessions (particularly in the sections on acceptance and language) to elucidate the comments made. The use of the Focusing sessions at this point in the thesis was described in Chapter 3. For instance, the section of a Focusing session from Joanna, which is reproduced in this chapter, is used in two different ways. Firstly it is used as an example of how the Focusing process may enable acceptance of pain (a finding identified in Chapter 4) and secondly how the process may challenge current concepts in the use of CBT in pain management (discussed in Chapter 1). Although it may appear unusual to incorporate large sections of dialogue at this stage it is congruent with the overall approach to integration taken in this mixed methods study.

Accepting and being with the pain

As noted in Chapter 1, within psychological approaches to chronic pain generally, there is a growing movement towards contextual cognitive behavioural therapy (CCBT). A key component of this approach is its reliance on an acceptance-based focus, based on acceptance and commitment therapy (ACT). Mindfulness processes are purported to support the development of acceptance, hence the use of mindfulness meditation in chronic pain CCBT programmes. Acceptance of pain has been defined as ‘acknowledging that one has pain, giving up unproductive attempts to control pain, acting as if pain does not necessarily imply disability, and being able to commit one’s efforts towards living a satisfying life despite pain’ (McCracken, 1998, p. 22). It should be noted that in the chronic pain literature acceptance is seen as a positive coping reaction or strategy. More generally in psychology there have been some discussions which place the studies on mindfulness-based treatments, and their conclusions that acceptance is a useful adaptation, alongside other studies which showed acceptance had negative consequences for mental and physical health (Nakamura & Orth, 2005). They suggest a distinction between active acceptance (which is associated with positive psychological outcomes) and resigning acceptance (associated with negative outcomes). Whilst bearing this in mind, the concept of acceptance in this study is that of active acceptance, one that is adaptive and

acknowledges the negative reality of a situation whilst encompassing a readiness to face the situation and make the best of it, as described by Nakamura and Orth (2005).

Results from this study

In this study, in the three participants who found Focusing to be particularly useful, these aspects of acceptance can be identified. This finding was described briefly in Chapter 4, here it is shown in a more expanded manner – thus exemplifying the developing process of acceptance. This is an aspect which qualitative studies can add to those already identified in the acceptance and chronic pain literature, and is not possible with the, predominately quantitative studies. Paula's attitude towards her pain, before Focusing, is exemplified in:

I mean it jolly well annoys me. And its, it just makes me feel less free, and less me really. So I'm constantly held back from my normal rush and shove kind of action in life, which is probably very good, but it's just not me somehow. (PB3,4)

Immediately following the Focusing sessions she said:

You have acknowledged that it [the pain] is there but ... it doesn't need to bother you. [...] if I said something like, "it's a part of me and I don't need actually to worry about it so much any more", then I think that might give a little bit of the flavour. It doesn't need to impinge. It's an accepted part and therefore not something I'm coming up against (PA20)

And, when talking about the efficacy of Focusing six months later Paula said:

I think it's quite an interesting thing that to deal with the issues around the pain is actually, in way, it's not really dealing with the pain itself but it deals with your mental attitude so the you can just wipe it. It has a direct effect, it has a direct impact. Because you can just set aside what you know is not really relevant. And the fact that you really dwelt on that and found that it isn't particularly relevant, or you have discovered its relevance and you can say, "that's fine, that is how it is". (PF14)

But her pain has not changed in its intensity when taken over the same time period, in fact it was higher at the follow up point than either of the two previous points. Although there is no improvement to her pain, over the same period of time her global quality of life score increased from 66 to 76 (Figure 4.11) and there were also marked improvements in the facets of the pain and discomfort module relating to anger, vulnerability and uncertainty (Figure 4.9). These indicate a reduction in concern over associated disability and an improved feeling of control over situations such as lack of diagnosis – key factors in the definition of acceptance above.

Joanna makes this even clearer in her comment:

It's really helped me to manage and listen to, and resolve the issues that come in relation to the pain.

R: would you feel comfortable saying a bit about what those issues are?

J: yes, they are... it's a limitation on my life, and at the feelings that come from that. Feelings of frustration or tiredness, low energy (JF5)

Joanna also said that she felt that Focusing enabled her to:

...value myself more. That's an example. Because it is so easy to beat myself up for it, for having this pain. So now I am valuing myself. In other words, being prepared to care for myself. ... It's enabled me it to accept it [the pain], and given me the strength and given me the resourcefulness. (JA3, 27)

Here there is clear evidence that Joanna found Focusing allowed her to work towards living a satisfying life – one of the areas found in the definition of acceptance above. Again, Joanna's quantitative measures showed improvements in the related areas over the extended period of time.

Studies on acceptance and pain in the first part of this decade indicated that acceptance of chronic pain was linked with better emotional, physical and social functioning and less use of healthcare and medication. These were not prospective studies, but McCracken & Eccleston (2005) demonstrated that acceptance accounted for changes when measurements were taken 4 months

apart. This was reconfirmed in a further study (McCracken & Vowles, 2008). These studies, and similar, have two points of measurement, at the time of the initial assessment and then when treatment began (usually about 4.5 months later). Very few studies follow concepts of acceptance through to a six month follow-up. There are an increasing number of studies published on acceptance and chronic pain – most based on the theoretical framework of Acceptance and Commitment Therapy (ACT). These studies are mostly quantitative, and I could find none that were based substantively on qualitative data. There is some occasional use of free text questions in the quantitative measure.

What this study brings.

In contrast this research study relies heavily on the qualitative data, and collects data at three points: before treatment, afterwards (8 – 16 weeks) and at follow up (6 – 8 months). It brings much needed qualitative data to support the importance for these individuals of acceptance in CLBP, and the quantitative data provides points of linkage with other studies. The qualitative aspect allows for a different exploration of the processes involved in acceptance.

Prior to those discussions on processes it is pertinent to note the current work being published on changing patient perceptions of their illness, and the subsequent question that, if these perceptions are modifiable, can outcomes be improved? (Macfarlane, 2008). During the discussion below changes in the beliefs of the participants will be suggested – for Joanna it is in believing that she has the resources to continue – and it could be understood that this is a change in her perception of her CLBP. The relationship between acceptance and perceptions is perhaps one that requires further exploration.

Processes of mindfulness

This study is not on mindfulness, but in order to discuss how the processes of Focusing may impact on acceptance of CLBP it will be helpful to try to gain an understanding of the processes of mindfulness meditation (MM) as it is currently described in this area, to enable comparisons and differences to be made. A broad picture of mindfulness meditation was provided in Chapter 1, a more detailed consideration of the processes is considered here in order to provide a comparison with the processes of Focusing which have become apparent in this

study. The following discussion about MM and chronic pain pulls mainly from two recent papers (McCracken, Gauntlett-Gilbert, & Vowles, 2007; McCracken & Thompson, 2009).

Mindfulness does not attempt to change the content of what is experienced (pain), but to change how it is experienced and its behavioural influences. Unlike CBT, which advocates the challenging or modifying of thoughts, MM is about developing an awareness which is broad, present-focused and behaviourally neutral. When practising MM the person learns to maintain their attention on a particular focus (frequently their breathing) and, whenever their attention wanders to other thoughts or feelings, the person takes notice of those thoughts or feelings and then returns their attention to their breathing. The emphasis is on just taking note and accepting, not making judgement or elaborating or adding meaning. As mentioned in Chapter 1, MM has been described as an ‘orientation that is characterised by curiosity, openness and acceptance’ (Bishop et al., 2004, p. 232).

Bishop et al (2004) identifies two processes key to mindfulness – the self-regulation of attention and the orientation to experience. By keeping attention on breathing the person sustains their awareness in the current experience. This self-regulation fosters a non-elaborating or ruminative awareness of thoughts, feelings and sensations; the person observes all these events, and, once acknowledged, returns their attention to the breathing. It is proposed that this aspect of MM is a metacognitive skill, allowing ‘cognition about one’s cognition’, requiring control of the cognitive processes. By maintaining an orientation to experience the person monitors their stream of consciousness and, Bishop suggests, with practice this leads to an ability to see relationships between thoughts, feelings and actions. (This is also the aim of CBT, that the person recognises the relationships between those factors. CBT then has the further aim of ‘correcting’ wrong connections between those relationships). In summary Bishop suggests that MM has the two processes of regulating attention and gaining insight, and McCracken and others suggest that MM is a key factor in acceptance-based therapy.

Processes of Focusing

So, how does this relate to this study on Focusing? By considering the process of Focusing it will be possible to identify concrete differences between the two and perhaps suggest that Focusing offers people with CLBP an alternative acceptance-based approach to managing their pain. It is interesting to note that Hayes & Wilson (2003) say that mindfulness is a ‘prescientific concept’, stemming from Buddhism whose ‘postulates and principles are not scientific’ (p. 161). On the other hand Focusing, which may seem non-scientific and rather ‘alternative’, derives from the Rogerian psychological science of client-centred psychology, has client-therapist scales to measure interaction and is solidly underpinned with the philosophical writings of Gendlin.

Like MM Focusing emphasises an orientation to experience, but this is not a singular experience but an ongoing experiencing. This semantic difference is a keystone in the understanding of Focusing and of its processes. To experience implies a temporal fixing of it, whereas Gendlin is clear that the ‘ing’ in experiencing indicates a process; one of concrete, ongoing events and one which is inwardly and bodily sensed (Gendlin, 1964). It is this experiencing, Gendlin argues, which constitutes the basic matter of psychological phenomena. In Focusing the person is required to attend to feelings or experiences or sensations within themselves and to describe these as accurately as possible. This means spending time exploring the feeling, finding words or other descriptors that fit the feeling – rather than noticing the experience and moving on. Gendlin calls this experiencing which is described, the ‘felt meaning’. This naming of the experiencing is important to how Focusing is understood and how it can relate to the primary question of this thesis – what are the meanings ascribed to CLBP before and after using Focusing. ‘Felt meaning’ is the experienced dimension of meaning, the description is experienced, or felt, before it is described and meaning made. The experiencing is the beginning of the process, the description carries it forward and the continual checking between the experiencing and the description enables meaning to be made.

So how is this process seen in the participants in this study? In the excerpt above Joanna said Focusing enabled her to value herself more, to care for herself and

accept her pain. In the following excerpts from her 5th Focusing session it is possible to see how the Focusing process enables that caring.

From Joanna's 5 th Focusing session (p 5-7 with some ellipsis)	Comments on the Focusing process
<p>J: yes, so I will just come back to the lower back area (0.57) Mmm, it's just going tingling, tingling, a sort of ... yes... general ache FC: so you are aware of a tingling going on and the fact that it is a general ache. I wonder if you could ask it a question, what it needs, or something, may be something body orientated, I'm not sure. Just a suggestion (0.20)</p>	<p>Joanna becomes aware of a felt sense in her back and begins to describe it. Her companion encourages Joanna to ask this felt sense what it might need, seeking the emotional sense of the feeling.</p>
<p>J: Mmm, it wants to be looked after [...] yes, it wants me to look after it FC: it wants you to look after it (0.18) J: so I am just checking what it means by that. (0.12) Mmm, it wants to be cared for. [...] so I'm just saying to it that I think I am caring for it. Is this good enough, is this what it wants, what I am doing? FC: right, so you are just going to check that (0.17) J: yes, it feels OK. This part is saying that it does want what I'm doing for it, it wants that, it wants me to look after it and care for it. [...]</p>	<p>Her felt sense has an emotional quality of needing to be looked after and cared for. Joanna checks that description back with the felt sense itself to ensure that her understanding (or felt meaning) resonates with the felt sense.</p>
<p>something is happening in my forehead too. FC: so you are aware of something happening in your forehead. J: Mmm, so I've got my hands there. (0.27)</p>	<p>Joanna becomes aware of another felt sense – this time in her forehead.</p>
<p>So... it feels like what is happening is a kind of acknowledgment and a surrendering. [...] Mmm, yes, it feels like the commitment and the willingness to look after my back pain and the surrender that it involves to most of the rest of me, you know it's like it's there again. [...] It feels like a huge surrender [...] really putting this place first. [...] The part of me that would just like to get on with my life and forget about it, you know, it's just had to surrender again and...</p>	<p>The emotional description of this felt sense is one of acknowledgement and surrender. And this part of Joanna would like to forget about caring for the pain and get on with life, but it has to surrender.</p> <p>The Focusing process has enabled Joanna to experience within her body, and in different places in her body, a tension between caring and wanting to forget. Again she spends some time checking that her understanding and description resonates with the felt sense.</p>
<p>... it feels actually, good to face it. Maybe that's what this is in my forehead and my face, it's about facing it.</p>	<p>Joanna makes a tentative connection between the 'something' in her forehead and the meaning that may be linked with it.</p>
<p>[...] (0.47) So this part is feeling like it's living with a handicapped child, and it just wants to go out and do things, but it can't, you know. [...] and maybe it's just for now. Another part is saying maybe it is just for now, and it's not always going to be like this.</p>	<p>Joanna uses a metaphor to further describe or symbolise what she is experiencing.</p>
<p>[...] I'm getting a sense of what the achy part wants when it wants to be looked after and cared for. It wants me to continue to invest all this time and money and energy into it. [...] so I've acknowledged that. (0.16) So it's helpful this focusing, because</p>	<p>Joanna describes a shift – Focusing has enabled her to understand what her back pain wants from her in order to feel</p>

<p>it's good to spend time and listen to it. And because the part that doesn't is so strong, it's good to make myself sit down and do that and listen to it. [...] (0.20) Mmm, It's helping to keep my resolve to continue to care for it.</p>	<p>cared for and gives her the resolve to continue.</p> <p>The Focusing process has enabling meaning-making to occur from the description and resonances from the felt sense.</p>
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Table 5.1: Excerpt from Joanna's 5th Focusing session

Differences between the processes of MM and Focusing

There is a clear difference from MM in the process outlined above. Although the attention to the felt sense is self-regulated (it can be returned to, as Joanna does at the end of the excerpt above) Focusing demands an elaboration of feelings and what is being experienced in the description and resonance of that description. This is cognition acting in a different way from the metacognitive skill required in MM. Leaning on Gendlin's (1962/1997) explanation of how meaning is created the cognitive involvement in the above excerpt can be explored further. Past experience, or what is being currently experienced, can be given a new aspect he argues, when two felt meanings emerge. In Joanna's description she had an achy felt sense in her back which developed into a felt meaning of needing care. The felt sense of 'something' in her forehead had a felt meaning of surrender which led to the symbolisation of the metaphor of the handicapped child. This symbolisation of something new seems to have created a new meaning for Joanna – a resolve to keep caring for her back. So instead of trying to ignore it and carry on but be hampered by the frustrations (as she was in her interview before the Focusing sessions began) her attitude towards her back pain has changed. In Gendlin's terms the old symbols and their felt meanings have made reference to each other and created a new meaning. It is possible that the making of this new meaning is a means of entering into what pain clinicians would call acceptance.

Focusing – a process of carrying forward

Focusing has enabled the bodily-held feelings to be realised and to form new meaning. The role of resonance, of finding the handle (or words) that fit the felt sense is key in moving from the implicit felt sense to an explicit felt meaning which can then lead to new meanings and, possibly, acceptance. Active acceptance has an implication of moving forward and the idea of carrying forward is central to the process of Focusing. This carrying forward may mean

that if a felt sense is returned to later it may well have a different felt meaning – when Joanna had spent time with her felt sense of an achy back in her 4th Focusing session the meaning she felt was around her back working hard under duress. Certainly a different felt meaning from that of needing to be cared for which is present in the 5th Focusing session. A symbolisation or metaphor that came in that 4th session was that of a knight in armour. Such different meanings and symbolisations from what would appear to be the same aching felt sense of the pain in her back. This demonstrates Gendlin’s point that ‘a given felt meaning may function as relevance toward a great many different symbolizations’ (1962/1997, p. 129). So using the Focusing process with CLBP is likely to be a process which develops and changes rather than a one off – a point which Teresa noted in her follow-up interview (TF16). And, within the qualitative data of the pain and discomfort module of the WHOQOL-PainUK (Figure 4.10) these changes can also be seen – not so much around the pain scores, but the aspects relating to the issues of frustration and anger and acceptance which lie around people’s response to CLBP.

In Chapter 1 it was noted that McCracken et al (2007) suggest that using MM with chronic pain may lead to behaviour patterns that are less caught up in distressing thoughts and emotions. These distressing thoughts and emotions could be captured quantitatively in the psychological domain of the WHOQOL-PainUK. All three participants who found Focusing useful also showed improvement in this domain (range 6%-22%, Figure 4.7) indicating that Focusing may have a similar action to MM. Joanna’s Focusing session also shows a change in distress towards the end of the excerpt. This study shows that, for these three participants, outcomes similar to those from the MM studies can be obtained with Focusing.

Thoughts and emotions are key concepts in the current CBT model used in pain management and this chapter now continues to explore this interaction.

Focusing, acceptance and theories of pain

So, can the observations made above link with the theories of pain and pain management described in Chapter 1? In Figure 1.6 suggestions were made, from

the literature review, of how Focusing might challenge the current CBT model in use in pain clinics. In Figure 5.1 below there is a demonstration of how Joanna's Focusing session (outlined above) relates to the questions raised there.

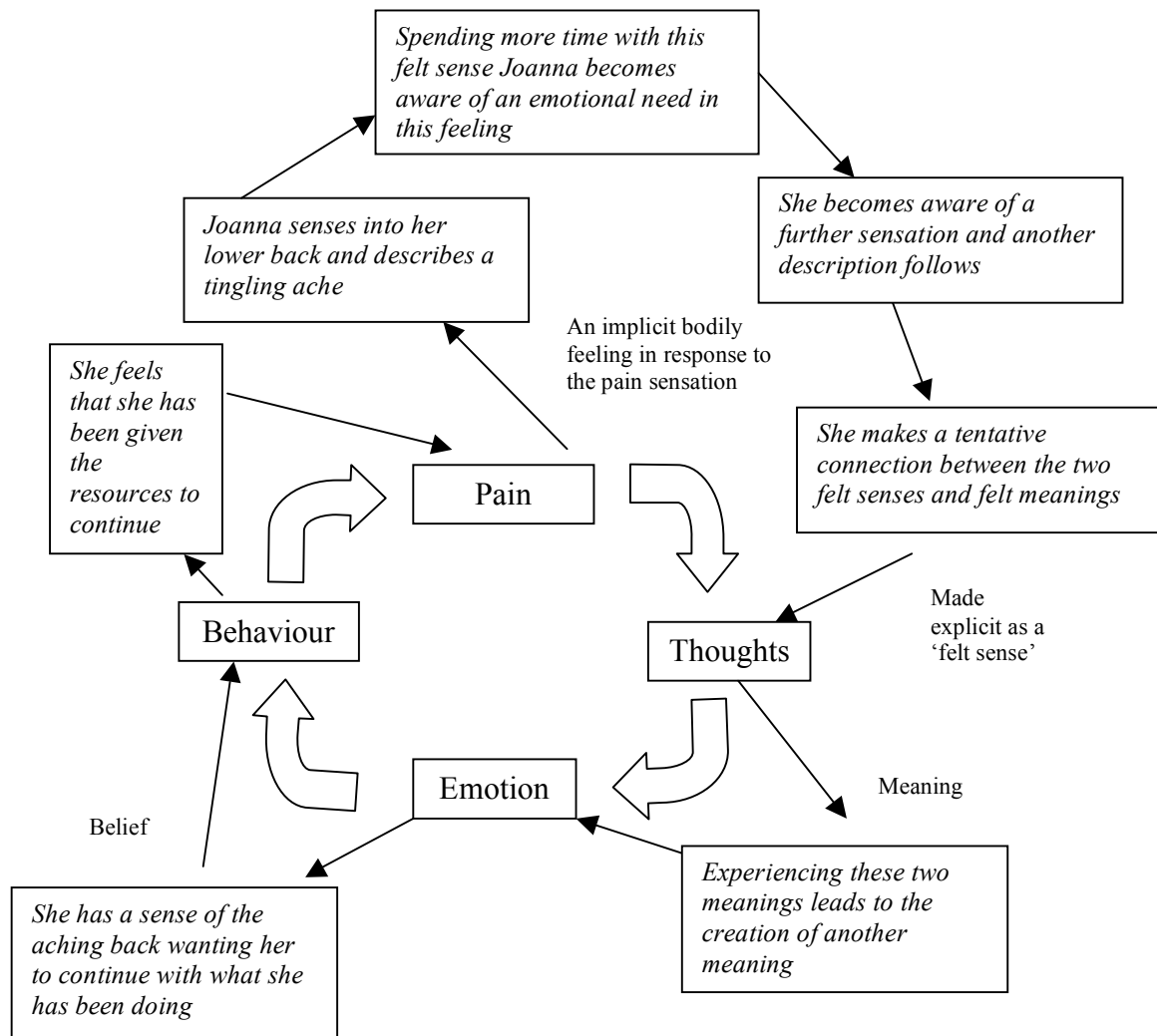


Figure 5.1: Integration of a specific Focusing session with the CBT model

In some ways this model is inadequate as it attempts to fit Focusing into the CBT model. There are some fundamental philosophical differences, the most obvious being that CBT is about challenging thoughts to affect emotional response and behaviour, whereas Focusing is non-judgmental and non-challenging. It is about experiencing and describing the experience, listening to the body and not trying to impose change. It is a body-based cognition throughout the process whereas CBT is based on more abstract cognitions.

Bearing these differences in mind, and returning to the neuromatrix theory of pain it is possible to make some suggestions as to where Focusing is acting in relation to the patterns of activity generated by the body-self matrix (See Figure 1.1). Taking one's attention to the pain appears to heighten the sensory signalling systems, increasing the perception of the pain. But remaining with the experience, listening to it and describing it would, I suggest, affect the input from the cognitive and emotion related areas. The quantitative data from this study would seem to indicate that, following Focusing on CLBP, stressful areas such as anger and frustration are ameliorated. This could be confirmed by studying such physiological responses as cortisol levels, and there are studies in MM (Galantino, 2005; Robert-McComb, 2004) which show a decrease in this response. It may be that Focusing acts in a similar manner. It is interesting that for some participants the perception of the intensity of their pain remained much the same, but the overall response was altered, something for which the neuromatrix theory of pain offers a means of explanation. Clearly the various inputs and outputs in the body-self matrix are held in a complex balance.

In Chapter 1 another definition of chronic pain was offered – that of chronic pain being a persistence of a memory of pain in the brain. It could also be suggested that Focusing, working as outlined above, helps to extinguish that memory. This suggestion brings closer the concepts of 1st and 3rd person science, where the experiencing body is enabling a learning which changes outcomes. However this is a very tentative suggestion.

Accepting and being with the pain – a summary

This section has considered the key findings in the study which seem to indicate that Focusing can offer a means of promoting an acceptance of CLBP in a way that is different from, but complementary to, current approaches such as CBT and MM. By considering a typical part of a participant's session from Focusing with chronic pain, it is shown that, for these participants, Focusing provides a dynamic, on-going way of experiencing CLBP in a non-judgemental manner. Comparison with current pain theories and pain management strategies indicate possible modes of action for the process of Focusing with CLBP in promoting acceptance.

Listening to and describing the pain

The second major theme which emerged from the data was that of ‘listening to and describing the pain’. From the findings in Chapter 4 and the discussion above it is clear that describing and listening to the pain are key movements in the process of Focusing with CLBP. In this next section the use of language and its interaction with CLBP will be explored a little further, looking at some of the challenges the participants faced and the opportunities that Focusing may provide in describing CLBP in both physiological and psychological ways. Also considered is how, or if, the language used by participants links with the findings relating to the questionnaire descriptors used and the observation about the pain finding its voice.

Participants noted that bringing attention to the CLBP seemed to increase the pain initially. This seems to concur with the commonly held idea that to spend time thinking about the pain and its impact only serves to allow it increase, thus suggesting it is counter-intuitive to focus on pain. Spending time thinking about one’s pain is seen as a negative coping strategy, something very passive. Yet recent work with patients who have cancer pain which may serve to challenge this assumption.

Based in the field of narrative medicine the study (Cepeda et al., 2008) describes that people who wrote a story with high emotional content about their pain for 20 mins per week reported less pain and better well-being scores than others. They surmise that the ‘disclosure of emotion contributes to the effect of narrative medicine upon health outcomes in patients with cancer pain’ (p. 629). Narrative medicine is based on a clinician hearing the patients’ stories, aims to give patients a sense of control and to make medicine more humane (Greenhalgh & Hurwitz, 1998). It facilitates therapeutic alliances and encourages patients to speak about their feelings (Elwyn & Gwyn, 1999). In the following section it is suggested that Focusing may also offer a way to explore and challenge the assumption that spending time focusing on pain is unhelpful. This suggestion is based on the experiences of the participants, draws on Gendlin’s philosophy and offers the possibility of discovering more-than description in pain narratives.

A changeable capacity?

As noted in the introduction chronic pain has multiple neurological pathways, with many junctions and a network of control systems. Add to this a ‘fathomless capacity for neuroplastic change’ (Henry, 2008, p. 64) and the constantly changing patterns of chronic pain as seen over the weeks in the lives of the participants is no surprise. As discussed above the neuromatrix theory (Melzack, 2005a) suggests that inputs to the neurosignature of pain come from multiple sources and the change seen in the reports of pain may therefore be due to changes in input from either sensory, emotional or cognitively related pain areas. The mechanisms of central sensitisation produce increased sensory input which may be perceived as increased pain by the person. They may begin to feel that the pain is getting stronger, demanding attention and dominating one’s life – as described by the participants in the pre-Focusing interviews. But this physical nature of the pain seems to change when Focusing attention is brought to it.

Exploring and describing pain

Daniel, who reported that Focusing was not particularly helpful for his pain, had some interesting moments in his Focusing sessions when he started to contrast the persistent pain in his back and hip with a new pain he identified in his right lower ribs. He describes this pain as giving him a feeling of being unbalanced, something that doesn’t happen with his ‘usual’ pain.

I am examining myself now and I’m thinking “is this way I feel unbalanced in my ribs, is that the way as I feel normally in my hips?”
And no it isn’t. It’s very much more noticeable, perhaps that’s because it’s newly acquired. It’s demanding a lot of attention. (3rd Focusing session, p 6)

Daniel recognises the demands being made by the pain, it’s insistence on being noticed, although he was not aware of that prior to the Focusing session. And during the Focusing he is enabled to sense something different about this pain. It seems that bringing his awareness to the ‘new’ pain has intensified it. This response underlines the folk message for dealing with pain – that one should not think about it, one should distract oneself from it. However, as Daniel stayed with this rib pain he noted:

D: that's interesting. I, trying to think into it, I actually felt it subsiding slightly... difficult to find the way to express that... it's like a pressure, it's like an inflation I suppose, and there was perhaps just a relief, a relaxing of the pressure.

FP: so, you were sensing that it's like an inflation somehow, or a pressure. And as you spent a little bit of time with it, and gave it a little bit of attention, you could sense that it deflated just a little, and there was a slight easing of pressure.

D: yes, it was, it was the transition that was noticeable. I can't say more than that really. And the sort of shift. I wouldn't know now whether it's back to where it was, or whether this is stable in its new state. I just noticed the change. (3rd Focusing session, p7)

Here is something unexpected. Spending time thinking about the pain (something society discourages and some facets of pain management programmes – such as the use of distraction techniques - also discourage) has brought a change to the physical nature of the pain – a relaxing of the pressure and some relief. Daniel notes that paradox himself and continues to spend some time in the rest of the Focusing session trying to find a way he can deal with this paradox. The pain has been unwelcome during the day, distracting him from his thinking, and now, during the Focusing session he is finding his thinking has actually distracted him from the pain in such a way that the pain has changed, has relaxed. The other participants also had experiences of discovering this counter-intuitive paradox that thinking about their pain could lead to a reduction in it, but Daniel, an engineer and self-confessed logical thinker, really found this perplexing. This change produced a tension, not picked up in his quantitative data where no noticeable change was apparent during the time of the study, which is clear in his interviews and Focusing sessions. It seems that Focusing challenged his thinking about the logical nature of thinking. It is possible that the pain assessment tools did not pick up these changes because they are either not sensitive enough, or do not measure outcomes which would note these subtle changes.

Struggling with the challenge of logic

Daniel continues, over the Focusing sessions, to worry away at the ‘logic’ of his pain.

it seems to be a one-way flow of information though. The nerves convey to the brain the representation of pain in a particular area and I am trying to send a message from the brain in the other direction to say it “No it doesn’t really hurt”, but it doesn’t work. (5th Focusing session, p8)

In trying to work with the messages concept of pain (one of which science speaks) Daniel finds it impossible to send messages in the opposite direction – ones that tell the pain that it doesn’t hurt. Responding to that inability he tries ‘to turn that mentally into “I really wish that I didn’t care that it wasn’t there” but it isn’t going to work. I can’t just dismiss it because it can’t be dismissed.’ (5th Focusing session, p9) and concludes that he ‘can’t see that I can ever think it away, but maybe I can learn to accommodate it’.

So, here is a challenge for the pain measurement tools used in this mixed methods study. Daniel’s qualitative data, his interviews and Focusing sessions contain evidence that he was able to perceive a change in the pain sensation and articulate a potential change in position to one where he can accommodate the pain. But no change is found in the questionnaire data. Of course things don’t always have to be tidy and real life rarely is. But this paradox, this tension begs exploration. The ‘usual’ scientific logic, as described by Daniel, doesn’t seem to be satisfactory.

Patterns – thinking beyond them

The questionnaires, and the way that Daniel is ‘logically’ thinking about his pain and how it is transmitted have a certain pattern about them. The pattern for the pain is laid by science, by the way that it has taken the task of attempting to explain how pain is perceived, that there is an order that can be placed on pain. That pattern may be adapted by a new finding, but it is still there. But Daniel’s experience, above, shows how people can sometimes find themselves in a position where they are aware of an uncomfortableness, a tension within themselves and their understanding. Daniel has, without realising it, stumbled

into the concept which Gendlin explores, that of ‘thinking beyond patterns’ (1991). In order to encompass the reality and intricacy of our humanness and the situations in which people find themselves, Gendlin argues that what is needed is a way of thinking outside - no, not just outside for that gives a dichotomy of being in or out, right or wrong - it is thinking beyond; crossing the boundaries of the logical forms and patterns normally encountered. But applying Gendlin’s thoughts to this study may mean dealing with some of the same problems that Giorgi encountered in trying to take something from a philosophical field (Husserl’s phenomenological enterprise) and using it within the field of psychological research. This tension of translating philosophical enterprise into an exploration of experience is enticing with its potential of possibility.

But how can the logic, the forms and patterns that are there, be challenged? How can ideas and concepts be spoken and explained? In describing pain, how can words used be challenged without using other words with other inherent explanatory difficulties? Perhaps Gendlin’s idea of thinking beyond can open horizons, ones that encompass and go further than our experience.

Phenomenological research provides an opening for this as it can enable the experience of others to be brought into personal understandings. It challenges researchers not only to think from within, from where they are, from their experience but also to think *beyond*, to more than personal experience, beyond the pattern in which assumptions rule to see if other things come; other forms, other thoughts, other ways of being.

Patterns of more-than-description

Constraints and paradoxes noted in Daniel’s comments above have already been noted; the counter-intuitiveness of dwelling on the pain, the logic of signals going up and down nerves, the fixedness of a pain which cannot be dismissed. Without being aware of it Daniel is already speaking and describing beyond the accepted patterns. Melzack (2005b) tells of collecting more than 100 words that people used to describe pain, and over 70 of them are in the McGill Pain Questionnaire. But ‘unbalanced’ is not there. Daniel, in spending time listening to and trying to describe his pain, brings a new word to the description. He

moves beyond what we would consider the normal pattern of describing pain.

But it is not just Daniel; Joanna says of her pain:

it's like it wants to be cared for, like it was a poorly child (1st Focusing session, p8)

it's feeling cold [...] and it feels isolated, lonely" (2nd Focusing session, p3)

it wants me to constantly attend to it [...] it's a sort of lively pain [...] constantly prickling, aching, shooting, gnawing (2nd Focusing session, p6)

like a grizzly bear that's going "grrr", that kind of grizzly" (3rd Focusing session, p2)

And Teresa describes hers like this:

in the mid back there is this kind of more concentrated numbness. And I see it like a little white circle, white and black circle with gray round it [...] there is a kind of centre ... it's like magnetic (2nd Focusing session, p4)

and she describes the image she has of her back:

I got an image of the vertebrae like those bicycle locks that have the numbers on. Or locks that have cylinders and you turn them to line up, or to unlock. And I'm seeing my vertebrae like that. And those little bits sticking out from one of them. (4th Focusing session, p4)

These are more-than-descriptions of pain. They go beyond the acceptable medical descriptions, drawing in the listener, enabling a sharing of the pain with the person with pain themselves and the person listening with them. When a more-than-description is used it conveys a meaning which may be hidden in the metaphor, may be hidden in the person until it is 'discovered' by an attentiveness to the body, to the sensation, to the feeling.

More-than-description when new to Focusing

Daniel 'discovers' a more-than sense of unbalancedness, a felt sense of which he was previously unaware and, in listening, both he and those listening to him have

a sense of his pain which wasn't there before. He also discovers that by listening to his body things can change. But this discovery is disconcerting:

D: I've now discovered by experiment that (I'm lying down) but if I'm quiet and listen to, or concentrate on an area, the pain goes down a little. And that is happening by experimentation rather than any coherent message from the area involved.

FP: so just through experimenting really, you have found that if you lie very quietly, and give it some attention, it does subside a little bit.

D: yes ... I'm trying to be as open as I can but I don't really know what I'm trying to, I don't know what to expect even. I don't know what to recognize, what else there might be. (3rd Focusing session, p8)

So, for someone just starting through Focusing to listen to their body and to come into contact with the felt sense there, description may lead to a sense of mystery, to a question of what might be expected and what might be recognised. This is an unknown place, the patterns Daniel has previously used in describing his pain are not there, he is starting to move beyond them. But this is difficult, he says 'I've got to be logical, I've come out of the comfortable state and the brain is whirring now' (3rd Focusing session, p11). The discovery of more-than-description challenges the logic and Daniel is caught in the middle. This then, is one of the difficulties for someone starting to use Focusing.

More-than-description and experienced Focusers

But for someone who is used to using Focusing, who is used to listening to the felt sense, how does the more-than-description work for them? For Joanna, in the section above (Table 5.1) there was a much more tangible emotional response to the description of the pain. The more-than-description of her pain at times was that of a poorly child, one that made its feelings known: it wanted to be cared for. But there was another feeling there too, the one that belonged to the part that was doing the caring. So there was more-than the pain present, there was a part that felt it had to look after the pain. The more-than pain part described its needs in being cared for – these include dietary changes, changes to physical activities. But there is another feeling present, a part feels that it has to surrender to the painful part, and it resists that surrendering.

Focusing enables Joanna to be with both parts, and hearing them both helps her to keep her resolve to care for herself. Her more-than-description created a new meaning, and through the exploration of the child metaphor led to a surrender which needed to be acknowledged, needed to be recognised.

Beyond patterns

This is one way that Focusing can interact with CLBP, that by focusing on the feeling, the felt sense, it is possible to more-than describe it. Daniel was beginning to struggle with grasping that feeling, that felt sense and beginning to find ways of describing it, and even in early times of Focusing he found a difference. Not long lasting, but he found that Focusing with, and describing his pain in a more-than manner made changes to the physical description of the pain ('it goes down a little'). Someone with more Focusing experience can expand the description, feeling into the emotional quality of the pain and the embodied feeling of it. With this embodiment Joanna was able to start to create a different meaning for her CLBP, one not constrained by the descriptors provided by questionnaires, but one which depended on her own body's description. She is thinking beyond the patterns which the pain world normally provides, the 0-10 of intensity, the logic of nerve function. Gendlin's challenge is to put feeling first, to attend to and describe the sense our body holds.

Beyond the usual – unbalancing language

This section began with a reconsideration of the physiological complexity of the neurology of pain, its plasticity and the recognition of the constantly changing patterns. This language of change is held securely within a scientific discourse which seeks, through science, to identify and label the changes, using the language of logic which Daniel found challenged when he was learning Focusing. Focusing challenges this logic as it requires non-judgmental acceptance and does not demand a search for explanation which fulfils the logic requirements. So it can encompass more-than-description and not question it in that scientific, logical manner. This is not to say that there is no logic present, it is just that at times it may seem one that is beyond our daily usage. So the language is different – both Paula and Daniel commented on the tensions they experienced in using 'Focusing' language (PA12, DA39). It is clearly not just the words that are used (words such as 'acknowledge' are in daily use) but it is the

concepts that are described by those words and the context in which they are applied. The participants new to Focusing found these ‘normal’ words being used in a context beyond that which they were used to. So not only is there more-than-description, there is also a more-than-usual aspect to language as it is used in Focusing. Small wonder, perhaps that Daniel used the word ‘unbalanced’.

This unbalancing is not only found in Focusing language – it can also be found in the language of poetry. Poetry frequently foregrounds feeling and plays with the logic of our usual linguistic syntax. The poetry of e.e. cummings (1994, p. 291) does exactly this and may offer an opportunity for a way to understanding which lies outside the usual logic of pain management.

since feeling is first
 who pays any attention
 to the syntax of things
 will never wholly kiss you;

wholly to be a fool
 while Spring is in the world

my blood approves,
 and kisses are a better fate
 than wisdom
 lady i swear by all flowers. Don't cry
 - the best gesture of my brain is less than
 your eyelids' flutter which says

we are for each other; then
 laugh, leaning back in my arms
 for life's not a paragraph

And death i think is no parenthesis

Perhaps Focusing can offer a way of thinking beyond the syntax of pain science – the nerve conjunctions and carefully crafted paragraphs. Remaining within the ‘balanced’ language may blind us to the possibilities opened by conversation and listening to the feelings. Pain places parentheses round peoples’ lives, constraining them - as made clear particularly in the pre-Focusing session interviews. The challenge for pain management strategies, both those sited in

science or the arts, is to find a way to challenge what seems the constrictive syntax of pain and provide a language that embraces change without constraint. This study suggests that Focusing, with its particular use of language, may offer some guidance in this respect.

Listening to and describing pain – a summary

This section discussed the way that the use of language in Focusing provides a challenge to the more common, or ‘normal’, logic of the way people speak and describe things. Using this more-than-description language of Focusing seems to offer a way of challenging the assumption that to focus directly on the experience of the pain increases that experience. Focusing on the felt sense and the felt meaning can produce relief as Gendlin (1964) suggests. More than this, using more-than-description language can also confront the logic and syntax of pain clinicians, as it foregrounds experience, ‘unbalancing’ the current patterns and asking that thinking goes beyond these patterns.

The value of Focusing – as found in this study

The title of this thesis requires that during this discussion areas where Focusing with CLBP provides value are identified. This latter part of the chapter considers this specifically in the areas of the physical, psychological and social areas of participants’ lives. The value of Focusing in promoting acceptance of pain and in providing more-than description of pain has already been covered. But prior to considering the specific physical, psychological and social areas some more general values identified by the participants will be discussed. At the end of this section reference will be made to Johnson’s (2007) definition of meaning and its relationship to these findings.

Focusing and CLBP – general values identified

The participants new to Focusing varied in their ability to ‘click’ with the skill, but this should not be surprising. Although Gendlin insists Focusing is a natural process he also acknowledges that, whilst some people learn it quickly, others may need weeks or months (Gendlin, 1978/2007). And some people probably just give up trying to learn. With the two participants who were new to Focusing this difference became apparent. Paula ‘clicked’ during her 5th Focusing session and that experience stayed with her; she commented on it in both the following

interviews. Daniel struggled more with the concept. There is a research tool for identifying people's experiencing level (Klein, Mathieu, Gendlin, & Kiesler, 1969) during their sessions, showing that those with a low experiencing level have a poorer outcome. However this tool has only been used in therapy sessions and not in learning Focusing as a self-management tool. Daniel reported that he found Focusing interesting and was aware that in learning Focusing he developed a greater awareness (DF4) and did not identify any negative outcomes, although the positive one he hoped for (a reduction in pain) did not occur (DF5). Paula summed up her experience of learning Focusing with her CLBP as 'it's simple but effective. What more can you want? It's been absolutely brilliant really' (PF39). Although the Experiencing Scale was not used it is likely that Paula had a higher experiencing level and seems to have had better outcomes, both reported in her interviews and in the questionnaire scores.

Importantly there have been no reports of negative outcomes. Both the participants who learned Focusing found it a valuable experience in itself – notwithstanding their pain-related outcomes. Even where Focusing seemed to confer no improvement, it was considered to have been a useful exercise to have experienced it. Daniel (who had to contend with bowel surgery and a diagnosis of cancer during the time of the study) still commented that Focusing would stay with him, even though it was not top of his list for exploring further at the moment (DF19/20). There was no inference that it was a waste of time, even though there was a substantial time commitment to learning Focusing. He felt it had an intrinsic value as a technique, even though he didn't feel it was particularly helpful specifically for CLBP.

The participants who were experienced Focusers also found a general value in using Focusing with their CLBP. Teresa was surprised how quickly Focusing shifted things around her pain and how effective it was (TF27), even though she has been using Focusing in her life for over 20 years. She had not used it very much with physical symptoms. Joanna has a similar response (JF24). So Focusing with CLBP for people experienced with Focusing can have a value they never imagined.

Focusing seems to change the perception participants had of their CLBP and the process by which this happens could be related to the role of acceptance in CLBP. Although the pain intensity may not decrease for a sustained period of time (as in the case of Paula) the impact the pain makes on daily life – as seen in aspects of the QOL measures as well as reported in interviews – is reduced and this improvement is sustained. The pain no longer means that things cannot be done, they are done alongside the pain; the pain is no longer central in deciding what is done. The sustained improvements were particularly noted in the areas related to the pain & discomfort module of the WHOQOL-PainUK and the physical, psychological and independence domains. In their narrative data participants continued to report more functional ability and feeling the pain was less, or less troublesome. A technique or skill which provides and maintains improvements in the management of CLBP is a valuable resource.

In Chapter 1 previous studies identifying the meaning ascribed to pain were discussed covering the physical, psychological and social meaning of the pain. The pre-Focusing interviews reiterated these and the following paragraphs will discuss how this study adds to those already published and identify the new aspects that it brings. This study is different to many of the qualitative studies cited as it takes a longitudinal look at meaning changing rather than basing the findings on one particular moment.

The value of Focusing - physical meanings

In Chapter 1 it was noted that studies showed chronic pain disrupts the activities of daily life, that it makes people feel fatigued and have less energy, exercise is limited, sleep is disrupted and the pain is variable. The pre-Focusing interviews picked up similar meanings, the constancy and variability of the CLBP making people live through a veil of pain, with reduced options for exercise and a sense of tiredness and even exhaustion. The findings immediately post-Focusing, for those with whom Focusing ‘clicked’, indicated improvements in many of these areas with sustained improvement over the following months. The WHOQOL-PainUK showed sustained improvement for Paula, Joanna and Teresa in the areas of daily activity, mobility and energy, resulting in an overall improvement in the physical domain. As Joanna said, ‘I’ve been gardening. And I’m enjoying

my walks more, and walking further without pain' (JA18). She reiterated these changes in her follow-up interview (JF14).

At very practical levels this improvement was commented upon by these three participants. In particular household tasks such as washing up, gardening and childcare were mentioned. These are tasks which are frequently seen by society as ones in which women often take the lead. And their comments about them would indicate they are areas which were important for these participants. To be able to complete the washing up may seem a small thing, but it is something that people with CLBP often cannot take for granted. To be able to do it can mean that the person feels they are contributing to household life and restore some self-esteem. These household, or family, chores are often invisible as they do not relate to areas often considered (such as employment) but do impact hugely on the life of people with CLBP (Strunin & Boden, 2004). Strunin & Boden's study shows that, for the women involved in their interviews, the limitation of household chores by their CLBP was the biggest reported problem area. So, although reported here as a physical meaning, it is clear that it also has some societal impact as well. For Paula the ability to take a fuller part in the lives of her grandchildren, and the physical demands that made (playing in the park, carrying them etc) was a very positive outcome from learning Focusing.

To have enough energy to go walking and swimming, and to enjoy these activities with less pain was something that Joanna and Teresa particularly commented upon. In Strunin & Boden's study 50-60% of women commented that their CLBP impacted on their vigorous exercise in a detrimental manner. This was an area that all four participants identified pre-Focusing; dance being mentioned in three of the interviews. In the later interviews walking and swimming featured more, both in the extent to which those activities were undertaken and in the pleasure found in doing them. The energy facet of the WHOQOL-PainUK improved for all the three women participants and that improvement was sustained over the study period. Daniel did not mention dance or vigorous activity in his post-Focusing interviews and his energy sub-scale remained unaltered.

Interestingly the pain scores did not sustain an improvement for all the participants who reported sustained improvement in their activity levels at the end of the study period. This may indicate that the meaning placed on the physical pain had changed. Although the pain was still present it was no longer seen as something that put such constrictions on the activities undertaken. Even the participants who reported a reduction in their pain reported it was still present, so the increased activity was still taking place in an environment which contained pain, if less than previously. The meaning of the pain had changed and no longer controlled or prescribed what the participant did in the way it had before using Focusing.

There were no reports in the interviews of the effects of CLBP worsening over the study period.

So, there are findings that show that Focusing can change the meaning ascribed to the physical meanings of their CLBP, and that this change is still present after a number of weeks varying from 14 to 26. This length of follow up compares very favourably with other studies, many reporting 3 month (12-15 weeks) follow up data.

The value of Focusing – psychological meanings

Previous studies have reported that chronic pain challenges the person's feeling about themselves or their identity, that it can affect their emotional responses making them more easily angered and frustrated, and may include the loss of hope and a feeling of grief. These themes were again found in the pre-Focusing interviews, indicating that, although a small group, the participants had similar responses to their chronic pain as those from other studies. The participants indicated that their CLBP brought feelings of anger, frustration, a sense of sadness and despondency, along with fears that they might find themselves in situations made unmanageable by the pain. The post-Focusing and follow-up data shows how these areas changed and sustained their improvement.

In Paula's case there was a continued improvement in the areas of anger and vulnerability in the PDM module of the WHOQOL-PainUK from completing the

Focusing sessions to the follow-up data, collected 21 weeks later. Her overall psychological domain score did not continue to improve, but it did not return to the lower pre-Focusing position. She mentioned, following the Focusing that she felt if she wanted to, she could do a marathon:

I said I could run half an marathon - I've no idea if I really could - but if I started to do some training and it didn't work, I would to be able to decide how I felt about that. And then leave it behind and not worry.

(PA64)

What is interesting about this statement is not so much the intention of running, but the level of acceptance shown if she failed to achieve what she had set out to do. Or, to be more precise, the knowledge that with Focusing she has a way to enable her to decide how she feels about a 'failed' situation and then a way of leaving it to one side and not picking over it (PA10). Paula really felt that using Focusing gave her a way to move on which she described as 'psychologically astonishing' (PA22). This ability to move on shows a response to her body and its abilities that was not there earlier. In her pre-Focusing interview Paula indicated a frustration with the limitations the CLBP put upon what she could do. Here she shows a quite different approach; even though it is theoretical she is quite clear in her exposition. She shows a willingness to consider something she would have dismissed before, and demonstrates a strategy for managing the situation if she is unable to do it. She is finding a way to deal with the restriction of the pain on what she might be able to do by accepting the 'unwanted self' (the part that has 'failed'), thus reducing the dichotomy of her body and her unwanted (or painful) body (Osborn & Smith, 2006; Williams & Bendelow, 1998).

For Joanna and Teresa, the experienced Focusers, the differences were even more marked. For Joanna there was a marked improvement in her mood. She remembered being quite distressed before the study began and crying frequently (JF13). At the follow-up interview she felt much less distress, and this was reflected in the WHOQOL-PainUK scores. Crying is often associated with loss or grief and, in her pre-Focusing interview, Joanna indicated that her CLBP had meant the loss of many things, reflecting the findings of other studies (Walker, Sofaer, & Holloway, 2006). By the time the study concluded (40 weeks later for her) she had been able to do more walking and gardening, and an improvement

in these physical domains may well have lessened the sense of loss she had felt in not being able to undertake them. Joanna said, in both the post-Focusing and follow up interview that she felt that the support she got from Focusing was key to her improvement in enabling her to value herself (see discussion earlier in this chapter).

In the interview data there is evidence of a change in the way that the participants viewed themselves, enabling them to feel more ‘themselves’, more how they felt before they had the pain and less aged by it. This could be seen as a restatement of identity, that they are less defined by the pain and the painful body, and discovering their ‘real’ self. The area of pain, self and identity is under-researched at present (Aldrich & Eccleston, 2000) and using Focusing may be one way of investigating this area. There is evidence of chronic pain changing identity; pain affects how people see themselves, generally in a negative way, and people feel this ‘new’ person is not them. Williams & Bendelow (1998) suggest that this difference may display itself by a change of meaning in peoples’ narratives. They ask if an intervention can change or affect people’s relationships to their body. It would seem that Focusing may be such an intervention that enables a way to change peoples’ relationship to their bodies, perhaps enabling them to find their ‘real’ selves. Should the management of CLBP be looking not only at the meaning of pain, but also at the meaning people ascribe to their body? For Joanna this discovery of the self seems to be part of what has led her to value herself more and to not give up on herself.

From this small study the findings suggest that, in using Focusing with CLBP, there are changes in the psychological meanings ascribed to pain. These are about the meaning and value given to oneself, as well as changing some of the attitudinal meanings around anger and frustration. It may be these changes in particular are those which are related to changes in acceptance – areas of anger, vulnerability and uncertainty in the PDM have been shown to correlate highly with acceptance (Mason, Mathias, & Skevington, 2008).

The value of Focusing – social meanings

Earlier studies showed that it was important for people with CLBP to have their pain believed by others, healthcare professionals in particular. Other social areas include employment and roles within the work and home environment. Isolation can occur as people withdraw from the company of others. The pre-Focusing data in this study picked up few of these areas, and the role of doctors in believing and providing support was spoken of. Paula returned to this in her post-Focusing interview, basically reiterating what she had said before. It would seem that using Focusing does not affect the attitude people take towards healthcare professionals and their understanding of CLBP.

It is important to keep in mind the recruitment criteria for this study, which does differ from many others in that people were not contacted through their GPs or pain services. This study was based on a community model, and only one participant (Daniel) had had any specialist input. This may give a different aspect to some of the findings when compared with other published studies.

The working environment was discussed by Daniel and Joanna in the pre-Focusing interviews but not subsequently. Daniel did speak about the impact that his pain had at work and how he navigated his way around the limitations. However he did not return to this subject in the following interviews. The national epidemiological data shows there is a big impact on the working environment. Daniel was the only participant in traditional employment. Paula is retired and Joanna and Teresa self-employed therapists who have to tailor their work to their capabilities at times (for instance Teresa (TB41) can lie down rather than sit to conduct some of her sessions). All of the participants had interesting social lives and friends with which to share it and the social isolation seen in some studies (e.g. Osborn & Smith, 1998; Seers & Friedli, 1996) was not apparent.

The role of the Focusing companion seems to be something important to the participants. Although Focusing can be done on one's own, all four participants mentioned in their interviews that it was good to have a companion and to spend time Focusing. Paula found it was useful to have someone there who will 'sense

when you're sliding away from the mark' and she thought that Focusing regularly with the same person could be helpful (PA36). Joanna had similar thoughts when she said that having a companion enabled her to stay with and deepen contact with some things (JA20). Daniel felt that having the hour for oneself legitimised talking about the pain. The studies above have reported that people don't like to talk about the pain to their friends as they think they will find it boring and people will not want to be friends – leading to greater social isolation. The Focusing sessions seem to provide a special time when it was OK to talk about one's pain and the usual 'social' response was not needed – the response was a Focusing one.

However, it must be noted that the social domain of the WHOQOL-Pain UK worsened for three of the participants over the study. Reasons for this are not clear, as stated in Chapter 4.

The value of Focusing – a summary

Using Focusing does appear to bring changes in the way these participants describe and ascribe meaning to their pain. In summarising from the above discussion three threads emerge which relate to, but are markedly different from, meanings the pain held before using Focusing. These are:

- a) The pain no longer controls what I do
- b) I feel more myself and able to value myself
- c) Focusing gives me a supported place to talk about my pain.

Meaning and meanings

Johnson (2007) argues that meaning is found in the body and carried forward and given voice through language and other forms of expression. From the explorations and discussions above, and the discovery of changed meaning it may be that Focusing, a self-help technique rooted in the body, is a means of enabling that meaning-making. Certainly Gendlin (1962/1997) believes that, and the changes in meaning identified in this study would support that concept. It is of interest that Paula talked about this idea of a change of perspective (about pain) coming from the body. Initially she was adamant it didn't and that it was from the brain (PF33) and then said that it was only by becoming still and aware of one's body that it was able to occur. The Cartesian dualism is certainly alive

and well in the general public! And it may be why a therapy such as CBT which emphasises the thought (mind/brain) processes is more acceptable than MM or Focusing.

These body-based practices certainly challenge concepts of meaning-making, and it is not surprising to see papers starting to emerge which try to place MM within a western model (c.f. McCracken et al., 2007). This present study suggests that the meaning of CLBP for some of the participants has changed in ways that can be aligned with Johnson's tripartite structure. They are relational and interconnected, exist in shared communication and are grounded in the body and bodily interactions. For example, the first changed meaning 'the pain no longer controls what I do' is clearly relational in time. The past is implicit – it used to control – and the relationship between the pain and what the person does is changed. The meaning has been shared – with the researcher but also the shared meaning will be seen by the people with whom the person interacts. Finally the meaning is grounded in the body, Focusing has ensured that and the pain has lost the power it had to control what the body could do.

Implications for practice

This study shows that for three of the four participants Focusing had a noticeable impact on the meaning they ascribed to their pain and to a number of related facets of their quality of life scores. It appears to have no side-effects and to be a gentle and non-threatening approach; Paula described it as a 'quietly revelatory' experience (PF26).

It appears that Focusing may offer some benefits for people with CLBP. It is not a skill that everyone finds easy to use and, if taken into practice in the NHS environment, clinicians may need some guidance in identifying those for whom it might work more easily than others. It might be that a screening questionnaire would be useful – the ones on levels of experiencing and outcomes from sessions are based on people who are having Focusing therapy sessions rather than self-help. However, in most current chronic pain management programmes people are not divided into separate groups, or screened, for CBT or MM, or even not to undertake CBT – everyone does it. There is, of course, a variety of outcomes,

and it could be that choosing processes on a more individual basis could improve outcomes all round. Clinicians use a variety of different medications based on symptoms and individual response, why not apply similar criteria to psychological interventions?

Most people who have CLBP do not see specialists for their pain management; as shown in Chapter 1 most people manage their pain themselves or see their GP or an alternative healthcare practitioner. This being the case, and Focusing being a self-help skill, there could be opportunities for using it in the community, perhaps through support groups (such as BackCare) or in local pharmacies. There is a financial implication and costs would have to be considered. The difficulty encountered in recruitment may suggest some reluctance from people to consider using Focusing, but this might be overcome by a recommendation from a GP or other healthcare professional.

One difficulty in introducing Focusing would be around finding appropriately trained people to teach the skill. There are just 27 practitioners identified on the British Focusing Teachers Association (BFTA) website (<http://www.focusing.org.uk/index.html>). Many of these practice other psychotherapeutic techniques which are not recognised by the NHS and there may be differences in world views that can make communication more difficult. The NHS is a fairly conservative environment; it has taken a number of years for psychology to be accepted to the level which is apparent today.

There are examples of Focusing being used in groups – there have been a number of ‘changes groups’ or ‘Focusing Circles’ in the USA (McGuire, 1985) and there are six in the UK identified on the BFTA website. This approach may be one that is suitable to apply in the community setting, appearing similar to the support groups which are already in place in many places.

The discussion on language and enabling more-than description suggested that healthcare practitioners may be able to enable patients to describe and become aware of their pain in a more embodied way. To do this would mean increasing awareness of the use of Focusing language, perhaps in the way that HCPs phrase

questions or comments (Klagsbrun, 2001) or in the way they listen (Summerville, 1999). Bringing this aspect into nursing practice could be further explored.

Limitations of the study

Many of the limitations have been acknowledged at different times during the writing, but will be recapitulated here.

1. **The sample size was small**, even for a phenomenological study. This did give opportunity for greater depth and analysis, but I feel it would have been enhanced by the addition of two more participants, particularly to improve the male/female ratio and attain the numbers suggested in the original design. This would have improved the sub-division of those learning Focusing for the first time and experienced Focusers. With the current sample it would be possible to construe that Focusing was only useful for women. However my explorations into Focusing and pain in the UK led me to helpful discussions with a number of men and one of them has written about his experience (van der Kooij & Wilson, 1998).

Many phenomenological studies undertake interviews with small samples, some as small as one participant (Galvin, Todres & Richardson, 2004) and many have between 6-12 participants. As this study took a longitudinal and comparative approach each participant was interviewed three times, generating a total of 12 interviews overall, more than 12 hours of interview data. The amount of data was comparable to other phenomenological studies which tend to have one, or occasionally two, data collection points. Importantly this study also collected quantitative data so the amount of data available is probably similar (or possibly greater), even though participant numbers were small.

N=1 methodology is a type of single case study and, in psychology, has been used to evaluate the impact of an intervention within an individual or across a small series of individuals - a 'small *N* design' (Turpin, 2001). This approach has been criticised (Cochrane, 1989) as having a high risk of false positive results, which may include biases relating to the placebo effect, polite patients or an

underlying belief in the efficacy of the intervention. In order to address some of these issues the $n=1$ trial may be adapted to a randomized controlled trial in drug therapy where the same person has both the active and the placebo intervention with a ‘washout’ period between the phases (Miller & Corner, 1999). In medical research this is the approach most frequently seen. This study takes an approach to the $n=1$ methodology as seen in psychology, one which sits well with the predominately psychological aspect of the study. The use of both qualitative and quantitative data, and a rigorous approach to the collection, analysis and discussion attempts to limit the possible biases.

The small sample size also had implications for the integrity of the statistics as basic descriptive statistics were employed, in much the same way as a clinician would in real life. Comparisons were within each participant in the study, considering individual change rather than cohort changes. To enable more general statistical tests a much larger group cohort would be needed and the focus of the study would have been quantitative, negating the main philosophical drive of the study. So, although a limitation, this was inevitable given the theoretical driver for the study.

2. **The decision to place this research in the real life of the participants** made it impossible to account for variations. The variations in the participants’ lives became part of the narrative of the Chapter 4, and some became apparent in the Focusing sessions. The fact that they carried on with other approaches to their pain (Joanna was seeing an acupuncturist and making dietary changes, Daniel had a consultation with the pain clinic in secondary care, Teresa saw a chiropractor following her car accident) may have had some impact on the efficacy of the Focusing or may not. What is important is that the participants perceived Focusing to be related to the changes they reported. As suggested by Macfarlane (2008), changing perceptions of their pain may result in improved outcomes for people with musculoskeletal pain.

3. **The time taken for each participant to complete various parts of the study – a longitudinal design** - and slow recruitment, led to a variation in the timelines through the study. The scale of the variation was not expected and was,

in itself, a problem at times. In the initial study design the follow up interview was planned for 46 weeks after the completion of the Focusing sessions. This was shortened when the difficulties with recruitment became apparent, and in the end a pragmatic approach meant that the data was collected as near to 26 weeks as was practical in relation to analysing and presenting the results within the time constraints of the fulltime PhD studentship. This may have some impact on the findings and the reported sustained improvements may decrease with time.

4. **I have been cautious in the inferences made from the study**, often because of these major challenges to the data, regarding it as very exploratory and with limited confirmatory ability. The data collected reflects personal changes and experiences and therefore it is not possible to draw inferences or generalisations to cover the broad pain population. What one can say is that for these participants Focusing had some impact and value, and warrants further investigation.

Contributions to knowledge

Notwithstanding the limitations acknowledged above this is the first research study to consider the value of using Focusing with CLBP. It is tentative and small in numbers, but has brought to light some interesting and unexpected results. It suggests a number of ways in which Focusing provides value in the management of CLBP. As so few studies existed using Focusing with CLBP this one is an important contribution to the area.

1. **Focusing appears to be a safe technique to offer**. There were no reports of negative side effects, and no worsening of the underlying condition. The gentleness and self-limiting exploration of Focusing has been reassuring – I had some concerns about people opening up areas that they would not be able to cope with, and which would cause distress. I did not see this happening in the study or in the surrounding work I did in Focusing to broaden my understanding of the process. All the participants found it interesting and useful, even if it made no difference to their pain. It was thought to be a low risk technique (see Chapter 1) and nothing from the study has altered that opinion.

2. **Focusing with CLBP enabled three of the four participants to change some meanings they ascribed to their pain.** It has been shown that the meaning or belief people hold about their pain affects their outcomes (eg Lamé et al., 2005). A change noticed in the change of meaning in this study was that some participants felt they were able to take control over what they did rather than let the pain control or dictate to them. In psychological terms this is a huge change. Although Gendlin's philosophical approach to making meaning through this experiential approach may not answer the 'how this happens' for all health care professionals, there is no avoiding the change that has taken place. However, with the growing interest in the different 'bodies' in medicine, and a search for explanation of techniques such as mindfulness meditation (MM), Gendlin's approach should not be discounted. The impact of Focusing on the physical as well as the psychological is an important contribution to current knowledge about the management of CLBP.

3. **This study provides pain specialists with another model for considering and enabling the processes of acceptance** which are under scrutiny in the management of chronic pain at present. Acceptance is linked with peoples' perceptions and beliefs and suggest that Focusing offers a way for people to become aware of those beliefs and the meaning that their pain has for them. In enabling a bodily awareness of their feelings about those meanings and beliefs Focusing offers a gentle and non-threatening way to explore them.

At present MM is the technique most used in this growing area of contextual chronic pain management. This study suggests that Focusing may offer a different approach to the same end. Its potential for some form of resolution through meaning making (at times) may appeal to some people who find the open-endedness of MM unsatisfactory.

4. **Focusing offers an opportunity to explore and describe pain in new ways.** All the participants in the study found this aspect of Focusing useful. It also offers health care professionals the opportunity to empower patients to describe their pain and its impact in this way by asking Focusing-like questions.

Some of the work around Focusing in healthcare suggests this may be meaningful for both the patient and the professional.

5 **Focusing may offer a tangential link with narrative medicine.** This small but growing area of medicine may prove to be one in which Focusing can find a place.

6. **The study demonstrates that the WHOQOL-PainUK is sensitive to individual change.** Not related to Focusing, but to a quantitative measure used, there is some confirmation in the changes noted with this tool and also found in the qualitative data. This supports the claims made that this tool is useful for assessing QOL change over time in individuals with chronic pain.

Summary of contribution to knowledge

Overall this study provides a number of contributions to the knowledge about using Focusing with CLBP. It contributes a substantial amount to the available research on Focusing and pain, exploring some of the possible processes and providing both qualitative and quantitative measures of effectiveness. It contributes to the current interest in acceptance and chronic pain and also to quality of life and chronic pain.

On a personal note I have been very surprised by the findings of this study. Following my initial exploration of Focusing I expected an approach which might help with some of the psychological aspects, but would make little practical difference. So the reported changes to the pain and the impact on the physical function and daily lives of three of the four participants came quite unexpectedly.

Summary of Chapter 5.

This chapter has discussed key findings from this study and shown how the two research questions on the differences ascribed to CLBP after using Focusing and the impact of Focusing on pain and QOL scores have been answered. The limitations of the study were acknowledged and the new knowledge identified.

The discussion has covered a wide variety of aspects of Focusing and CLBP. It has shown how the processes of Focusing differ from those of cognitive behavioural therapy and mindfulness meditation and how Focusing could provide a different way to enable people with CLBP to find a way forward in areas of acceptance around their pain. The importance of language and description has been discussed and how, in using the descriptive language of Focusing in this study, it enabled more-than-description leading to changes in the syntax of pain. The value of using Focusing and its impact on the meaning ascribed to CLBP in the physical, psychological and social areas of life were summarised and suggestions made as to how Focusing might be included in current chronic pain management practice. Finally the limitations inherent in this study were discussed and the new knowledge and surprises gained from this study in the areas of its contribution to knowledge about Focusing and CLBP were identified. .

Chapter 5a – Discussion of methodological findings

In Chapter 2 a number of challenges in taking a mixed methods research (MMR) approach to this study were identified. Ways of meeting these challenges were suggested and this chapter considers what the value of taking a MMR approach was for this study. The usefulness of the ‘context of stability’ model introduced in Chapter 2 will also be discussed. This chapter has been written in a more personal style to demonstrate the personal benefits and challenges of using this approach.

The value of a mixed methods approach

The third research question posed in this study was ‘Does using a mixed methods approach add to the study?’ Has it proved to be an approach which enriched the study, and, on reflection, has it worked within the integrative framework suggested (Teddlie & Tashakkori, 2009) in Chapter 2 (Table 2.1) as a touchstone? In that chapter it was suggested that reasons for using a MMR approach included the ability to ask exploratory and confirmatory questions, that it provided a ‘utility’ of presenting finding and discussions in multiple languages, and that using multiple ways of considering life experience enables the possibility of ‘thinking outside of the box’. A further question asks if the final product of this study is more than the sum of the individual quantitative and qualitative parts (Bryman, 2007).

Using a MMR approach has added significantly to this study; in its design and execution as well as in increasing current knowledge about integration in MMR. In exploring these issues this sub-chapter will consider three specific and pertinent areas: what MMR has brought to this study, what this study brings to MMR and, finally, the difficulties encountered in this approach.

What MMR brings to this study

A key consideration in using MMR was the search for a method that could bring a more-than approach to the research, one which would reflect the demands of the daily life of the participants and be responsive to the demands of the healthcare professionals who deal daily with people with CLBP. It also needed to

answer the questions posed – all of which were exploratory to some extent as it was a new area of research. Using Yin's (2006) counterpart approach the qualitative and quantitative questions explored different aspects of the participants' experience which were discussed in Chapter 5. I believe that in answer to the research question asking what a MMR approach has brought to the study there are five particular aspects, each of which are explored briefly below.

It has spoken in the discourses of science and art

Taking a mixed methods approach has enabled the bringing together of both science and art discourses – seen in the exposition of the theories of pain and pain management and the ensuing discussion earlier. Although possible with single method studies, it seems to be much more natural with mixed studies. The juxtaposition of both discourses allows for different exploration of common questions using language from both. (This has the potential for a lack of clarity at times, as discussed later.) The smallness of the numbers of participants has proved problematic at times as the science of statistics requires a rather larger data set. But this has been acknowledged and changes to quantitative data over the study have been related to the individual, using $n = 1$ methodology, and no attempt has been made to extrapolate this to the wider community. But the addition of some quantitative data gives some indication of what measures might be useful if further studies were to be undertaken.

Using both languages also adds to the utility of the study, enabling future presentation of results to start from different positions. Both data types need to be presented, as they are inseparably intertwined, but provide different ways into the data.

It has provided confirmatory evidence.

Rather surprisingly, the two different data sets were more convergent in their findings than expected. Perhaps that is an indication of my inexperience as a researcher, but it was certainly easier to cope with data that did not appear to contradict itself. It also indicated the appropriateness and ability of the chosen measures to reflect those aspects of the participants' experience that they covered. The quantitative data is a very small part of the data collected but the

coherence adds weight to the way the measures were chosen, outlined in Chapter 3.

It has given voice to different perspectives.

Creswell et al (Creswell, Shope, Plano Clark, & Green, 2006) suggest that one reason for qualitative research being emphasised in MMR within experimental studies is that it allows voice to be given to different perspectives. In this study, with its emphasis on the qualitative question, the quantitative aspect allowed a different voice to be heard. In a working and living environment where the two aspects are part of ‘normal’ life, to take them both in a research project seems utterly coherent. This was well demonstrated in the discussion on descriptive language in Chapter 5, where the qualitative voices added to the descriptors provided in the questionnaires.

It enabled an intersubjectivity

By this is meant that using MMR enabled a movement between theory and people’s experience. This has been demonstrated in the section of the value of Focusing in Chapter 5. The participants’ experiences, and interpretation of their world of living with CLBP has been related to theories of pain and other publications which explore responses to pain and interventions. Most of these papers have come from a quantitative perspective and the mixed method findings from this study have been involved in a close interplay of intersubjectivity. Using MMR has meant that a wider field of previous research was open for use in this study. It enabled comments to be made, such as the observation in Chapter 1 that the quantitative literature was identifying an aging in brain tissue; the qualitative research identifying that people reported the CLBP made them feel older. MMR is in an enviable position to bring together these type of observations, frequently not addressed in single paradigm studies.

It has generated theory grounded in both discourses

I would suggest that using only one approach would have limited the discussion on the interplay of the processes of Focusing, acceptance and the model of CBT. Evidence for the efficacy of CBT relies mostly on quantitatively based studies, as do the current studies on using mindfulness meditation as a pain management strategy. The results of this study offers a way to develop a new theory on how Focusing might challenge or provide a different way forward towards acceptance

than that offered by current theories. Having both qualitative and quantitative data enables a fuller discussion.

What this study brings to MMR

MMR is a relatively recent approach to research and some papers identify aspects of it which need further exploration. These include the area of integration (Teddlie & Tashakkori, 2009) and the presentation of findings in an integrated manner (Bryman, 2007) and the use of specific qualitative, quantitative and mixed methods questions (Bryman, 2006). I believe this study offers some way forward in each of these areas. In the theoretical section dealing with potential issues of congruence I believe this study also offers new ways of approaching that issue. Finally, using a MMR approach has enabled discussion of the interplay between 1st and 3rd person perspectives. These areas are discussed below.

Integration of the design and interpretations

Embedding the presentation of the quantitative findings within the qualitative provides a reflection of the overall design of the study. Using the questions around inference quality raised by Teddlie and Tashakkori (2009) and discussed in Chapter 2 enabled a rigorous approach to the issues of integration. In presenting and discussing the findings I have endeavoured to refer back to the statements there on interpretative rigour, although there have been challenges – particularly in interpreting the statistical results. The section discussing the value of Focusing in the various domains was the most challenging in this respect. In these sections it was a challenge to bring together previous evidence from mostly quantitative studies to integrate with the findings of this study.

New ways of describing findings

As discussed in Chapter 4 this study has taken a rather unusual approach to the presentation of the findings. It may be that both qualitative and quantitative researchers find this approach unsettling. For qualitative researchers the incorporation of numerical data into a phenomenological description will appear perverse. Quantitative researchers will baulk at a study using such small numbers and based on an $n=1$ approach at this level. However people with CLBP see themselves as individuals who need an individual approach, and clinicians are

only too aware that what works for one patient does not necessarily work for the next. So, pragmatically, a presentation of the findings in a mixed fashion reflects daily life. Blending the two findings also allowed me the privilege of using both languages (as discussed above). This led to my decision to include the narrative response in the section of the findings from the pre-Focusing session interviews, to try and portray in a more evocative style my responses, as a researcher, to the findings at that point. This is not unknown in qualitative studies and serves to foreground the fact that this study did not give an equal weighting to the different types of data and the contribution they made to the study. The study does, however, deal equally seriously with both sets of data.

The use of specific questions

In his content analysis of mixed method social science papers (232 in total) Bryman (2006) notes that in ‘only 10 articles was there a clear indication that quantitative and qualitative research had each been designed to answer specific and different research questions’ (p. 110). This study has specific qualitative and quantitative questions, which reflects ‘the current state of the art’ in MMR (Tashakkori & Creswell, 2007, p. 208). It also has an explicit mixed methods question which, they suggest, is more recently being thought of as appropriate in mixed methods research studies. The exploration of the balance of these questions and of the place of the research on the qualitative/quantitative continuum led to the development of the application of a context of stability to the method.

Developing a context of stability

In designing the research method care was taken to ensure that the constituent parts were as balanced as possible. In Chapter 2 it was suggested that the application of Schoenberg’s harmonic principles might form a basis on which to build this stability. Monzo’s visualisation of this provided the inspiration for the following visual diagram of the various weightings and balances of the basic design structure. This is an area which does not feel complete, but is a new way of thinking about the design elements in a MMR study. The design elements considered by Creswell and others (and used as a basis for this study) do not weigh the parts in such a visual manner. This way provides the researcher with a different way of seeing the balance of a study, and gives an idea as to where the

study pivots on the continuum. Constructing Figure 5a.1 enabled me, as the researcher, to see how parts of the study fitted together and the weight given to each part. By seeing the various parts in a diagrammatic format I was able to ensure a balance to the study which worked together with the more structured approach of Teddlie and Tashakkori's (2009) framework. This also seemed to bring together, or integrate, the science and art within the study.

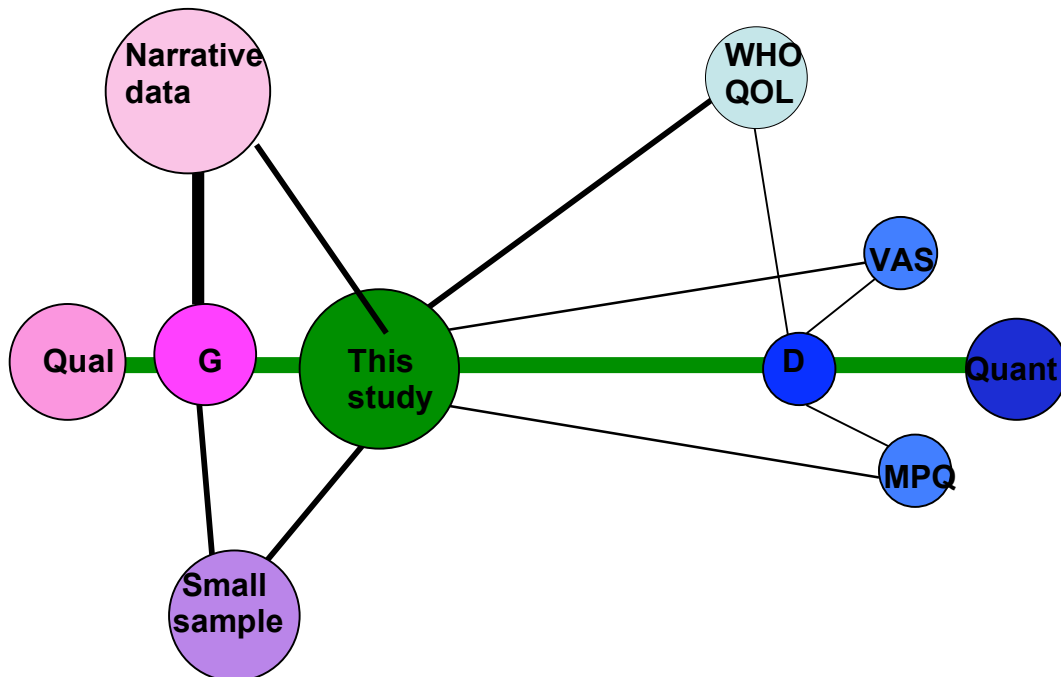


Fig 5a.1: The design of this study, based on Monzo's 'Tonescape' concept. (G=Giorgi's descriptive phenomenological psychological method; D= descriptive statistics; MPQ= short form McGill pain questionnaire; VAS= global VAS scale; WHOQOL= WHOQOL-Pain UK)

1st & 3rd person perspectives

Using a phenomenological approach in this study foregrounded the 1st person perspective of living with CLBP and the experience of using Focusing in that lifeworld. The addition of questionnaires adds a 3rd person perspective in that, in the design of the questionnaires information has been analysed to which both the participants and the researcher do not have access. Within a quantitative framework this distancing to the 3rd person is usual but using a MMR there is the potential for the blurring of these two perspectives. I have not found any mixed methods literature which addresses this potential challenge and this study makes

an attempt to acknowledge the possibility – both of the challenge but also the possible benefits. The discussion around the use of descriptive language in Chapter 5 is an example of the 1st person and 3rd person perspectives bringing different viewpoints to the phenomena of describing pain. The participants' descriptions of the meaning of their pain, and even the terms they used in describing it, are different from the numerical score given to the intensity of the pain in the SF-MPQ. In CLBP the example of neurological imaging findings on an aging brain and reports of feeling older is another example of the interface between 1st and 3rd person perspectives. The opening up of this discussion is a valuable contribution to MMR from this study.

The difficulties encountered using this approach.

Using a MMR approach provided challenges, and many of the points mentioned above came about due to finding ways of meeting these challenges. Key difficulties in relation to MMR and this study are outlined below.

Maintaining clarity about the stance being taken.

Keeping an integrated mixed methodology in the centre of the description and discussion of the findings has been difficult at times. It would have been easy to report one type of findings and then the others in a sequential manner. During the writing up of the findings I was continually conscious of the different languages I was using, and being aware of the position taken at the various times. It was important to be clear about the stance of a mixed methodologist as, at times, it would have been easy to work in an entirely phenomenological manner. I found returning to the data regularly helpful in maintaining this balance.

Choosing appropriate papers

The areas of CLBP and QOL are both huge and the number of publications on both, are so many as to be daunting. Even experienced researchers find this (see, for example, Niv & Kreitler, 2001) a problem. Using a MMR approach opens up the fields to be explored as both qualitative and quantitative data is used. I was grateful to find a paper outlining a technique called 'berrypicking' (Bates, 1989) which, although a few years old now, seems to provide a pragmatic answer to a practical problem. To manage the vast amount of data available the other way forward seemed to be that of a vigorous limitation of the search criteria.

However, with this latter approach the possibility of not encountering interesting and appropriate information is almost inevitable. Bates suggests that as a person travels through the information needed they change direction and the search evolves as various leads and shifts in thinking occur. Various documents and information are produced by this movement until the search feels satisfactory. A number of search techniques may be used to get to this point. Using a MMR approach may mean that this type of approach to literature searching becomes one which is acknowledged more frequently.

Undertaking both types of research

This has also been very challenging, and I am aware that the amount of statistical analysis in this thesis is very limited. This is due to the type and amount of data but it has been a juggling act at times to switch from one type of data analysis to another. When mixed method academics write about MMR projects they frequently refer to the use of a team with different skills who will, individually, take responsibility for the different analyses. The team comes together to make comments on the overall findings.

While this approach is possible for teams undertaking research it is less helpful in the case of the sole researcher, as in a PhD. These teams may have disadvantages in truly integrating their studies; it must be more difficult to integrate analysis, findings and discussions when different people with different world views undertake those parts of a single study separately. It is possible that sole researchers may make a contribution to the furthering of MMR presentation because they are in close contact with both types of data continuously.

In conclusion the value of a mixed methods research approach was evident both in what that approach brought to the study, and in what the study brings to the approach. In exploring the challenges of integration and balance within the study the modelling of a ‘context of stability’ provided a way to visualize the various aspects of the study. MMR also offers the opportunity to provide a platform on which both 1st and 3rd person perspectives can be placed – an exciting possibility for bringing together differing viewpoints on the same phenomena.

Summary of Chapter 5a

In summary, using a MMR approach ensured that the research was bedded firmly with a focus on daily life and the realities that encompasses. It brought the richness of both science and humanities and gave voice to different perspectives. It generated theory related to developments in pain management strategies as well as theory in relation to the development of MMR. In particular the 'context of stability' can provide a visual way to 'see' the various parts of a research project. But these additions are not without challenges which have themselves been part of the development of the study.

Chapter 6 – Conclusions

Introduction

Managing chronic low back pain (CLBP) continues to be a challenge for the person with pain themselves, their family and friends and healthcare professionals (HCPs). The publication earlier this year of the NICE (2009) guidelines and the animated discussion that followed in the rapid responses section of the BMJ during June 2009 shows how much of a challenge the whole area of low back pain is for HCPs. Further guidelines were also published from the American Pain Society (Chou et al., 2009) this year. These, and other publications referred to in Chapter 1, review a wide range of treatment options with variable levels of evidence for effectiveness. This wide range of possible treatments indicates the complex nature of the problem. Even within the non-invasive and non-pharmacological treatments there is a vast range of options. Psychological treatment has, for a number of years, been based on cognitive behavioural therapy (CBT) but recently this has widened to include treatments such as mindfulness meditation (MM) in a move towards contextual CBT.

Focusing is a skill identified from the field of client-centred psychology (Gendlin, 1978/2007) which enables people to develop a relationship with how they sense or feel about something. It encourages people to listen to their own body and develop an ability to find the body's felt sense about things. It is known as 'experiential' because of this emphasis on experiencing. Not widely known in the UK it can be learned face-to-face or by telephone. There are a few, mainly anecdotal, reports about its effectiveness in dealing with physical symptoms. This study set out to see if there were any changes in the meaning ascribed to CLBP or to measures of pain and quality of life when using Focusing when living with CLBP. A central part of the study was a desire to understand how, if changes were noted, the processes of pain and Focusing inter-related. What was happening, and how?

A review of the literature on living with CLBP (see Chapter 1 for details) identified various meanings that people ascribe to their pain. Physical meanings included the disruption of normal activities of life such as walking, sitting and

performing household and parenting tasks. There are also reports of being tired, having reduced energy and interrupted sleep. A diagnosis for this physical pain was also sought by people with CLBP, although frustratingly frequently no definitive diagnosis is given. The psychological meanings ascribed to CLBP include seeing the painful body as different from the ‘real’ person. This is related to the loss of identity reported. Loss of hope may lead to anger and frustration at themselves, the pain and the situation. Many people struggle to accept their pain and the impact it has on their lives. Socially many people with pain feel that no-one understands them, both lay and professionals. CLBP can lead to unemployment, financial difficulties, lowered self-esteem and a withdrawal from others.

This forms the background for the present study. Four people who reported CLBP for more than 12 months took part in this mixed methods study. Two were completely new to Focusing and two were Focusing practitioners who had never used it with their CLBP. They were interviewed before commencing the study, after finishing six hour-long Focusing sessions and then 3-6 months after that. They also completed a number of questionnaires related to pain scores and quality of life (QOL). The study design was that of a concurrent nested model with the quantitative data nested in the larger phenomenologically driven qualitative data.

The rest of this chapter continues to succinctly report the findings of the study in relation to the extant literature and the research questions, identify the contribution this study has made to the current knowledge about CLBP and Focusing and finally considers what further study may be appropriate.

The research questions

What are the differences ascribed to the meaning of CLBP before and after using Focusing?

The meaning of their CLBP reported by the participants in this study were similar to those found in the literature. The participants described how they lived through a veil of pain – trying to get through it day by day - and the impact it had on the things they could do. They felt it was not fair and, although they had tried

many things, nothing got rid of the pain. They all reported that the pain changed them – they were not themselves any more.

After learning and using Focusing three of the four participants reported changes in these areas. The fourth reported no changes for better or worse but, notwithstanding that, said he was pleased he had learned Focusing and felt he had gained from it. The changes noted were still present at the follow-up interviews, indicating that, for these participants, Focusing provided a skill which was sustained. The meanings post-Focusing which were markedly different to those at the beginning are:

The pain no longer controls what I do. The participants reported an increase in the amount of physical activity they undertook, including walking, gardening, swimming and cycling. Household tasks became less troublesome – one participant being able to stop using paid help for hoovering and other housework. Caring for grandchildren was easier and there was a change in the sense of control that the participants had. One participant described this saying that she used to feel she should stand upright, now she felt she wanted to. Another said how, following Focusing, she had been able to take control of her pain and the issues surrounding it. This is very different from the literature and pre-Focusing position where the pain was controlling the activities undertaken.

I feel more myself and able to value myself. Both the literature and the pre-Focusing findings showed how people with CLBP feel they are not themselves; the pain has changed them. Their self-esteem can be low as they do not value themselves and what they can do. In this study the findings post-Focusing showed real changes. One participant said she felt less aged and distressed by her pain, another that she felt more like herself. The literature suggests that people lose their self-identity with CLBP; this study suggests that Focusing with it may enable them to find themselves again. These movements lead to an ability to value one's self – something also noted by a participant following the Focusing sessions in the study.

Focusing gives me a supported place to talk about my pain. There is evidence in the literature that people with CLBP feel constrained in talking about it to friends, family and HCPs, feeling that they may be disbelieved. Taking time to Focus with a companion legitimised talking, feeling and thinking about their pain without the necessity for the appropriate ‘social’ response.

These three areas of changed meanings stem directly from the findings in this study. They point towards areas in the management of chronic pain which are currently receiving attention. The literature shows that Acceptance and Commitment Therapy (ACT) is having an impact on approaches to the psychological input in pain management. In particular mindfulness meditation (MM) is being used with some promising results (as noted in Chapters 1 and 5). In considering the processes by which Focusing works, and the philosophy which underlies it, there is a suggestion in this study that the changes noted above may be due to achieving a greater sense of acceptance. Certainly the participants reported that they noticed changes in their attitude towards their pain. A key process in Focusing is that it enables a carrying forward by using the body-based felt sense to enable meaning-making. By listening to their bodies, and how their bodies felt about the pain (‘like a tortoise’, ‘angry’, ‘like a handicapped child’), a felt meaning and a shift occurs. This shift enables a forward movement in the person, and it is this movement, it is suggested, which is related to what is called acceptance. This is a different process to that found in MM but, this study suggests, may lead to similar outcomes. However it must be remembered that this is an exploratory study and these are tentative suggestions.

Secondly the way that language is used in Focusing and in describing pain was explored. This had a number of points of contact with other areas in the management of pain. It linked with the current neuromatrix theory of pain, setting a challenge to think beyond the commonly-held patterns and enabling people to use a more-than-descriptive approach to talking about their pain. People with pain frequently find it difficult to describe their pain and the participants found that Focusing opened up descriptions which went beyond the usual medical description. This also links with some very new work in the area of narrative medicine where it was shown (see Chapter 5) that people with

cancer pain who wrote with a high emotional content about their pain for a short time each week reported less pain than others. Although not written (although it can be) using Focusing in this study gave an opportunity for just that type of description.

In summary this study found that using Focusing with CLBP did change the meanings ascribed to the pain and that these changes could be linked with other current research in the areas of acceptance and language in pain.

Does Focusing impact on pain scores and quality of life measures?

The quantitative data in this study was limited using a $n=1$ methodology. In taking repeated measures over the duration of the study it has been possible to see the changes in individuals and it is this which is reported on here.

In the narrative data participants spoke clearly about improvements in their pain. However a less clear picture emerged from the quantitative pain score measures. The number of descriptive terms (both sensory and affective) for their pain from the short-form McGill Pain Questionnaire (SF-MPQ) reduced but the VAS (0-100 score) intensity score was much more variable. This perhaps indicates that in the qualitative data participants were speaking about their perception of the pain and the impact it had on their lives rather than its direct intensity. It appears that Focusing did not make a noticeable difference to the intensity of pain when measured by a standard pain tool. This begs the question as to whether or not intensity of pain is an appropriate measure in measuring the efficacy of strategies for managing CLBP and whether it is possible to bring together 1st and 3rd person perspectives in one measure.

The picture from the quality of life measures is different. For three participants there was a significant improvement in the global measure and the fourth participant showed no change at all. This global picture was replicated in the overall score from the WHOQOL-PainUK measure. This latter measure has various domains related to quality of life embedded within it as well as a specific pain and discomfort module. There were improvements made and sustained

across all facets of the pain and discomfort module and the physical, psychological and independence domains of the measure. The social, environment and spiritual domains were more ambivalent and mixed in results. The improvements in the areas identified link clearly with the areas outlined in the discussion on meaning above.

In summary it would seem, that for these participants, Focusing made little difference to their reports of pain, but did impact on their quality of life, both overall and in the specific physical, psychological and independence domains.

Does using a mixed methods approach add to the study?

Using a mixed methods research (MMR) approach brought challenges to the study, particularly in the areas of design, congruence and integration. It was hoped that using a MMR approach would give the research a certain utility in disseminating the information across the various disciplines involved in the management of CLBP. It also reflected the real-life clinical experience where quantitative and qualitative data is used in making treatment decisions with patients.

The concurrent nested design chosen allowed for a dominance (or theoretical driver) for one type of approach – in this study that was the qualitative phenomenological approach taken. Finding quantitative measures that had some congruence with this led to the development of an idea of a ‘context of stability’, based on Schoenberg’s musical harmonic principles. This allowed for a visual element to the weighting of various elements in the design.

This study also attempted to be fully integrated so that both methods were constantly in use during all phases of the study. The design is clearly integrated and the data was collected concurrently. The major challenges were around the analysis and the discussion. A counterpart analysis approach was taken which meant that the same variable (for example the physical meaning of the pain) was taken and seen through the lens of both the qualitative and quantitative findings. Embedding quantitative results in qualitative analysis is unusual but gives the opportunity to bring the humanities and sciences together in a new and exciting

way. It offers the possibility of integrating 1st and 3rd person perspectives and enabling a ‘conversation’ between them, rather than separating them as the paradigmatic approach tends to.

In summary using a MMR approach did bring challenges to the study, but it brought opportunities to explore different ways of writing and presenting findings. Finally I hope it captured the real-life experiences of the participants in a way that speaks to the real-life experiences of HCPs.

The contributions this study makes

This is the first research study to consider Focusing and chronic low back pain, and specifically the processes by which Focusing impacts on CLBP. It has identified links between these processes and current understanding in pain management, particularly in the area of the acceptance of pain. A further exciting discovery was the way in which Focusing enabled people to describe their pain in new and meaningful ways.

This study shows that three quarters of the participants in the study found Focusing with their CLBP to be useful, both in changing the meaning they ascribed to their pain, and to their quality of life scores. It suggests that these changes may be due to the way the processes of Focusing interact with those processes surrounding the manner in which people live with pain. There may also be links with the use of language and narrative medicine.

The literature review in Chapter 1 detailed the paucity of research around Focusing and pain and this study makes a large contribution to what is now known.

In relation to the theories of pain and models of pain management this study has suggested where links may be made with Focusing and current pain theories. It suggests that Focusing may provide a different way of moving through the various stages of the CBT model, encouraging the person to engage in their bodily feeling in response to the pain situation rather than moving directly to a cognitive response. Using the experiential approach enables a meaning-making, a

movement from the implicit to the explicit in a non-judgemental way. This is unlike CBT where the person is encouraged to make judgements about their thoughts and challenge them. Based on the neuromatrix theory of pain it is suggested that Focusing may affect the perception of pain by altering the input to the brain from cognitive and emotion-related brain areas. It was also tentatively suggested that, in relation to new and developing theories of chronic pain, Focusing may enable a means of extinguishing the memory of pain laid down in the brain thus providing a tangible interface between 1st and 3rd person science.

The participants in the study who were new to Focusing found it to be an acceptable intervention, interesting (even when not perceived as directly useful), and to have no negative side-effects. This is a factor to be considered when considering potential interventions. Those who had used Focusing previously were surprised by its efficacy when used with CLBP.

This study contributes to the current UK government initiatives (DH, 2007) which support people with long-term conditions in the area of self-management. It shows that for the participants (whose long-term condition is that of chronic low back pain) it provided a useful self-help intervention and it is possible that, within the framework of the long-term condition collaboratives, Focusing circles may be considered as part of the support networks.

It is of note that the pain intensity scores did not reflect the narrative data in the study. The Care Quality Commission (CQC, 2009) is a government initiative which takes an interest in the use of metrics in healthcare and there is a growing requirement to use metrics to measure outcomes in both primary and secondary care. The observation from this study makes it clear that the choice of the pain score measure in this study, which is validated and used in other research, may not measure outcomes which are important for people with CLBP.

In the area of research methodology this study has suggested a novel way of considering balance within mixed methods research, using a 'context of stability' model based on harmonic theory. The study also foregrounded issues of integration in the design, analysis and presentation of findings in MMR.

Areas where further study may be appropriate.

Further study is required to see if these results can be replicated in a wider cohort of people with CLBP before any further conclusions can be made. The results from this study would be useful in guiding the type of measures that would be appropriate, perhaps including a validated measure for acceptance of pain. Bearing in mind the current self-help initiatives it would be interesting to perform a study in collaboration with a community-based support group and compare the findings with those from a specialist pain management group.

There is a growing literature using functional magnetic imaging studies with psychological interventions. Alongside the recently published studies in mindfulness meditation it would be interesting to see if imaging studies on the brain whilst Focusing with CLBP produced similar results and might therefore provide similar acceptability.

In the long-term it may be that Focusing would be suitable for other types of pain, chronic and acute, but this is yet to be established.

This study suggested that the relationship between perception of CLBP and acceptance would be an area for further research.

There is also an indication from this study that the perception of pain, and changes to that, is not recognised by a currently acceptable pain measurement tool. A further area for study would be to explore further whether or not these pain score measures do measure what patients really experience.

Finally, in the context of MMR, it would be useful to consider other applications for the 'context of stability' model.

Summary of Chapter 6

This chapter has brought together, concisely, the major findings of this innovative study, the first to consider the value of using Focusing in the

management of chronic low back pain. It has shown that Focusing enables changes to the meaning of CLBP for individuals and that there are tangible improvements to quality of life scores. The interaction of the processes of Focusing and CLBP have been briefly described and the contributions of this study to the wider political healthcare arena have been suggested. The contribution to the development of mixed methods research is also acknowledged. Finally suggestions for further study have been made.

Epilogue

This thesis began with an imagined Focusing diary entry. During the time of this study I learned to use Focusing and, at times, used it to get a sense of how the study was progressing. The following is an excerpt from my notes, when I was considering the data I was finding in online blogs, the conversations I had been having with people who used Focusing (and had occasionally used it for pain) and the data I was collecting.

Just re-read Merleau Ponty's primacy of perception lecture which left me with the final thought that 'to perceive is to render oneself present to something through the body'. I've been aware of a slight discomfit around Focusing and pain so I thought I'd try and see what happened if I mixed M-P and Focusing.

So... how am I present to my understanding of Focusing and pain?

The first thing I am aware of is a worry, felt in the left side of my chest. Worry isn't right, it is a greyness with an edge of panic. It wants to run away, but it can't, it's trapped in a grey, suffocating cloud.

And the edge of panic becomes fearful... why this perception of panic, fear and suffocation when I try see how I am present to that understanding?

Let me try some other concepts with this fear ...

Is it fear of getting it wrong?

- maybe a little but not much. The panicky part is still the same

Is it fear of getting it right?

- don't think so, No change to the fearful part, but a small joy or excitement moved lower down.

Is it fear of exposing people to ridicule?

- well, that made it really jumpy. I could feel my heart start to thump - and when I asked about exposing me to

ridicule it really didn't like that. Yes - the word fear-of-ridicule fits but it doesn't take away the feeling. In fact it seems to be becoming more intense and constricting.

Thinking about how to address the ridicule quietened the feeling and when I asked if it wanted to be brought to supervision it seemed content.

So, here it is. My intellect tells me I have lost the plot but maybe it is something I need to think about further.

This Focusing session enabled me to really consider the way I would present the data in the study so that it made sense to the part of me that was the western-trained healthcare professional who dealt with things that had substance, not body-feelings and meaning-making. Throughout the study I was aware of this tension, of finding something exciting and new but which fell outside my usual experience. I was quite surprised to find that the word that fitted this particular time was 'ridicule' – a very strong and emotive word. Ridicule of both myself and the participants. It made me think about the protective role I had ethically towards the participants and that in the presentation of the data I had to ensure that I was true to it, but careful in the discussion of it. It was salutary to discover I was worried about being ridiculed myself - a recognition that I was researching an intervention that would struggle to find a place in my clinical world, albeit one in which I was discovering links to what was already acceptable there.

Reaching the end of the journey I can now reflect on a deep gratefulness for the exposure to Focusing, to learning about its strengths, not just in relation to pain, but as a life skill. However there remains a part of me which remains sceptical, and perhaps is faintly concerned about the possibility of ridicule in mainstream healthcare. But Focusing has given me a way of recognising and finding ways of dealing with that.

So I finish this study with feelings both of completeness and incompleteness, not knowing how Focusing will impact in my clinical life but with an expectation that it will.

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Appendix A – LREC approval

The front page of the letter of approval.

	
05 December 2007	National Research Ethics Service Dorset Research Ethics Committee (REC)
	<small>Poole Hospital NHS Trust D Block (Eddie Hawker Wing), Room 2D Longfleet Road Poole, Dorset BH15 2JB</small>
Ms Ruth Day Doctoral Student Bournemouth University 2nd Floor, Royal London House Christchurch Road Bournemouth BH1 3LT	<small>Tel: 01202 442 737 Fax: 01202 442 954 Email: caroline.hemsley@poole.nhs.uk</small>
Dear Ms Day	
Full title of study:	Does Focusing impact on the meaning of chronic low back pain? A mixed methods study
REC reference number:	07/H0201/114
Thank you for your undated letter responding to the Committee's request for further information on the above research [and submitting revised documentation].	
The further information was considered at the meeting of the Committee held on 29 November 2007. A list of the members who were present at the meeting is attached.	
Confirmation of ethics! opinion	
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised].	
The Committee pointed out that it would be advisable to put a sentence in the Participant Information Sheet stating that "The Study has been reviewed by the Dorset Research Ethics Committee".	
Ethical review of research sites	
The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.	
Conditions of approval	
The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.	
<small>An advisory committee to South West Strategic Health Authority</small>	

Appendix B – information sheet for study

Do I get paid?

There is no financial benefit for taking part. However, up to £5 per session is available to help cover any travel expenses if needed.

What are the possible benefits of taking part?

You will learn how to use Focusing – a self-help technique which some people have found useful. The information that you give me during the study will improve our understanding of the meanings of chronic low back pain, and whether these meanings can change.

I'd like to take part, what happens now?

Thank you. If you have any questions give me a ring. Then please sign and return the consent form. I'll contact you to arrange dates for the interview and Focusing sessions.

Information about the research



Does Focusing impact on the meaning of chronic low back pain? A mixed methods study.

I would like to invite you to take part in a research study. Before you decide whether or not to be involved it is important that you understand why the research is being done and what it will involve. Please take time to read this leaflet carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear, or if you would like more information.

<p>Ruth Day School of Health and Social Care Royal London House Christchurch Road Bournemouth BH1 3LT</p>	<p>dayr@bournemouth.ac.uk 07970 866325</p>
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The study has been reviewed by the Dorset Research Ethics Committee

What is Focusing?

Focusing gently enables people to develop a sense in their body about situations, problems or issues. When people make contact with these subtle and sometimes vague inner feelings, they can become aware of the meaning associated with them. Focusing can help you change, enabling you to become more friendly towards what is happening in your body. It is difficult to describe in a few words, you can find out more about it on www.innerrelationship.com or by asking me.

Once you have learned how to Focus you can do it on your own, with a partner or as part of a group. It hasn't yet been studied and used for people with chronic pain in the UK. There is no evidence that it has any harmful effects.

A typical Focusing session lasts between 30 – 60 minutes. It is a quiet process and you will take a little time at the beginning of each session to relax and gently start to become aware of the sensations in your body. The Focusing practitioner will help you to describe and explore these subtle feelings in a reflective way.

What is the purpose of this study?

We know that people with chronic low back pain feel their pain means different things to them. To some it means a sadness or loss over things they can't do now, others feel it will go on for ever, and for some it has meant a change in relationships with family and friends.

I am interested in studying how people with chronic low back pain use Focusing and their experiences of it.

Who may be involved?

Anyone who has chronic low back pain, and has had it for over 12 months. I am looking for 6 people who would like to take part. I will, of course, let you know if you are interested but the places are already taken.

What will I have to do if I take part?

The research will take place over 12 months. At the beginning you will be interviewed by me (in the place where the Focusing sessions will take place) and asked to fill in some questionnaires. The interview will be recorded and last about an hour. The questionnaires are about your pain and quality of life; they take about 40 minutes to complete.

Then I will arrange for you to have six one-to-one Focusing sessions on a weekly basis with an experienced Focusing practitioner. These will probably be on a Thursday or Friday. They are also recorded. During this time there will be a short diary to fill in each week which will take 5–10 minutes to complete. During your first session you will be given a manual on Focusing and after the third session there will be the opportunity to practice using Focusing over the phone with me. These calls may last up to 40 minutes and are not recorded as they are a time for you to practice what you are learning.

At the end of the six sessions there will be a further interview and you will be asked to re-do the questionnaires. Over the rest of the year you can use Focusing as you like. After 12 months I will phone you to make a date to re-interview you and ask you to complete the questionnaires for a final time.

Is this all confidential?

Yes. All information collected about you will be kept strictly confidential. The recordings will be typed up and analysed by me. Your name will be changed on the documents to ensure you can't be identified, the information will be kept safely in a locked cabinet and the computers password-protected. The data will not be passed to anyone else without asking you first.

When the study is finished it will be presented as a thesis for my PhD. Any quotes will be anonymous. I also hope it will be published and presented at conferences. You are welcome to have a copy of any paper written.

What if I change my mind or have a complaint?

You are free to withdraw from the study at any time if you want to and you don't have to give any reason. It won't affect any future treatment. If you have a complaint about the research which can not be resolved then please contact my supervisor, Dr Eloise Carr (ecarr@bournemouth.ac.uk or 01202 962163).

Will it affect my current treatment?

Focusing is not a specific treatment for back pain and you should continue with whatever treatment you are currently having. It doesn't matter if your treatment changes over the time of the study. I will ask your permission to let your GP know that you are involved in this research.

Please turn over

Appendix C – weekly participant diary

PARTICIPANT DIARY



Thank you for taking time to fill in this diary each week. There are two short questionnaires. It should only take a few minutes to do. Please bring it with you to your next Focusing session.

**Ruth Day
07970 866325**

Date:

Week:

Study Number:

1.

Global Visual Analogue Scale

Please place a mark on the vertical line below to indicate how you would estimate your quality of life (QOL) as a whole over the past week.

Worst
Imaginable
QOL



Perfect
QOL

2.

Short-Form McGill Pain Questionnaire

A. Please place a tick (✓) in the column that represents the degree to which you feel each type of pain.

	0	None	1	Mild	2	Moderate	3	Severe
Throbbing	0		1		2		3	
Shooting	0		1		2		3	
Stabbing	0		1		2		3	
Sharp	0		1		2		3	
Cramping	0		1		2		3	
Gnawing	0		1		2		3	
Hot-Burning	0		1		2		3	
Aching	0		1		2		3	
Heavy	0		1		2		3	
Tender	0		1		2		3	
Splitting	0		1		2		3	
Tiring-Exhausting	0		1		2		3	
Sickening	0		1		2		3	
Fearful	0		1		2		3	
Punishing-Cruel	0		1		2		3	

B. Please mark along the line to show the intensity of your pain now.

No Pain _____ Worst Possible Pain

C. Please place a tick (✓) in the column that describes your pain now.

0	No pain	
1	Mild	
2	Discomforting	
3	Distressing	
4	Horrible	
5	Excruciating	

Appendix D – participant Focusing sessions

These are found on the attached CD. Each participant has a separate file and the Focusing sessions are labelled with the participant's initial and the number of the Focusing session.

Appendix E – interview analysis

These are found on the attached CD. Each participant has a separate file and the interviews are labelled with the participant's initial and the interview (pre, post, follow-up).